HEALTH INEQUALITIES:
A PRIORITY AT A CROSSROADS

The final report to the Department of Health

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and
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2002
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LIST OF ABBREVIATIONS

ABI  Area-based initiative
CHD  Coronary heart disease
CMO  Chief Medical Officer
DETR  Department of Environment Transport and the Regions
DH  Department of Health
DPH  Director of Public Health
GP  General practitioner
HA  Health authority
HAZ  Health Action Zone
HDA  Health Development Agency
HIA  Health impact assessment
HImP  Health Improvement Programme
IMD  Index of Multiple Deprivation
LA  Local authority
LMR  Local modernisation review
LSP  Local strategic partnership
NDC  New Deal for Communities
NHSE  National Health Service Executive
NSF  National Service Framework
PCG  Primary care group
PCT  Primary care trust
PSA  Public service agreement
R&D  Research and development
RDA  Regional Development Agency
SaFF  Service and Financial Framework
SEU  Social Exclusion Unit
SMR  Standardised Mortality Ratio
SRB  Single Regeneration Budget
EXECUTIVE SUMMARY
FINDINGS
At the very start of its first term the Labour Government made reducing inequalities in health a key priority in its health strategy. The New NHS gave health authorities (HAs) lead responsibility for taking this forward at the local level. They were required to work in partnership with local authorities (LAs) and other parts of the National Health Service (NHS) to develop and implement three-year rolling strategies - Health Improvement Programmes (HImPs) - to do this. As Labour moves into its second term, it has embarked on a significant reorganisation of the NHS, outlined in Shifting the Balance of Power within the NHS. Although in many ways this is a continuation of earlier changes, in other ways it represents a major shift in the foundations of the local framework to address health inequalities. Primary Care Trusts (PCTs) now lead local efforts to tackle health inequalities; HAs have merged into 25 strategic health authorities to oversee and to performance manage the local system.

The aim of this project was to assess how HAs could make an effective contribution to tackling inequalities in health. More specifically, it aimed:

♦ to describe what health authorities are doing to tackle health inequalities;
♦ to assess what factors affect the priority given to health inequalities by health authorities and their ability to tackle them;
♦ to develop policy lessons for the NHS about how best to develop and to implement local policies to reduce health inequalities.

The underlying approach adopted for this project draws on the ideas of realistic evaluation and ‘theories of change’ to breakdown strategies to tackle health inequalities, both at the national and at the local level, into their key mechanisms and then to examine how these operate in different contexts to achieve their overall goals. Based on a review of all HImPs, surveys of all HAs and regional offices, and case studies in five places, the report begins by presenting a comprehensive snapshot of HAs’ efforts to address health inequalities at the end of the year 2000. It then goes on to examine how national policies to promote health inequalities on the local agenda have operated locally.

The significant reorganisation of the NHS that has taken place during the lifetime of this project mans that HAs – the main focus of this study – will cease to exist in their current form. Nevertheless, many of the key mechanisms employed by the Department of Health (DH) to achieve local change will continue to operate, albeit in a new organisational context. This report therefore, draws out the implications from the findings of this study for the new policy framework.

Mapping local strategies to tackle health inequalities
Many HAs had embraced the greater national priority given to reducing health inequalities and developed goals and strategies to address them. However, HAs’ definitions of health inequalities were broad and goals were often vague, if they existed at all. Few HAs had outcome targets for reducing health inequalities at the time of the survey. Clear strategies with transparent rationales, which shaped local priorities and implementation plans, were also difficult to identify. Nevertheless, nearly all HAs were engaged in significant activities to reduce health inequalities. These included:
♦ working in partnership to tackle the root causes of ill health;
♦ promoting community capacity;
♦ improving access to healthy lifestyles for communities and individuals;
♦ promoting equity of access to health and social care services;
♦ undertaking R&D to improve ways of tackling health inequalities locally.

Partnership working was a core feature of local efforts to reduce health inequalities, and HAs worked with a range of departments in their associated LAs as well as other NHS agencies and voluntary and community groups. However, PCG/Ts and NHS Trusts were perceived to give health inequalities a lower priority compared to other agencies, and this was cause for concern among respondents anticipating PCTs taking the lead in this area in the future.

In contrast to the efforts being put into addressing health inequalities, much less emphasis was currently being placed on improving equity of access to mainstream services by HAs. While some HAs were beginning to recognise and to investigate this issue, few were actively engaged in strategies to make mainstream services more equitable.

Overall, most HAs felt that they had made reasonable progress in addressing health inequalities. For many, this meant that the issue was finally on the local agenda and was receiving serious attention. The ‘next steps’ identified by many respondents were ‘more of the same’. There was still felt to be a need to gain more local commitment to tackling health inequalities. In addition, respondents felt that a framework to reduce health inequalities needed to be built into local systems, policies, plans and structures in a more systematic and meaningful way.

The survey of regional offices suggested that they were not systematically supporting or performance managing HAs in relation to their efforts to reduce health inequalities, although there were a number of innovative initiatives taking place. HAs expressed considerable frustration at this lack of support. It is clear that strategic health authorities will need to provide support and to performance manage PCTs more effectively, than regional offices were able to do for HAs, in the future.

**Mechanisms to get health inequalities on to the local agenda**

Drawing on a review of a broad range of policy documents, the report develops a framework of mechanisms that the DH has established to put health inequalities on the local agenda, which can be divided into four broad areas:

♦ making health inequalities a priority for the NHS;
♦ restructing the NHS to give key organisations - HAs and primary care groups (PCGs) - responsibility for tackling health inequalities;
♦ requiring health organisations to work in partnership with other agencies and the community to develop HImPs;
♦ strengthening a number of underlying foundations to enable and to require local agencies to tackle health inequalities, including: public health; performance management systems; funding; and, the evidence base.

The priority given to tackling inequalities in health and the foundations on which to do so, such as partnership working and community development, were seen to have
increased tremendously under Labour. This was greeted with considerable enthusiasm by key local actors. However, tackling health inequalities was seen very much as a second order priority to Government ‘must dos’, such as waiting times. In addition, there was a general perception that the Government’s commitment to tackle health inequalities had waned with the publication of The NHS Plan. Many local agencies struggled to deliver on the overwhelming range of targets that they had been given. As a result they felt that they had little capacity to address issues that in some respects were seen as ‘luxury’ items on the agenda.

Moreover, it was often felt that being a national priority was a necessary but not sufficient condition to get health inequalities on the agenda locally. It also needed powerful local champions to ensure it was taken up by partnerships in a significant way. For example, a key factor in PCTs’ attention to health inequalities appeared to be the level of interest of the chair or chief executive. While the importance of champions was acknowledged, many felt that this priority should not be left to the interests of individuals, but institutionalised to ensure that health inequalities received the attention it deserved.

At the time of this study, health authorities were beginning to see the potential of their role in addressing health inequalities. Many HAs had been deeply embedded in supporting PCG/Ts to establish themselves. Only now, as PCG/Ts were taking on much of the commissioning processes, were HAs beginning to be able to exploit the space this created to focus on health inequalities. Alongside working with PCGs, HAs have spent considerable time developing partnership relationships and setting up their HIMP processes. Again, these efforts were beginning to bear fruit as the relationships and processes bedded in and matured.

Primary care organisations were still developing their structures and struggling to come to terms with the overwhelming agendas that they faced. Health inequalities were not seen a priority in this. HAs often recognised this gap in their thinking, and many saw that their key role over the next year would be to try ensure that PCG/Ts engaged in the health inequalities agenda more effectively.

People were concerned about whether PCTs were the right agencies to lead on tackling health inequalities or if they had the necessary skills for effective partnership working. There was also significant concern about what was the appropriate scale to take strategic lead for addressing inequalities. Some people felt that the locality level was the most appropriate as at this level agencies could really focus on meeting the needs of particular communities. Others were concerned that such a focus might create inequalities between different localities. Moreover, addressing health inequalities often required structural changes and therefore a more strategic approach was needed. People only appeared enthusiastic for PCTs to lead on this agenda in the future if individual PCT leaders were committed to reducing health inequalities and if PCTs were coterminous with LAs.

Collaboration with other statutory agencies, the voluntary sector and communities was seen as crucial to local efforts to address health inequalities. The Government also requires local areas to involve communities in the governance and the planning of their services. There is a recognition, both nationally and locally, that this often requires efforts to build community capacity first.
Processes to establish better partnership working for health, particularly through the HImP, and to engage with local voluntary and community groups, were all felt to have improved under the Labour Government. However, there were still a number of problems that needed to be addressed. In relation to partnership working between agencies, other partners such as LAs and acute trusts were not always actively engaged in efforts to address health inequalities, as they were required to address their own ‘must dos’ first. Other concerns relating to partnership relationships included: difficulties working across geographic boundaries and with two-tier councils, and problematic partnerships at a strategic or senior level that inhibited effective relations on the ground.

The breadth of Government initiatives to address issues of social exclusion and hence reduce health inequalities was very much welcomed. However, people felt overwhelmed by the number of policies and partnership activities that they needed to address. Individuals and organisation not only felt overloaded, but that many of these initiatives were misaligned. Better joined up government at the centre and a rationalisation of local partnership initiatives is required. While some people were hopeful that local strategic partnerships (LSPs) would achieve this, others were concerned that it would be another layer of partnerships without ensuring more integrated working at the local level.

The HImP was generally felt to have been helpful in promoting health inequalities on the local agenda and improving some aspects of partnership working and community involvement. However, it was unclear what the boundaries of the HImP should be or how health inequalities should be built into them. In the future PCTs will be responsible for leading on the development of health improvement and modernisation plans, drawing on the local modernisation reviews (LMRs). However, although reducing health inequalities is included in one section of the LMR and it is not systematically built into other policy areas. This needs to be done.

Efforts to promote community involvement were being developed, although these were generally felt to have been of only limited success so far. Increasingly local areas were recognising the need to build community capacity to enable more effective involvement, as well as to promote health. While there was felt to be some recognition of this at the local level, mainstream services were still only providing limited funding. Both community development projects and the voluntary sector were heavily reliant on short-term funding, which had a number of problems. Local people were hopefully that the Compact, LSPs and community planning process would all enhance the status of community development and the voluntary sector and provide more effective ways of engaging with the community to promote health in the future.

Public health in its broadest sense was seen as a crucial mechanism in local efforts to address health inequalities. In many ways people did feel that the Government had advocated a broader perspective on public health, as well as developed policies to strengthen the public health function and evidence base. However, there was a strong concern about the possible fragmentation of public health and, despite local innovation, there was a sense that public health was not receiving the investment or support it needed. In particular, non-medical public health and health promotion staff often felt unvalued and unsupported. In addition, efforts to broaden the public health role of community nurses had, in most of the case study areas, been inhibited by workload pressures on staff.
Performance management was seen as the crucial determinant of what got implemented locally. There was a general consensus that unless reducing health inequalities became a core part of local agencies’ performance assessment, it would remain a second order priority. However, there was a concern that performance management pushed agencies towards focusing on short-term targets, which did not sit easily with the long-term nature of a strategy to achieve reductions in health inequalities. Moreover, many of the activities required to address health inequalities required joint action. Until the performance review systems of different agencies were made more consistent, it was felt that effective local action would be hard to achieve. One final concern among some respondents was that the Government’s focus on disadvantaged areas of the country had not enabled relatively affluent places to galvanise local action to address pockets of deprivation. The Government’s recent assertion in response to the Health Select Committee that they expected all NHS organisations to address inequalities within their boundaries will therefore be welcomed in such places.

Additional resources are also a strong incentive for action. The availability of short-term funding for projects to address inequalities in different ways had enabled action to take place that would otherwise never been funded. Those places that had received the health inequalities adjustment had also been able to use this to address health inequalities in ways that would not have received core funding. In relation to mainstream funding, people were pleased that ‘reducing health inequalities’ was to become an allocation criterion. However, there was concern that unless funding to address health inequalities was ringfenced in some way, it would be consumed by health care imperatives.

Finally, in relation to the evidence base a concern raised was that people did not really know how best to tackle health inequalities at the local level. Very little evidence was seen to exist about how best to improve the health and access to services of the most disadvantaged groups. Moreover, there was little evidence to help them develop the crucial pathways between current local activities and long-term national goals. Respondents were keen to have access to information about good practice and to consider innovative ways of sharing such lessons. In addition, there was a desire to invest in local evaluation to understand how different initiatives affected local population groups. However, the skills and the resources to undertake these kinds of evaluations locally were seen to be lacking.

The way forward

Tackling inequalities in health is at a crucial crossroads. Looking forward, there are both encouraging and worrying dimensions to the Government’s general strategy for change in local arena. On the positive front, the national targets to address health inequalities and the consultation document on their delivery are to be welcomed. The commitment to build reducing health inequalities into performance management systems for the NHS and their existing place in the local modernisation reviews is positive. Similarly, the concept of LSPs is generally thought to be constructive, and the inclusion of health inequalities targets in New Deal for Communities and Neighbourhood Renewal areas is a good step forwards in integrating accountability mechanisms in areas where joint working is essential. However, there are no such mechanisms in other locations. Within the NHS, there is considerable concern about whether PCTs are the right agencies to lead this agenda, or if health inequalities will
find any space on their already overcrowded agendas. Shifting the Balance of Power sent out unfortunate signals in this respect, by only discussing tackling health inequalities in the appendices.

Against this background, this report examines how to enhance key mechanisms for getting health inequalities on the local agenda and for tackling them more effectively. The ‘headline’ implications are set out below. Given that one of the aims of this project was to develop policy guidance for the future, the draft version of this report was submitted to the consultation process on the plan for deliver for health inequalities, which asked for comments on ‘the proposed systems and processes to support this work and the ways they can be strengthened to support action to address health inequalities’ (p.29). Despite the significant changes in policy that have acted as a backcloth to this project, the findings do provide important lessons for taking forward local strategies to reduce health inequalities within this new policy context.
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PART 1

INTRODUCTION
INTRODUCTION

At the very start of its first term the Labour Government made reducing inequalities in health a key priority in its health strategy. The New NHS (Cm 3807, 1997) gave health authorities (HAs) lead responsibility for taking this forward at the local level. They were required to work in partnership with local authorities (LAs) and other parts of the National Health Service (NHS) to develop and implement three-year rolling strategies – Health Improvement Programmes (HImPs) – to do this. Saving Lives, the Government’s Public Health White Paper, made it clear that HImPs were the key vehicle for addressing health inequalities. They would not only describe how local agencies would meet national targets but also:

set out a range of locally determined priorities and targets... with a particular emphasis on addressing areas of major health inequalities in local communities ... Taken together, the Health Improvement Programmes across the country, combined with the Government’s role ... will form a concerted national programme to improve health and tackle health inequalities (Cm 4386, 1999, p.40).

This report describes the findings from a study funded under the Department of Health’s (DH) health inequalities research initiative, which examined how health authorities, through their HImPs, have begun to tackle health inequalities and what lessons can be learnt from their experiences for the future.

As Labour moves into its second term of office it has embarked on a significant reorganisation of the NHS – outlined in Shifting the Balance of Power within the NHS (DH, 2001a). Although in many ways this is a continuation of earlier changes and builds on existing policies, in other ways it represents a significant shift in the foundations of the local framework to address health inequalities. Primary Care Trusts (PCTs) will now lead local efforts to tackle health inequalities, HAs will merge into 25 strategic health authorities to oversee and to performance manage the local system and the current NHS Executive regional offices will be abolished with most of their functions being devolved to strategic health authorities. However, while the specific agencies that have been the focus of this study will not continue in their current form beyond April 2002, their roles in relation to reducing health inequalities will be taken on by other agencies. The findings from this study, therefore, do provide important lessons for taking forward local strategies to reduce health inequalities within this new policy framework.

Before describing these findings, this section begins by setting out the main aims and objectives of the project and highlighting how they have been affected by the changing policy agenda. It then sets out develop a framework for the analysis drawing on an assessment of the key mechanisms that the DH established to facilitate and to support local action to address health inequalities. Next, it briefly describes the broad methods employed. Finally, it explains the structure of the remainder of the report.

AIMS

The project’s central aim was to assess how HAs could make an effective contribution to tackling inequalities in health. To achieve this, it has examined what HAs have done to reduce inequalities in health, why they have done it, and how they could do it more effectively in the future. In particular it had three distinct objectives:
♦ to describe what health authorities are doing to tackle health inequalities;
♦ to identify inhibiting and enhancing factors in getting health inequalities on the local agenda and how to tackle them effectively.
♦ to develop policy lessons for the NHS about how best to develop and implement local policies to reduce health inequalities.

During the lifetime of this project there have been significant policy developments relating to both the context of local strategies to tackle health inequalities and the role of the HA. Towards the end of the fieldwork, whilst interviews were still being carried out in our case study sites, the Secretary of State for Health (Milburn, 2001a) set out the Shifting the Balance of Power agenda, including the merger of all HAs into 25 - 30 strategic authorities. This did affect the perspective of informants, but perhaps more importantly, it now means that the original aims of the project - to inform the future role of HAs - are less directly relevant. However, the findings do still point to key areas of policy development that are required if the new organisations are to build on the efforts of current HAs and regional offices to advance local efforts to reduce health inequalities.

Ways of responding to the rapidly changing policy have been sought throughout this project in order to make the analysis and the findings as useful as possible for future policy developments. In this spirit every effort has been made to shape the discussion of the implications of the findings for future policy development to tackle health inequalities around the emerging scenario. It should be borne in mind, however, that this future policy framework intention was not clear while the data were being gathered.

A draft report was produced in November 2001 and submitted to the DH R&D Office as well as the Department of Health’s (DH) consultation process on tackling health inequalities. This final report has been revised in the light of referees’ comments. However, given all of the policy changes that have taken place in the life of this study, see below, we have not updated it from the policy position that existed in November 2001 - the end of the consultation period for the strategy to address health inequalities - as this seems the most appropriate point at which to draw the line.

Research questions

The original proposal contained five broad research questions.

♦ What priority have health authorities attached to reducing inequalities in health in their decision making?
♦ What factors have influenced the priority given to inequalities in health within HAs?
♦ What sorts of contributions have HAs made to reducing inequalities in health?
♦ How are HAs developing their new lead responsibility to tackle inequalities in health?
♦ What are the opportunities and constraints that might influence the capacity of health authorities to develop better approaches to reducing health inequalities in the future?
Given the policy developments that have taken place, the focus of these questions has been broadened from being solely about HAs, to considering the range of agencies that they have worked with to deliver local health improvement. In this way the findings will be of use for the health improvement agendas of strategic health authorities, PCTs and local strategic partnerships (LSPs).

FRAMEWORK FOR THE ANALYSIS

The description, analysis and evaluation of HAs’ approaches to tackle health inequalities is complex because they have long-term goals that: are difficult to measure; include multifaceted interventions and processes; involve a wide range of actors; and, operate within changing social, policy and political contexts. To guide and to shape this project, we have drawn on a number of different approaches to evaluation that aim to link the interventions and processes that are adopted with the context in which they are operating and their long term goals.

The most well known articulation of this approach in Britain is the work by Pawson and Tilley (1997), known as Realistic Evaluation. Their approach can be summarised in a simple formula:

\[
\text{Context (C) + Mechanism (M) = Outcomes (O)}
\]

A programme introduces a range of change mechanisms into existing social relationships in particular local contexts in order to achieve the desired outcomes. The purpose of the evaluation is to identify which specific CMO configurations work or do not work so that better policies can be developed in the future. Realistic evaluation was adopted as the framework for the national evaluation of total purchasing pilots in this final year (Evans et al., 2001). They suggest that their evaluation would have benefited from adopting this approach from the outset, and that ‘it is potentially applicable to a wide range of future evaluations of complex policy’ and hence ‘its utility should at least be considered in planning such evaluations’ (p. 237). In contrast a recent evaluation of the health improvement role of primary care organisations (Abbott et al., 2001) rejected this approach as they felt that the concepts of ‘mechanisms’ and ‘outcomes’ were too narrow for the complex interactive processes that are required to bring about health improvement. While we would agree that health improvement requires a complex interaction of process, we feel that the realistic evaluation approach is broad enough to encompass this complexity.

A similar approach to evaluation has been developed in North America, based on work by Weiss and colleagues known as ‘theories of change’ (Connell et al., 1995). This ‘theory of change’ approach is defined as ‘a systematic and cumulative study of the links between activities, outcomes and contexts of the initiative’ (Connell and Kubisch, 1998, p.35). The approach aims to gain clarity around the overall vision or theory of change of the initiative, meaning the long-term outcomes and the strategies that are intended to produce them. In generating this theory, steps are taken to explicitly link the original problem or context in which the programme began with the activities planned to address the problem and the medium and longer-term outcomes intended. This framework has much in common with the CMO configurations of realistic evaluation.

Many of the examples of evaluations that have been conducted using these approaches have been of specific interventions. However, the national evaluation of Health Action Zones in Britain has drawn these two approaches together to evaluate
HAZs at the overarching strategic level of the community health improvement process (Judge et al., 1999). This approach is illustrated in the figure below. The starting point is to agree strategic goals taking into account the context within which initiatives operate – the resources available in the communities and the challenges that they face. The next step is to specify a rationale for intervening in relation to priority issues. This strategy should be translatable into clearly defined change mechanisms – purposeful investments in activities, interventions and processes. The challenge is to then specify targets for each of these investments that satisfy two requirements. First, they should be articulated in advance as the expected consequences of actions. Secondly, these actions and their associated milestones or targets should form part of a logical pathway that leads in the direction of strategic goals or outcomes.

The project reported here is only exploring HAs’ strategies to address health inequalities at one point in time, to develop a better understanding of their approaches, rather than evaluating them over time to assess if they achieve their goals. Nevertheless, this broad approach – of examining the link between context, mechanism and outcomes – is a useful framework to follow. This has been done in a number of ways.

First, in our efforts to map and to understand HAs’ strategies to tackle health inequalities, the component parts of their community health improvement process have been identified through the review of HImPs, the survey of HAs and in the case study interviews. Secondly, the factors that have enabled or inhibited HAs putting health inequalities on the local agenda, in particular key policy mechanisms established by the DH, have been explored. The starting point, therefore, is the nationally set CMO or ‘theories of change’ to promote local efforts to address health inequalities. Using national policy documents, we have identified the mechanisms that the DH has introduced to enable local HAs to put health inequalities on the agenda and to tackle them. In our case studies we examine how these mechanisms have played out in reality. Obviously, a key issue in this is how these mechanisms operated in each local context. Did the DH’s ‘theories of change’ about how to change the local

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**Figure 1 Community Health Improvement Process**

<table>
<thead>
<tr>
<th>Context</th>
<th>Strategy</th>
<th>‘Change’ Mechanism</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Resources and Challenges</td>
<td>Rationale for Intervention</td>
<td>Purposeful investment in activities, intervention and processes</td>
<td>Negotiation of Prospectively Specified Expected Consequences yield practical milestones</td>
</tr>
</tbody>
</table>

Strategic Goals

Source: Judge et al., 1999
agenda with respect to health inequalities achieve their goal? We begin, therefore, by identifying the mechanisms that the DH introduced to put health inequalities on the local agenda.

Policy framework for local action to tackle health inequalities

When Labour took office in May 1997, it asserted its determination to make tackling inequalities in health a ‘key part’ of its health strategy. Given the general policy context, the DH introduced a number of mechanisms – both ‘sticks’ and ‘carrots’ - through a multitude of policy documents in the following months and years, to achieve this broad goal. Appendix 1 briefly highlights these. Cumulatively, these provided the framework for local action to tackle health inequalities at the time of this study. This framework is therefore outlined below and used to organise the analysis of the material from the case study areas. However, the Shifting the Balance of Power agenda has significantly changed the future configuration of local health organisations, and it is in this context that the policy lessons from this study need to be developed. This new framework is therefore described in Part 4 to provide the context for the discussion of the policy implications of this study.

Getting health inequalities on the local agenda

Successive policies and summaries of Government action to tackle health inequalities emphasise the range of broad social policies that the Government has adopted that will reduce the health divide (e.g. DH 1999a; DH 2001b;c). Beyond that, however, the Government has made it clear that ‘the overall aim of [health policy is] to develop a coherent strategy for public health ... a key part of this will be tackling inequalities in health’ (NHSE, 1997). Box 1.1 sets out the approach they introduced to do this within a broad ‘theories of change’ perspective and is described in more detail below.

Overall aims

Initially, the Department of Health simply articulated the Government’s goal as being to tackle or reduce inequalities in health. However, in the Green Paper Our Healthier Nation, it specified this more clearly as ‘to improve the health of the worst off in society and to narrow the health gap’ (Cm 3852, 1998). This was again refined in The NHS Plan (Cm 4818-I, 2000) as part of the Department of Health’s Public Service Agreement (PSA) with the Treasury. In this, the aim is articulated as being: ‘to narrow the health gap in childhood and throughout life between socio-economic groups and between the most deprived areas and the rest of the country’. This aim was translated into two specific national targets in February 2001, relating to reducing the gap in infant mortality between social classes, and narrowing the difference in life expectancy between health authorities (DH, 2001d).
**Box 1.1 The Department of Health’s policy framework to get health inequalities on the local agenda (Labour’s first term)**

<table>
<thead>
<tr>
<th>Context</th>
<th>Key mechanisms</th>
<th>Overall aims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before the election</td>
<td></td>
<td></td>
</tr>
<tr>
<td>♦ Health inequalities were generally ignored by the Conservative Government.</td>
<td>A. Making health inequalities a priority</td>
<td>June 1997</td>
</tr>
<tr>
<td>♦ Health for All, healthy cities, etc – meant that health inequalities were on the ‘unofficial’ agenda.</td>
<td>♦ Made health inequalities a national priority.</td>
<td>To tackle inequalities in health.</td>
</tr>
<tr>
<td>♦ There was increasing political and professional attention on health inequalities in the years preceding the election.</td>
<td>B. Restructuring the NHS</td>
<td>February 1998</td>
</tr>
<tr>
<td>♦ Health of the Nation (Cm 1986, 1992) and DH sub-report on ‘variations in health’ (DH, 1995) – emphasised approached based on changing individual behaviour, which caused antagonism with LAs.</td>
<td>♦ Gave HAs strategic responsibility to lead on tackling health inequalities.</td>
<td>Our Healthier Nation</td>
</tr>
<tr>
<td>♦ There were some local attempts to address health inequalities.</td>
<td>♦ Created PCGs to take over HAs’ commissioning role, as well as to be responsible for improving health and developing primary care for their communities.</td>
<td>‘To improve the health of the worst off in society and to narrow the health gap’ (Cm 3852, 1998).</td>
</tr>
</tbody>
</table>

| | C. Working in partnership | |
| | ♦ Placed duty of partnership on NHS and LAs to work together to promote health (associated changes to LAs e.g. duty of well-being). | July 2000 |
| | ♦ Introduced HImPs, 3-year strategy to integrate local action to promote health. | DH’s Public Service Agreement |
| | ♦ Placed emphasis on the need to involve the public and build community capacity. | ‘To narrow the health gap in childhood and throughout life between socio-economic groups and between the most deprived areas and the rest of the country’ (Cm 4818-I, 2000). |

| | D. Supporting and enabling foundations | |
| | ♦ Plan to change funding formula so that it ‘reduces avoidable health inequalities’. | February 2001 |
| | ♦ Changed the Performance Management Framework for the NHS to include equity and improving health and required local areas to set local inequalities targets. | National targets |
| | ♦ Increased recognition of public health within NHS and legitimisation of social model of health. | Precise targets specified to operationalise PSA goal (DH, 2001d). |
| | ♦ Emphasised the need for policy and action to be evidence based, and invested in research, development and dissemination to support action. | |

| | | |
| | HAZs introduced as ‘trailblazers’ in tackling health inequalities, and as a direct mechanism by making additional investments in disadvantaged places. | |

**Underlying policy agendas**

**TACKLING SOCIAL EXCLUSION**: Introduction of a large number of local area-based initiatives (ABIs) to address range of social problems.

**MODERNISING PUBLIC SERVICES**: Range of policy changes established that are transforming the context within which these mechanisms operate.
Context
There was a significant change in the policy context for tackling health inequalities when Labour took office in 1997. The previous Conservative Government’s action to tackle them had been noticeable mainly by its absence, although in their last few years in office, they did begin to take account of ‘variations in health’, at least in their health service policies (Benzeval, 1997). However, these policies received substantial criticism for putting considerable emphasis on the role of lifestyles (Fulop et al., 1998). At the same time there continued to be a stream of significant research published showing the existence of health inequalities and exploring its causes (Benzeval et al. 1995). Such evidence was increasingly used to raise the political profile of health inequalities in professional and public domains and to put pressure on the Government to address them (Benzeval, 2002).

Against this formal policy context, in the 1980s and 1990s, a number of health authorities and local authorities had become ‘healthy cities’ or adopted a ‘health for all’ approach. These World Health Organisation-initiated movements placed a strong emphasis on tackling health inequalities, took a broad view of the determinants of health and focused on a community-led response (Ashton, 1992). Other local areas were also undertaking a range of activities to address health inequalities (Benzeval, 1999).

Key mechanisms to tackle health inequalities
It is against this background that the Government introduced a range of mechanisms, set out in Box 1.1, to encourage local health agencies to address health inequalities. These can be grouped into four broad areas:

A. making health inequalities a priority for the NHS;
B. restructuring the NHS to give key organisations responsibility for tackling health inequalities;
C. requiring health organisations to work in partnership with other agencies and the community to develop HImPs to improve health and health care locally;
D. strengthening a number of underlying foundations to enable local agencies to tackle health inequalities.

Finally, underpinning these specific mechanisms, the Government has introduced much broader policy agendas both to address social exclusion, and to modernise public services. These policies interact with, and shape the specific initiatives described above. They are not described here, but are touched on in the analysis of material from the case studies as they affected the operation of the specific mechanisms to address health inequalities in these areas.

A. Making health inequalities a priority
The DH made health inequalities a national priority for the NHS. In the first year of the Labour Government, this was simply a general statement in the planning and priorities guidance that health inequalities were a key part of their strategy (NHSE, 1997). In the next year’s guidance ‘cutting health inequalities’ had its own section and a clear set of specific priorities for health authorities to include in their strategies to tackle health inequalities (DH, 1998a). Subsequent guidance has continued to include health inequalities, but within broader sections focusing on improving health, with health inequalities no longer being a headline priority e.g. (DH, 1999b). Moreover,
there is a general perception that The NHS Plan (Cm 4818-I, 2000) placed much less emphasis on reducing health inequalities than previous policy documents had done (House of Commons’ Health Committee, 2001), although the Government deny this (Cm 5242, 2001). Nevertheless, a distinction is increasingly being made between ‘must dos’ and other priorities, and reducing health inequalities falls into the second group.

B. Restructuring the NHS

Next, as already highlighted above, The New NHS White Paper (Cm 3807, 1997), began to restructure the health service and created a new role for HAs to take ‘lead responsibility for improving overall health and reducing health inequalities’. The centrality of reducing health inequalities to HAs’ new role was reiterated in subsequent policy documents (e.g. NHSE, 1999). It also established PCGs with three broad responsibilities: to improve the health of their communities and reduce health inequalities; to commission services; and, to develop primary care. HAs had to support the development of PCGs and transfer their responsibility for commissioning to them. Different stages of development for PCGs were identified, with the final transition being to a PCT, which, as well as being a free-standing agency responsible for all local commissioning, would also provide community services. The New NHS made it clear that in the medium term, as responsibilities transferred to PCG/Ts, it might make sense for some HAs to merge and to pool skills in order to achieve economies of scale in their new role. Saving Lives (Cm 4386, 1999) continued to develop and refine the health improvement roles of HAs and PCGs, but their broad thrust remained the same.

C. Working in partnership

Linked to the new responsibility for HAs to improve health was a requirement to work in partnership to do this. The New NHS placed a duty of partnership on health authorities to work with local authorities to promote health. At the same time Modern Local Government (Cm 4014, 1997) set out the LAs’ role in working with the local NHS to improve health. Subsequent legislation placed a duty on LAs to produce community strategies to improve wellbeing, which enabled them to contribute to such activities (DETR, 2001a). Alongside these partnerships for health improvement, the Government introduced a range of other partnership initiatives that involved health and local authorities, many of which have been key sources of additional funding for local efforts to address the causes of health inequalities. However, in recognition of the overlapping remit of many of these partnerships, the Government has introduced LSPs to act as an umbrella organisation to co-ordinate local efforts and to lead on the development of community strategies (DETR, 2001b; SEU, 2001).

The New NHS (Cm 3807, 1997) also introduced an obligation on HAs to produce a HImP – a three-year rolling strategy to promote the health of its population and to improve health care. Again, there was a requirement to do this in collaboration with local authorities. Saving Lives (Cm 4386, 1999) expanded on this, extending the requirement to collaborate on the HImP to other NHS agencies, and making it accessible to the public. It also set out the broad principles behind the HImP. In particular, the HImP needed to specify an ‘agreed programme of action to address ... national and local health improvement priorities’ (p. 125) with the latter placing ‘particular emphasis on addressing areas of major health inequalities’ (p.125).
Across a range of public service areas, the Government has placed increasing emphasis on the need to involve the public in governance and in service development. The New NHS required HAs to consult the public in relation to HImP developments. Saving Lives took this a stage further and argued that local agencies needed to develop the capacity of their communities as an important part of local activity to improve health and reduce health inequalities. The National Strategy for Neighbourhood Renewal (SEU, 2001) also placed great emphasis on the need to involve the community in strategy development and to build capacity in the community and in the voluntary sector, as ways of addressing disadvantage in general.

D. Supporting and enabling functions

A number of supporting mechanisms were also introduced to make health inequalities a priority and to enable HAs and PCG/Ts to work in partnership to address them.

In 1997 the Government (DH, 1997) announced its intention to make ‘reducing avoidable health inequalities’ the key mission of the overall resource allocation formula for health services in England. Although the DH is still developing an appropriate methodology for this, it was an important early signal about the central importance of reducing health inequalities to their strategy. In the meantime, the DH has provided temporary additional resources for local areas to address health inequalities. In the first year of this, (1999/2000), these funds were solely for Health Action Zones (HAZs), but the scheme has now been expanded to a ‘health inequalities adjustment’ for all health authorities designated as disadvantaged (DH, 2000a).

The Government began, in two different ways, to develop accountability mechanisms to hold local agencies to account for public health, equity and health inequality activities. As part of the reform of performance management in The New NHS White Paper, the DH introduced both a health improvement and equity of access dimension to the performance assessment framework. Subsequent policies introduced further specific targets for health improvement. For example, Saving Lives (Cm 4386, 1999) identified targets for average improvements in health and required local areas to develop local targets for reducing health inequalities.

More recently, a range of targets that aim to reduce health inequalities have been produced. In the main, these concentrate on improving health in disadvantaged areas. The aim of the first national health inequalities target (DH, 2001d), published in February 2001, is to increase the life expectancy of the most disadvantaged fifth of health authorities. Similar targets exist for New Deal for Communities (NDC) and neighbourhood renewal areas, together with an aim to reduce teenage pregnancy rates in disadvantaged areas (DETR, 2001b). Two targets have also been published that aim to reduce social class differences in relation to infant mortality (the second of two national health inequalities targets) and in relation to smoking (as part of the Cancer Plan, DH, 2000b). Finally, the Government’s response to the Health Select Committee’s Report on public health stated that indicators of health inequalities would be incorporated into the performance assessment framework for PCTs by 2002 (Cm 5242, 2001).

The Government has tried in a number of ways to raise the profile of public health within the NHS and to broaden its focus. A range of specific initiatives has been introduced to do this. Probably the most immediate and visible was the development of a Ministerial post for Public Health in the first few days of the new Government.
Next, in the Public Health Green Paper (Cm 3852, 1998), the Government set out a social model of health, which legitimised a broader perspective on the causes of ill health and hence the policies required to address them. Alongside this process, the Chief Medical Officer (CMO) began a review of the public health function to ensure that it encompassed this broad public health perspective (Calman, 1998; Donaldson, 2001). Saving Lives (p.128) acknowledged that ‘the quality of public health practice is mixed’. It set out a range of plans to strengthen it, placing particular emphasis on: the leadership role of DPHs; the need to improve the status of non-medical public health professionals; and, developing the public health role of midwives and community nurses.

The last broad mechanism the DH adopted to address health inequalities was to put in place a number of initiatives to develop the evidence base. The first and most prominent of these was to commission Sir Donald Acheson to chair an Independent Inquiry into Inequalities in Health to review the scientific evidence and ‘identify priority areas for future policy development ... to reduce health inequalities’ (Acheson, 1998). At a more structural level the Government abolished the Health Education Authority and developed the Health Development Agency (HDA) in its place. The HAD is responsible for promoting the development of an evidence base to improve health and to reduce health inequalities (Cm 4386, 1999). This has been supported by the development of a public health R&D programme (DH, 2001e) and the establishment of a public health development fund to provide finance for innovative approaches to tackling inequalities in health. Saving Lives also announced the establishment of regional public health observatories to co-ordinate local public health information and evidence.

**Health Action Zones**

Alongside these mechanisms, the Government also introduced HAZs in selected places to act as ‘trailblazers’ in tackling health inequalities and modernising local services (Dobson, 1997). The HAZ initiative encompasses all of the mechanisms outlined above. For example, they were given extra resources and required to form local partnerships and work with their communities. From this foundation, they were required to develop seven-year strategies to reduce health inequalities, based on local needs and a broad public health perspective. HAZs were held accountable for their activities through a performance management system and were required to be learning organisations and to evaluate their efforts. At the same time the Government invested in a national evaluation of HAZs (Judge et al., 1999).

**The way forward**

Given the analysis of Government policy above, we chose to focus our fieldwork on the extent to which the ten key mechanisms identified have made a difference to the local capacity to address health inequalities. In particular, we have examined how they have manifested themselves locally and what other factors have facilitated or hindered their aim to promote local action to tackle health inequalities. Given that HAZs are subject to a national evaluation, it was agreed with the DH that this project would not examine in any detail the experience of HAZs in addressing health inequalities.
METHODS

The overall aim of this project is to map the approach taken in tackling health inequalities across all HAs and to explore some HAs’ strategies in more depth in order to contribute to policy learning. Four main methods of data collection were employed:

♦ a systematic review of relevant documents, in particular the first wave HImPs;
♦ a survey of all HAs;
♦ in-depth case studies in five selected areas;
♦ telephone interviews with key players in the eight NHS Executive regional offices.

A chronology of the timing of the different phases of data collection and analysis are shown in Appendix 2. All of the qualitative material was analysed using the Framework method (Ritchie and Spencer, 1994), as described in Appendix 3. The Framework method involves the systematic sifting, charting and sorting of material according to key issues and themes, and is particularly useful when projects are conducted by more than one interviewer.

HImP review

The original proposal contained plans to review both the last year of purchasing plans (for 1998/99) and the first year of HImPs. The aim of these reviews was to identify the broad approaches adopted by health authorities to tackle health inequalities, in order to provide a general orientation to the way health inequalities were defined, identified and tackled. The 1998/99 purchasing plans were produced in autumn 1997 and did not really take on board the full extent of the policy shift in terms of the attention given to tackling health inequalities. The study has therefore not drawn on them. The analysis of HImPs was used to underpin the study, to design the questionnaire of HAs and of regional offices, and to shape the case studies. The questions explored in the review of HImPs are set out in Appendix 3.

In common with other researchers who have reviewed the HImPs (see for example Hamer, 2000; Marks and Hunter, 2000; Marks, 2001) it was noted that they varied hugely in their size and detail. Some were simply syntheses of existing strategic documents, while others attempted to develop an entirely new strategy. Some focused on simply producing an outline for the Service and Financial Frameworks (SaFFs), while others placed much more emphasis on improving health, and hence were produced in partnership with other agencies. The extent to which HAs met the requirement to consult their communities about the HImPs also varied tremendously.

In terms of their focus on reducing health inequalities some health authorities argued that everything they undertook would reduce health inequalities and hence the whole HImP was relevant. Others had specific sub-strategies, or only one geographic locality that was interested in inequalities.

Given this diversity, it did not prove possible to develop a consistent analysis of each HAs’ strategies to reduce health inequalities. Instead the HImP analysis was used to identify key dimensions of a strategy to tackle health inequalities and information on these dimensions were collected systematically through the survey. The mapping of
HAs’ strategies to reduce health inequalities is therefore mainly based on the survey findings, and only draws on the analysis of the HImPs when additional detail was required to illustrate key points.

**Survey of HAs**

The aim of the HA survey was threefold. First, to confirm the findings from the analysis of HImPs. As described above, it proved necessary to use this research as an opportunity to collect a more systematic examination of HAs’ strategies than it was possible to extract from first wave HImPs. The second aim of the survey was to acquire information on the perceptions of key protagonists about the role of HAs in this pursuit and their progress and reasons for it. Thirdly, the survey attempted to begin to explore the inhibiting and facilitating factors in HAs’ efforts to address health inequalities, in order to shape the case study design and analysis.

Drawing on the conceptual framework of the community health improvement process illustrated above and the HImP analysis, a number of general dimensions to strategies to tackle health inequalities were identified and used to structure a questionnaire for HAs. These included:

- the local history of the problem and efforts to tackle it;
- the definition of health inequalities;
- the specification of goals;
- the priority given to health inequalities, and factors behind this;
- the overall strategic approach;
- illustrative activities;
- progress to date and expectations for the future, and the key factors that were seen to influence both of these.

The questionnaire was piloted in a small number of HAs and sent to the DH for comment. After some minor changes it was distributed to all Directors of Public Health (DPHs) in England in November 2000. A rigorous follow-up process was adopted, and by March 2001 a response rate of 77 per cent had been achieved. The majority of questionnaires were completed by the directors of public health themselves (60 per cent), but a range of other individuals also filled them in. More details of the follow up process and information about respondents can be found in Appendix 4.

The quantitative data collected in the survey were coded and inputted into SPSS. Themes were identified from answers to the open questions using the framework method and categorical variables were created for these. All data entry was checked by a second person. As well as examining basic frequencies for all of the survey questions, a range of analyses were conducted to explore whether there were systematic differences in the approaches by different kinds of HAs. Appendix 4 provides more information on these analyses.

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1 It should be noted that the survey has also been conducted in Wales and Scotland. It is intended to undertake a comparison of the different local approaches to address health inequalities in the near future.
In depth case studies

In depth case study interviews were conducted in five HA areas. They had two broad aims. First, to identify ways of overcoming barriers to change in getting health inequalities on the local agenda and tackling them. Secondly, to assess what opportunities could be created in the future for health authorities to reduce health inequalities. Given the significant structural changes that had taken place in the local health economy since the commencement of the grant, this aim was expanded to cover the range of local players, including LAs, PCG/Ts and emerging LSPs, that were relevant to addressing health inequalities.

Six case study sites were chosen a priori on the basis of two broad criteria:

♦ the extent of health problems and health inequalities within the HA, based on analysis of the health domain of the Department of Environment Transport and the Regions’ (DETR’s) ward based Index of Multiple Deprivation (IMD) 2000 (see Appendix 5);
♦ the extent to which reducing health inequalities appeared to be a local priority, based on the responses to the survey.

In addition, every attempt has been made to ensure a reasonable spread of case study sites between regions, and a mix of HA areas where Primary Care Groups (PCGs) had already developed into PCTs and others where this process had still to take place. It was agreed with the DH that this study would not include any HAs that were part of HAZs. Unfortunately, one case study site declined to participate when fieldwork was already underway and hence it was too late to select a replacement, so only five HAs were included in the fieldwork. Full details of the selection process are described in Appendix 6.

In each case study area interviews were conducted with a range of key players in the relevant local organisations:

♦ the health authority, in general, and in public health, in particular;
♦ PCGs or PCTs;
♦ acute trusts, and where appropriate, community trusts, especially health promotion departments;
♦ local district and, where appropriate, county councils;
♦ local voluntary groups and community groups;
♦ various specific large regeneration partnerships;
♦ key local projects aimed at reducing health inequalities.

In all, 64 interviews were conducted across the five case study areas. A specific breakdown of the respondents who participated in the case study interviews can be found in Appendix 6, as can the broad interview schedule that was followed. All interviews were transcribed and the data collected were analysed according to the principles of the framework methodology.

Regional office survey

The aim of the survey of NHS Executive regional offices was to assess the framework that different regions created for local agencies in their efforts to address health
inequalities. Of particular interest was any development support that regions were offering, as well as how they were holding HAs to account in terms of setting targets, and performance managing them. Telephone interviews were conducted with regional directors of public health or other managers with key responsibility for health inequalities in all eight regions. The schedule is shown in Appendix 7.

**STRUCTURE OF THE REPORT**

The remainder of the report is divided into four broad sections. Part 2 focuses on mapping local strategies to tackle health inequalities across the community health improvement process. The majority of this section examines the different dimensions of local HA strategies, drawing primarily on the results of the survey and the analysis of the HImPs. In doing this it briefly examines some of the factors that have helped to get health inequalities on the local agenda and have enabled local areas to make progress in tackling them. However, this is done in a very ‘broad-brushed’ way, based solely on the survey; these policy mechanisms are examined in much more depth in Part 3. Part 2 also reviews the findings from the survey of regional offices in terms of the support they provide HAs, and the way, if at all, the DH’s policy framework, outlined above, to examine each of the key mechanisms for getting health inequalities on the agenda. It looks in depth at how they have operated in the local areas and identifies the implications for future policy development. Part 4 draws on the findings of this project and examines them in the light of the new DH policy framework for tackling health inequalities that has emerged as Labour move into their second term of office. It then identifies the implications for future policy developments. Finally, Part 5 draws the report to a close. It considers the ways in which this study has added to existing knowledge about how to develop local strategies to address health inequalities, and highlights some of the issues about adopting a ‘realistic evaluation’/’theories of changes’ approach to a strategic policy evaluation such as this.
PART 2

MAPPING LOCAL STRATEGIES TO TACKLE HEALTH INEQUALITIES
INTRODUCTION

At the start of its first term in office, the Labour Government made reducing inequalities in health a key priority in its health strategy. In its early policy documents it gave health authorities leadership responsibilities for taking this agenda forward, as well as supporting the development of PCGs. Regional offices were required to ‘hold HAs to account for progress in their new strategic leadership role’ (Cm 3807, 1997, p.60).

The aim of this section is to examine how each of these agencies responded to these challenges. While neither health authorities nor regional offices will exist in their current forms in the future (DH, 2001a), the lessons from their experiences will be important to consider in developing the roles of primary care trusts and strategic health authorities in relation to tackling inequalities in health locally.

HEALTH AUTHORITIES' STRATEGIES TO TACKLE HEALTH INEQUALITIES

This section reviews local action to tackle health inequalities across England, based on a survey of all HAs, and underpinned by a review of first wave HImPs. The purpose is to map and to understand the different community health improvement processes that HAs have developed in their local contexts. It is organised around five broad questions, which seek to elicit the context, mechanisms and outcomes relevant for each HA. These areas of analysis provide the descriptive components of the community health improvement process framework outlined in Part One.

♦ What do HAs mean by health inequalities, how significant a problem do they perceive them to be, and what goals are they setting to address them?
♦ What priority is attached to reducing health inequalities and why?
♦ How are HAs going about reducing health inequalities?
♦ What progress have they made to date?
♦ What do they see as the way forward, and what factors might inhibit or facilitate their plans?

Health inequalities: the problem

The purpose of this section is to examine what HAs mean by health inequalities, the extent to which they consider them to be a problem in their area, and what goals they are setting to tackle them. In order to examine responses to the survey in different contexts, HAs have been grouped according to the extent of ill health and health inequalities experienced within their boundaries. These data are derived from the health domain of the IMD (DETR, 2000) and are employed here to explore answers to the survey in different contexts. Appendix 5 describes the health dimension of the IMD and how it has been employed here to construct a measure of average health and a measure of health inequalities (based on the coefficient of variation) for each HA. For the purpose of the analysis of the survey and the selection of case study areas, these two measures have been used to create four crude groupings of health authorities, as set out in Box 2.1 and shown in Figure 2.1.
The left-hand side of Figure 2.1 depicts the most advantaged HAs with levels of ill health lower than the median for England and a low level of health inequality between wards. Twelve health authorities fall into this category, including places such as Kingston and Richmond, Oxfordshire and Buckinghamshire. Only 12 per cent of wards in these HAs are in the poorest half of the health distribution in England. As the average level of ill health increases so does the level of inequality between wards, so that those HAs with overall levels of ill health close to the median for England have the highest levels of health inequalities. Thirty-six authorities fall into this group, which includes East Sussex, Hillingdon and Norfolk. Just under 40 per cent of wards in these HAs are in the poorest half of wards in England in terms of their health. From this point, as the overall level of ill health for HAs continues to rise, the level of internal inequalities starts to fall. However, there are still some health authorities that also experience higher than average levels of both inequalities and ill health. This is true of 14 authorities, such as Ealing, Hammersmith and Hounslow, Leeds and South Derbyshire. Nearly, 70 per cent of wards in these HAs are among the poorest half of wards in England. Finally, among those HAs with very high levels of poor health by this index, there is very little variation in health between wards, suggesting that they have a universally poor health experience. This is true of 37 HAs including places such as Liverpool, Manchester and Bradford. Just over 90 per cent of wards in these HAs are in the most disadvantage half of wards in England in terms of their health.

**Box 2.1 HAs grouped by levels of overall health and health inequalities**

<table>
<thead>
<tr>
<th>Group 1</th>
<th>Good health, low inequalities</th>
<th>Average ill health less than median; variations in health less than median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 2</td>
<td>Reasonable health, high inequalities</td>
<td>Average ill health less than median; variations in health greater than the median</td>
</tr>
<tr>
<td>Group 3</td>
<td>Poor health, high inequalities</td>
<td>Average ill health and variations in health greater than respective medians</td>
</tr>
<tr>
<td>Group 4</td>
<td>Universally poor health</td>
<td>Average ill health greater than median variations in health less than median</td>
</tr>
</tbody>
</table>
What do HAs mean by health inequalities?
The analysis of first wave HIMPs suggested that HAs used the term ‘health inequalities’ to encompass a broad range of problems and issues. The survey began therefore by asking respondents to define what they believed their HA meant by the term ‘health inequalities’. Table 2.1 shows a categorisation of their responses.

Table 2.1 Definitions of health inequalities

<table>
<thead>
<tr>
<th>Definition</th>
<th>Per cent of respondents that mention this dimension</th>
</tr>
</thead>
<tbody>
<tr>
<td>HA does not have definition</td>
<td>3</td>
</tr>
<tr>
<td><strong>Differences in health</strong></td>
<td></td>
</tr>
<tr>
<td>- general statement (doesn’t specify between whom)</td>
<td>41</td>
</tr>
<tr>
<td>- socioeconomic</td>
<td>40</td>
</tr>
<tr>
<td>- geographic</td>
<td>21</td>
</tr>
<tr>
<td>- gender</td>
<td>12</td>
</tr>
<tr>
<td>- ethnic</td>
<td>12</td>
</tr>
<tr>
<td>- age</td>
<td>6</td>
</tr>
<tr>
<td>at least one of above</td>
<td>79</td>
</tr>
<tr>
<td><strong>Access to health care</strong></td>
<td></td>
</tr>
<tr>
<td>- general statement</td>
<td>46</td>
</tr>
<tr>
<td><strong>Determinants of health</strong></td>
<td></td>
</tr>
<tr>
<td>- general</td>
<td>12</td>
</tr>
<tr>
<td>- socioeconomic</td>
<td>27</td>
</tr>
<tr>
<td>- equal opportunities for all</td>
<td>15</td>
</tr>
<tr>
<td>at least one of above</td>
<td>49</td>
</tr>
<tr>
<td><strong>Mention fairness or unacceptable differences</strong></td>
<td>9</td>
</tr>
<tr>
<td><strong>Combined definitions</strong></td>
<td></td>
</tr>
<tr>
<td>Differences in health only</td>
<td>28</td>
</tr>
<tr>
<td>Access to health care only</td>
<td>4</td>
</tr>
<tr>
<td>Determinants of health only</td>
<td>6</td>
</tr>
<tr>
<td>Health differences and access to health care</td>
<td>16</td>
</tr>
<tr>
<td>Access to health care and determinants of health</td>
<td>7</td>
</tr>
<tr>
<td>Health differences and determinants of health</td>
<td>18</td>
</tr>
<tr>
<td>Health differences, determinants of health and access to health care</td>
<td>18</td>
</tr>
</tbody>
</table>

N = 68

As the table shows, most people provided a definition of health inequalities, although two respondents said their HA ‘didn’t have one’ and another that ‘it was self-
explanatory’. Not surprisingly, the majority of definitions provided made reference to some notion of differences in health. For example, one respondent defined health inequalities as ‘variations in health outcomes across the patch’ and another ‘the difference in health experience between one group and another’. Most commonly, respondents mentioned socioeconomic differences in health, although this was true of only 42 per cent of the sample. For instance, one respondent wrote ‘the health of the wealthiest is better than health of the least well off’. Other people made broader references to a range of different dimensions of inequalities in health, including geographic, ethnic, gender and age. Some respondents emphasised that their definition of health inequalities focused on those differences that are avoidable, while others emphasised their concern being about those inequalities that are ‘unfair or unacceptable’. For example:

... differentials in health outcome or exposure to health risk that arise from the avoidable and unfair distribution of power and resources in society.

... unequal health experience which arises as a result of social experience, which is amenable to change, and which has at its base an element of injustice.

Along similar lines, some respondents - 15 per cent - defined health inequalities as a concern for ‘equal opportunities for all’. Implicitly or explicitly this group of definitions appear to be about life chances in general. Virtually half of the respondents made reference to the causes of ill health. While some people made very general statements about the ‘determinants of health’, most were more explicit and focused on the need to address socioeconomic factors, such as ‘poverty, unemployment and low incomes’.

Another dimension of respondents’ definitions of health inequalities focused on access to health services. Approximately half of the respondents included some description of access to care issues, although only five per cent gave this as their entire definition. Finally, many respondents had multiple definitions of health inequalities that included reference to outcomes, access and determinants. For example:

... differences in health status between different parts of the population mediated in the main by determinants of health and access to health care.

A shared definition

The survey asked about one individual’s perception of the definition of health inequalities employed in their HA. Respondents were therefore asked about the extent to which they felt that key partners shared this definition. As one respondent pointed out as part of their definition:

I mean inequalities in determinants of health; my HA sees it as access to health and social care and occasionally outcomes.

Table 2.2, however, shows that there was reasonable confidence on the part of respondents that other partners shared their definition of health inequalities to a ‘great
or reasonable’ extent. This was most true of local authorities, 72 per cent of respondents felt that LAs would share their definition; and, least true of other NHS agencies, where only half of respondents felt their definition would be shared.

**Table 2.2 The extent to which the definition of health inequalities is shared by partners**

<table>
<thead>
<tr>
<th>Partner</th>
<th>To a great extent</th>
<th>To a reasonable extent</th>
<th>To a modest extent</th>
<th>To a limited extent</th>
<th>Not at all</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other staff within HA</td>
<td>13</td>
<td>49</td>
<td>13</td>
<td>17</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Other NHS agencies</td>
<td>8</td>
<td>41</td>
<td>24</td>
<td>19</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Local Authorities</td>
<td>17</td>
<td>53</td>
<td>11</td>
<td>11</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Community or voluntary sector</td>
<td>23</td>
<td>39</td>
<td>16</td>
<td>9</td>
<td>4</td>
<td>9</td>
</tr>
</tbody>
</table>

N = 75

What kinds of inequalities are important?
The review of the first wave HImPs, and the definitions above, showed that HA's identified a range of different dimensions of inequalities, for example, socioeconomic, geographic, age, gender, ethnic etc., that they wished to address. The survey investigated the relative priorities of these. Table 2.3 shows the rank that respondents gave to these different kinds of inequalities.

**Table 2.3 The most important types of health inequalities**

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>1 highest</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7 lowest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Socio-economic</td>
<td>61</td>
<td>19</td>
<td>10</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Geographic</td>
<td>45</td>
<td>38</td>
<td>13</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Ethnic</td>
<td>13</td>
<td>20</td>
<td>25</td>
<td>10</td>
<td>10</td>
<td>21</td>
<td>1</td>
</tr>
<tr>
<td>Gender</td>
<td>3</td>
<td>6</td>
<td>14</td>
<td>24</td>
<td>24</td>
<td>28</td>
<td>24</td>
</tr>
<tr>
<td>Age</td>
<td>1</td>
<td>4</td>
<td>18</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>16</td>
</tr>
<tr>
<td>Health problems</td>
<td>6</td>
<td>4</td>
<td>19</td>
<td>27</td>
<td>21</td>
<td>24</td>
<td>0</td>
</tr>
</tbody>
</table>

N = 68-72

*Note a number of HA's gave joint ranks to different dimensions of inequalities, hence the total for each rank position is different.
Approximately 60 per cent of respondents ranked socioeconomic inequalities as the most important consideration for their HA, while 45 per cent said that geographic inequalities were the most significant and 13 per cent believed that ethnic inequalities were the most important. In contrast, very few HAs argued that age, gender, or inequalities between people with different health problems were the most important types of inequalities.

Extent of the problem

As part of the community health improvement process, each HA develops its strategy to tackle health inequalities in the context of the particular local experience of the problem. The analysis of HlmpS and of the survey, therefore, explored the ways in which HAs described and understood the problem of health inequalities locally.

Many HlmpS contained detailed descriptions of the health needs of their areas. To do this, HAs drew on a wide range of mainly routine data, including:

- demographic information about the size and the composition of their population by age, sex and ethnicity;
- mortality rates for a range of causes and population groups;
- other health outcomes, such as cancer registrations, teenage pregnancy rates, long-term illness rates;
- information on lifestyles, such as smoking rates, etc. from local population surveys;
- the socioeconomic status of the area, especially various indices of deprivation, unemployment rates, etc.;
- use of health services, including immunisation and screening rates, hospital admissions, availability of GP and other primary care services.

Evidence about inequalities in health was more limited and often based on geographical differences between the whole HA and a national or regional average, or between localities within the HA. Often particular 'pockets of deprivation', wards and enumeration districts, were highlighted. Where special surveys had been conducted some HAs were able to explore local inequalities in more detail by looking at differences in health by social class or ethnicity. Other HAs used national data to illustrate these relationships and linked the discussion to descriptions of the socioeconomic composition of their area. Evidence relating to differences in the availability or the use of health services was much rarer. Sometimes such information was presented by localities, but not often, and rarely was it related to measures of need to give an indication about whether or not local services were equitable.

In the survey, therefore, respondents were asked about their perception of how significant both inequalities in health and inequalities in access to health care were to their HA.

In relation to inequalities in health, virtually all respondents - 95 per cent - said that health inequalities was an ‘important’ or ‘very significant’ problem. Table 2.4 compares respondents’ perceptions of the problem in their HA by the actual level of ill health and health inequalities measured by the IMD.
The most striking aspect of the table is the different pattern of results between those HAs whose overall level of ill health is greater than the national median (groups 3 and 4) and those that are lower (groups 1 and 2). The former are more likely to say that health inequalities are a ‘very significant problem’ and the latter that it is ‘important’.

Table 2.4 Perception of the problem by IMD (health domain)

<table>
<thead>
<tr>
<th>Health domain of IMD</th>
<th>Extent of the problem</th>
<th></th>
<th></th>
<th></th>
<th>N</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Very significant</td>
<td>Important</td>
<td>Of average concern</td>
<td>Limited</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 1: Good health, low inequalities</td>
<td>0</td>
<td>78</td>
<td>22</td>
<td>0</td>
<td>9</td>
<td>12</td>
</tr>
<tr>
<td>Group 2: Reasonable health, high inequalities</td>
<td>28</td>
<td>66</td>
<td>3</td>
<td>3</td>
<td>29</td>
<td>38</td>
</tr>
<tr>
<td>Group 3: Poor health, high inequalities</td>
<td>73</td>
<td>27</td>
<td>0</td>
<td>0</td>
<td>11</td>
<td>15</td>
</tr>
<tr>
<td>Group 4: Universally poor health</td>
<td>67</td>
<td>33</td>
<td>0</td>
<td>0</td>
<td>27</td>
<td>36</td>
</tr>
<tr>
<td>Per cent</td>
<td>45</td>
<td>50</td>
<td>4</td>
<td>1</td>
<td></td>
<td>100</td>
</tr>
<tr>
<td>N =</td>
<td>34</td>
<td>38</td>
<td>3</td>
<td>1</td>
<td></td>
<td>76</td>
</tr>
</tbody>
</table>

Only 28 per cent of Group 2, which has the highest levels of internal inequalities of all of the four groups, felt that inequalities were a ‘very significant’ problem. It would appear, therefore, that it is the difference between the overall level of health of an HA and the national median that influence people’s perceptions of inequalities, more than the extent of inequalities in health within the HA boundaries. This seems to reflect a greater emphasis by central Government on inequalities across the country at a reasonably high level of aggregation, rather than the variations that occurs even within quite affluent areas. For example, one respondent wrote that local efforts to tackle inequalities would be enhanced if there was:

Recognition at the centre that although [X], on average, scores well on most indicators it does have pockets of deprivation which need to be addressed.

A number of commentators have raised concerns about this focus on the average disadvantage of places in determining policy priorities. For example, Fieldhouse and Tye (1996) showed that the most disadvantaged LAs in England contain only a small proportion of the most disadvantaged people, and that all LAs contain a substantial number of people living in disadvantaged circumstances. While Haynes (2000) shows that people in disadvantaged circumstances in rural areas are ‘hidden’ by favourable averages for such places, even when using wards or enumeration districts as the unit of analysis. In this analysis, the recognition of health inequalities as a significant problem by HAs in groups 3 and 4 with the poorest average levels of health is welcome. However, the lower proportion of HAs in group 2 believing health inequalities to be a significant problem, when 40 per cent of their wards are in the most disadvantage half in the country, is worrying.
Table 2.5 explores the focus of HA’s inequalities definitions further. Respondents were asked to place themselves on a five point spectrum, from being entirely concerned with inequalities within their area, to being concerned entirely with inequalities between the average for their area and an external reference point. Table 2.5 compares their responses with health dimension of the IMD. In the main, the pattern is, as one would expect. Most of the group of health authorities with universally poor health have an external focus to their definition of inequalities, while those HAs with high levels of variations in health between wards have a significant internal focus.

**Table 2.5 Spectrum of inequalities by IMD (health domain)**

<table>
<thead>
<tr>
<th>Health domain of IMD</th>
<th>Focus of concern in relation to inequalities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Entirely internal</td>
</tr>
<tr>
<td>Group 1: Good health, low inequalities</td>
<td>0</td>
</tr>
<tr>
<td>Group 2: Reasonable health, high inequalities</td>
<td>4</td>
</tr>
<tr>
<td>Group 3: Poor health, high inequalities</td>
<td>0</td>
</tr>
<tr>
<td>Group 4: Universally poor health</td>
<td>4</td>
</tr>
<tr>
<td>per cent</td>
<td>3</td>
</tr>
<tr>
<td>N =</td>
<td>2</td>
</tr>
</tbody>
</table>

In relation to whether access to health care within the HA was equitable, answers were more mixed. Some respondents said that they did not have any evidence on which to base their answer or that it varied considerably between different services. However, as Table 2.6 shows, more than half of those that replied said that they felt access to health care was ‘not very equitable’ or worse. Less than a fifth of respondents felt that health care within their HA was at least ‘reasonably equitable’. Only half of the those HAs with levels of health better than the national median said that access to health care locally was ‘not very equitable’, while this was true of over 80 per cent of those HAs with poorer health compared to England as a whole.

**Table 2.6 How equitable is access to health care within HA?**

<table>
<thead>
<tr>
<th>How equitable are NHS services in relation to need?</th>
<th>Per cent of HAs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very equitable</td>
<td>1</td>
</tr>
<tr>
<td>Reasonably equitable</td>
<td>16</td>
</tr>
<tr>
<td>OK</td>
<td>17</td>
</tr>
<tr>
<td>Not very equitable</td>
<td>56</td>
</tr>
<tr>
<td>Very inequitable</td>
<td>7</td>
</tr>
<tr>
<td>N = 73</td>
<td></td>
</tr>
</tbody>
</table>
Goals and targets
In order to develop an effective community health improvement process, it is important to have a clearly articulated goal that is shared by all key stakeholders. This section examines the extent to which this was true.

Most HAs begin their HImPs by setting out their overall vision statement. The vast majority of HAs acknowledged their role in improving health as well as managing the health care system. Many of the HImPs go on to articulate a separate goal of reducing health inequalities. For others, it becomes clear in their discussion of improving health that they are including reducing health inequalities as part of this goal.

Many of those HImPs that explicitly state that ‘reducing health inequalities’ is a goal, say no more about what they mean by this objective. This makes it difficult to determine what they are trying to achieve or how they will be able to assess if they have succeeded. Some health authorities do try to be more specific. The most common definition of a health inequalities goal is to reproduce the aim from Our Healthier Nation ‘to improve the health of the worst off in society and to narrow the health gap’ (Cm3852, 1998). Unfortunately, this still provides little evidence of what the HA is trying to achieve. What is meant by health, who are the ‘worst off’ and between whom do they wish to narrow the health gap? Survey respondents were asked to describe their HA’s goals to reduce health inequalities. A broad categorisation of their definitions is shown in Table 2.7.

Approximately 16 per cent of respondents to this question said that their HA did not have a specific goal relating to reducing health inequalities. Of those that did provide a specific goal, a small number - only seven per cent - defined it as improving overall health, although one of these commented that ‘improving overall health in [X] is the same as reducing inequalities’.

More specifically, of those respondents who provided a description of their goal to tackle health inequalities, most – 57 per cent - made very general statements about ‘reducing the health divide’. Very few specified the type of inequalities that they were aiming to reduce, or the size of reduction that they hoped to achieve. Similarly, very few definitions explicitly stated that they planned to reduce the gap by improving the health of the worst off. Finally, approximately one quarter of HAs’ goals also included an aim to promote access to health care, while one third mentioned the need to address the determinants of health, often specifying the need to do this by working in partnership, especially with local authorities.
Table 2.7 HAs’ goals to reduce health inequalities

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Per cent of respondents that mention this dimension as part of their goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>No inequalities goal*</td>
<td>16</td>
</tr>
<tr>
<td>Say have an inequalities goal, but definition provided does not include reference to inequalities*</td>
<td>7</td>
</tr>
</tbody>
</table>

**REDUCE INEQUALITIES IN HEALTH**
- general statement 57
- specify focusing on worst off/disadvantaged/vulnerable groups 11
- specify percentage reduction in health gap 7
any of above 61

**ADDRESS DETERMINANTS OF HEALTH**
- general statement 25
- specify through partnership working 21
either of above 34

**IMPROVE HEALTH SERVICES/ACCESS TO SERVICES**
- general statement 18
- specify need to target disadvantaged areas/groups 7
either of above 25

N = 44

* This may be because they are trying to improve overall levels of health within their boundaries to reduce inequalities between themselves and the national average.

As well as asking if HAs had an explicit goal to tackle health inequalities, the survey asked whether they had set targets to reduce health inequalities locally. In examining the answers to this question it is important to bear in mind that the survey was conducted at the end of 2000, before the launch of the national health inequalities targets.

As Table 2.8 shows, just over half of those respondents who answered this question said that their HA did have health inequalities targets. However, many of the targets cited as examples actually focused on processes or activities rather than health outcomes. Of those that did not have health inequalities targets at the end of 2000, most were in the process of developing them and/or waiting for national guidance so that they could develop, or plan, this process in the near future. A small proportion said that they had ‘tried and failed’ to identify appropriate targets. Just over ten per cent said that they had no plans to develop targets in the foreseeable future.
Table 2.8 Have HAs set health inequalities outcome targets?

<table>
<thead>
<tr>
<th>Health inequalities targets</th>
<th>Per cent of HAs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>51</td>
</tr>
<tr>
<td>No</td>
<td>49</td>
</tr>
<tr>
<td>- Currently developing them*</td>
<td>21</td>
</tr>
<tr>
<td>- A waiting national guidance*</td>
<td>6</td>
</tr>
<tr>
<td>- Tried but too difficult</td>
<td>4</td>
</tr>
<tr>
<td>- Planning to develop some in near future*</td>
<td>4</td>
</tr>
<tr>
<td>- No attempt to develop them</td>
<td>11</td>
</tr>
<tr>
<td>- No explanation</td>
<td>4</td>
</tr>
</tbody>
</table>

N=73

* Note a number of respondents who said they were currently developing targets or planning to, also said that they were waiting for national guidance

Summary

Most health authorities have a very broad definition of health inequalities, although when asked about the relative importance of different kinds of inequalities they are mainly concerned with socioeconomic, geographic or ethnic inequalities. Those HAs with high levels of poor health appear to feel health inequalities are a more significant problem than those with high levels of health inequalities between their wards. Most goals that have been set to address health inequalities are rather vague. It is difficult to understand, therefore, exactly what HAs are hoping to achieve. While some HAs have set themselves specific targets in relation to health inequalities, at the time of the survey, many were waiting for national targets to be set before doing so. Within a community health improvement process, the general ambiguity in relation to health inequalities goals outlined above, will make it more difficult to develop clear strategies to tackle them and to monitor how successful these efforts are.

What priority is given to tackling health inequalities?

There is a general perception that the priority given to tackling health inequalities has increased as a result of the Labour Government (Benzeval, 1999, Exworthy et al., 2002). This section examines whether this national priority is reflected at the local level and explores the range of factors that have contributed to the local priority attached to health inequalities.

Level of priority

Figure 2.2 shows the priority that respondents felt that their HA had given to tackling health inequalities over the last ten years. Clearly caution is required in interpreting these results, since this is a retrospective perception of each individual.
In the period 1990 to 1995, over half of the respondents felt that their HA had given ‘low’ or ‘no’ priority to tackling health inequalities, and only 17 per cent felt it was given ‘very high’ or ‘high’ priority. In 1995 there was increased activity around issues of health inequalities. In particular, the DH published its report Variations in health: what can the Department of Health and NHS do? (DH, 1995) and the NHS priorities and planning guidance began to mention the need to consider ‘variations’ in their planning (NHSE, 1995; 1996). From 1995 until the 1997 election, therefore, less respondents felt that their HAs gave health inequalities ‘low’ or ‘no’ priority, while many more felt health inequalities were given a ‘medium’ priority, although very few felt the priority had increased to ‘high’ or ‘very high’.

After the election in May 1997, the pattern changed substantially. Fifty-nine per cent of respondents felt their health authority gave tackling inequality in health a ‘high’ or ‘very high’ priority and only 12 per cent thought that it was ‘low’. By the time of the financial year in which the survey was conducted - 2000/01 - the perceived priority given to health inequalities had increased again, with nearly three quarters of respondents feeling their HA gave them a ‘very high’ or ‘high’ priority, and only five per cent that it was ‘low’. This continued growth in priority is slightly counter-intuitive given a general perception that health inequalities began to fall from the Government’s agenda mid term (e.g. House of Commons’ Health Committee, 2001). For example, one respondent said: ‘Government’s continuing interest, if sadly weakening practical focus, as next general election approaches’.

Given that tackling inequalities in health requires action across a range of agencies, respondents were also asked about their perception of the relative priority given to health inequalities by key partners. The results are shown in Table 2.9. Over three quarters of respondents felt that their HA, LA partners, and key community and voluntary groups gave tackling health inequalities a high priority. In contrast they felt that only 60 per cent of PCG/Ts and 33 per cent of NHS Trusts did, with 29 per cent of Trusts giving health inequalities a ‘limited’ priority or no priority at all. Given the
emphasis on PCTs taking the lead in tackling health inequalities locally in the future (DH, 2001a), this is a matter of concern.

**Table 2.9 Perceived relative priority given to tackling health inequalities by different local agencies**

<table>
<thead>
<tr>
<th>Percent of respondents reporting following levels of priority for each agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very important</td>
</tr>
<tr>
<td>HA</td>
</tr>
<tr>
<td>PCG/T</td>
</tr>
<tr>
<td>NHS Trusts</td>
</tr>
<tr>
<td>LAs</td>
</tr>
<tr>
<td>Community/Vol. groups</td>
</tr>
<tr>
<td>N = 74</td>
</tr>
</tbody>
</table>

Finally, it is important to consider whether those HAs that have the biggest problem are those that are giving health inequalities the highest priority. Table 2.10 compares the relative priority given to health inequalities with the level of overall health and the extent of health inequalities in the area. To some extent there does appear to be a correlation. For example, a third of those HAs with good health and low inequalities give health inequalities ‘average’, ‘limited’ or ‘no’ priority, compared with only 17 per cent overall. While 82 per cent of those authorities with poor health and high inequalities say that health inequalities are ‘very’ or ‘reasonably important’ to their HA. However, over a quarter of those HAs with universally poor health gave health inequalities only ‘average’ or ‘limited’ priority. This may reflect the fact that such places are more concerned with improving average levels of health rather than reducing inequalities.

**Table 2.10 Priority given to health inequalities by IMD (health domain)**

<table>
<thead>
<tr>
<th>Health domain of IMD</th>
<th>Level of relative priority given to health inequalities by HA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Very important</td>
</tr>
<tr>
<td>Group 1: Good health, low inequalities</td>
<td>0</td>
</tr>
<tr>
<td>Group 2: Reasonable health, high inequalities</td>
<td>36</td>
</tr>
<tr>
<td>Group 3: Poor health, high inequalities</td>
<td>46</td>
</tr>
<tr>
<td>Group 4: Universally poor health</td>
<td>15</td>
</tr>
<tr>
<td>N = 75</td>
<td></td>
</tr>
</tbody>
</table>
Factors affecting priority
To explore this issue further, respondents were asked what factors they felt had influenced the priority given to health inequalities by their HA. Table 2.11 shows a broad categorisation of respondents’ explanations. It is important to note that this only gives a broad map of the general perspectives across the country in relation to which factors influence local priorities. Part 3 examines the key policy mechanisms identified in Part 1, which are raised here, in much more detail.

External factors
In terms of external factors, on the positive side, the most frequently mentioned explanation – by 67 per cent of respondents - was the increased priority given to health inequalities within central Government’s health policy. Most made very broad references to this.

- Government interest in inequalities – chapter in NHS Plan, Saving Lives OHN.
- National Priorities and Planning Guidance/inequalities higher on agenda within national priorities.
- NHS government policy - requirement for PCGs and HImPs to tackle inequalities.

Closely associated with this was the positive influence on local priorities of the more general commitment by central Government to tackling social exclusion and poverty, which was mentioned by nearly half of the respondents. A number of respondents mentioned the benefits of joined-up Government at the centre or ‘some signs at least’, while many emphasised the positive effect of the neighbourhood renewal policy.

Linked to this, half of the respondents also mentioned the role of short-term funded partnership initiatives such as the Single Regeneration Budget (SRB), SureStart, HAZ, and healthy living centres. Such initiatives were believed to influence HA’s in a number of ways. First, the availability of additional money gave local agencies the capacity to invest innovatively in ways that it was not possible to do within core funding. Secondly, the resources provided local agencies with an incentive to work together. Thirdly, the availability of such funds, and local eligibility to bid for them, raised awareness of the problems of social exclusion and their link with health. Finally, the bidding process, and subsequently working together on the initiative, contributed to the development of partnership working between agencies. Of those HAs that are part of HAZs, just under half cited being a HAZ as a significant factor in influencing the local priority given to health inequalities.

Nearly a quarter of respondents also identified the significance of the increased national awareness and research on health inequalities, and in particular the influence of the Acheson Report (1998), in promoting the issue of health inequalities locally.

Two other external factors were mentioned, each by just under ten per cent of respondents. First, being a ‘Healthy City’ or more generally the influence of ‘Health for All’ was seen as a positive factor. Secondly, the pressure and the support from regional offices, either in terms of developed regional strategies to tackle health
inequalities, or by probing HAs through the performance assessment and the review system. The role of regional offices is discussed further below.

**Table 2.11 Factors influencing local priority given to tackling health inequalities**

<table>
<thead>
<tr>
<th>Factor influencing priority</th>
<th>Per cent of respondents mentioning factor</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>POSITIVE</strong></td>
<td></td>
</tr>
<tr>
<td><strong>External</strong></td>
<td></td>
</tr>
<tr>
<td>National Government NHS priorities &amp; policies</td>
<td>67</td>
</tr>
<tr>
<td>Government commitment to address social exclusion etc.</td>
<td>46</td>
</tr>
<tr>
<td>Role of short-term funded initiatives</td>
<td>50</td>
</tr>
<tr>
<td>Increased awareness of health inequalities nationally, (esp Acheson Rpt)</td>
<td>23</td>
</tr>
<tr>
<td>Health for All, Healthy Cities etc</td>
<td>9</td>
</tr>
<tr>
<td>Role of Regions</td>
<td>9</td>
</tr>
<tr>
<td><strong>Internal</strong></td>
<td></td>
</tr>
<tr>
<td>Local health and socioeconomic problems</td>
<td>53</td>
</tr>
<tr>
<td>Poor quality or access to health services locally</td>
<td>16</td>
</tr>
<tr>
<td>Increasing local awareness of problem (publishing of reports etc)</td>
<td>41</td>
</tr>
<tr>
<td>Key local player(s) commitment/campaigning to tackling health inequalities</td>
<td>23</td>
</tr>
<tr>
<td>Influence of partnership working locally</td>
<td>37</td>
</tr>
<tr>
<td><strong>NEGATIVE</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Internal</strong></td>
<td></td>
</tr>
<tr>
<td>Affluent area</td>
<td>2</td>
</tr>
<tr>
<td>Need to address acute sector issues</td>
<td>3</td>
</tr>
<tr>
<td>Problematic partnership working</td>
<td>3</td>
</tr>
<tr>
<td>Lack of interest by key players</td>
<td>1</td>
</tr>
<tr>
<td>Lack of funds</td>
<td>3</td>
</tr>
<tr>
<td><strong>External</strong></td>
<td></td>
</tr>
<tr>
<td>Restructuring of HAs &amp; PCTs is distracting</td>
<td>4</td>
</tr>
<tr>
<td>Government priorities focus on waiting lists, balancing books etc</td>
<td>7</td>
</tr>
</tbody>
</table>

N=70

**Local factors**

Not surprisingly, the most frequently mentioned local influence was the extent of local socioeconomic and health problems, to which just over half of the respondents made reference. The socioeconomic factors described ranged from the level of disadvantage in the area, to specific problems, such as the closure of particular
industries, poor housing, low incomes, poor educational attainment and high unemployment. A large number of respondents also mentioned the needs of black and minority ethnic populations in general, and of refugees and asylum seekers in particular. Finally, people made reference to the specific nature of inequalities within the area. In particular, a number of respondents identified concerns about ‘small pockets of deprivation hidden by surrounding affluence’. In relation to health issues, respondents generally focused on the overall level of health in their area, but a number mentioned particular concerns such as teenage pregnancies or high levels of coronary heart disease. A number of HAs mentioned being at the bottom of the high level performance indicators league table for particular conditions as having galvanised them into action. A smaller number of people mentioned specific problems with either the access to, or the quality of, local health services; primary care, in particular, appeared to be a cause for concern.

Many respondents felt that raising awareness of the problem locally, and/or having key people championing it, were also very significant factors in getting health inequalities on the agenda. Forty-one per cent of respondents mentioned the importance of raising awareness locally, mainly through the analysis of local data and publishing the results. A number of respondents cited specific reports, particularly public health reports, that they felt had been particularly influential in generating local interest in the problem of health inequalities.

The importance of champions in getting issues on the agenda is often a significant factor (Stocking, 1985). Twenty-three per cent of respondents mentioned having a local advocate championing health inequalities as being a key factor in getting them on the local agenda. In some cases, respondents mentioned the benefit of having a sympathetic chair or chief executive, while others focused on the role of public health and health promotion in general. A few mentioned the benefit of joint appointments in this respect, for example, the director of public health also being responsible for policy or strategy development and the HImP.

Finally, linked to this, is the role of institutional champions promoting the issue of health inequalities locally. Over a third of respondents mentioned the positive influence of key partners in getting health inequalities on the agenda. A number of groups of factors appeared important here. The most commonly mentioned was the role of the voluntary and community sector, but also important was local authorities’ interest in health issues, and in particular, the significance of local politicians in picking up this agenda. The final key group was PCG/Ts. A number of respondents mentioned the benefit of PCGs beginning to establish their own agenda as contributing to raising awareness of particular health inequalities issues. One or two respondents also mentioned the benefits for the HA of PCTs ‘releasing’ them from direct commissioning and hence enabling them to have more time to focus on health inequalities.

Given the significance of partnership relations to the priority given to health inequalities, this issue was explored further. HAs that said that they had engaged in partnership working for more than ten years and those that were coterminous with their LAs were more likely to say that health inequalities were ‘very important’. HAs that worked with two-tier local authorities (county and district councils) were more likely to say that health inequalities were not a high priority (although it is important to note that these HAs are also more likely to have better than average health).
Perhaps somewhat disappointingly, HAs within HAZs were only slightly more likely than other HAs to say that health inequalities were very important.

**Negative factors**

Very few respondents mentioned factors that had a negative influence on priority, perhaps because, almost universally, the priority given to health inequalities was seen to have increased. Nevertheless, a number of negative themes were identified. Among those HAs that have lower than average levels of ill health, respondents felt that local players could be ‘complacent’ about local affluence, not acknowledging pockets of deprivation or the needs of key vulnerable groups. Other factors mentioned were: poor partnership working locally; lack of interest among key local stakeholders; lack of funds; the significant distraction that had occurred because of restructuring; and, the growing role of PCTs. Finally, at the local level, the dominance of the acute sector was felt to overshadow health inequalities issues.

Among all of the respondents who had identified health inequalities as having less than high priority, the explanation cited most often was the dominance of other more significant national ‘must dos’ such as achieving waiting list targets or financial balance. All of these factors also featured prominently among the issues raised in the case study areas, as described in Part 3, and are also cited below as impediments to future action.

**Summary**

Health inequalities appear to be given a high priority by most HAs and their partners, although this is less true of NHS Trusts and PCG/Ts. A range of factors, both external and internal, had helped to make reducing health inequalities a high priority. In particular, the extent of local problems and awareness of them, support of key individuals to tackle them and the availability of additional funding was seen to be crucial. A similar set of factors was found to be crucial in the extent to which primary care organisations had developed health improvement strategies (Abbott et al, 2001).

Hall et al. (1975) suggest that an issue must be high in relation to legitimacy, feasibility and support before it will reach an agency’s agenda. The Labour Government gave tackling health inequalities a legitimacy that it had never achieved before. It has also begun to establish some of the foundations – such as partnership working to tackle the root causes of ill health, a better evidence base and financial support – to make addressing it feasible. Local public support, however, is mixed. While some politicians and public consultations do support addressing health inequalities, they also argue strongly for protecting and investing in local hospitals. These two priorities are often seen to compete locally for scarce resources, with the acute sector always winning. These issues are all developed further in Part 3 in relation to the findings from the case studies.

**Strategies to tackle health inequalities**

A fundamental challenge for mapping local efforts to tackle health inequalities, within the framework of the community health improvement process, is to find a systematic way of describing both the overall strategies, and the key priorities chosen within them, and why. Within this, it is important to consider the balance between different types of investment, different ways of working to address these issues and particular foci in terms of socioeconomic or health problems, population groups and geographic...
areas. This section begins by providing an overview of local strategies and then examines how HAs are working to try to address health inequalities and what their key priorities are.

Overall strategy
The attention given to tackling health inequalities in HAs’ strategies has increased beyond comparison from the last purchasing plans under the Conservative Government – where only ten HAs mentioned it as any kind of aim - to the first HImPs under Labour, where nearly all HAs said that reducing health inequalities was now a central part of their agenda. However, the way in which this was followed through within the HImPs varied considerably. The analysis of first wave HImPs undertaken for this project suggested that tackling health inequalities had been incorporated into them in three broad ways.

♦ Inequalities as a key organising focus to whole HImP
There were two groups of HImPs in this category. First, those that argued that their priorities had been chosen explicitly as the best way of reducing health inequalities. In this respect, some HAs had focused on particular health problems, others key determinants of health or health behaviours, and others particular localities. How and why these combinations of priorities were seen as being the key to reducing health inequalities was often less clear. Other HImPs acknowledged that such decisions are problematic and hence chose examples of different kinds of priorities. For example one HA had identified one determinant, one behaviour, one population group and one health problem, as a starting point for its efforts to tackle health inequalities.

The second group of HImPs that fell into this category were those that, having agreed a general set of health priorities, then set out how they were going to reduce health inequalities within each of these areas - be they health problems, health service issues or determinants of health or lifestyles.

♦ Self-contained sub-strategies
Other HImPs had specific sub-sections of their strategy that focused on reducing health inequalities. First, and at their most basic, were those HImPs that simply ran through the key areas set out in the 1999-2001 National Priorities Guidance (NPG) under the ‘cutting health inequalities’ heading (DH, 1998). However, other HImPs in this category went beyond the national priorities guidance to add their own priorities or produced alternative ways of thinking about reducing health inequalities. At their most complex, such strategies included action to tackle the key determinants of health lifestyle issues, as well as action to improve access to health services. These activities were sometimes focussed across the whole HA or targeted on specific disadvantaged localities or groups.

Finally, in this category were those HImPs where the priorities had been chosen by PCGs or localities, and the overall HImP simply represented a synthesis of locality priorities. In such examples, reducing health inequalities, or specific dimensions of such a strategy - for example tackling teenage pregnancy, improving the health of ethnic minority groups or addressing a key determinant of health - were one of the three priorities chosen by a particular PCG.
Overall statements with no connected action

HImpS under this heading fell into two quite different groups. First, those that, having articulated a goal to reduce health inequalities, had no real discussion in their documents about how they might do this. Secondly, there were those that said their whole HImp was focused on reducing health inequalities, but again did not articulate how any of the programmes of action would do this, or why they had been chosen for this purpose.

For as many HImpS that tried to articulate their strategic approach to reducing health inequalities, there were a similar number who said that a priority for the next HImp would be to develop a clear strategy to meet this goal. Others fell between the two camps, describing some parts of their strategy to tackle health inequalities but highlighting others that required more development work. In addition, most HImpS acknowledged that more work needed to be done on their ‘foundation stones’ - developing partnership structures or working with communities to identify priorities for the future.

The extent to which HAs had developed explicit strategies to address health inequalities or were planning to do so was investigated more systematically in the survey. Table 2.12 shows that, when the survey was conducted at the end of 2000, less than a fifth of HAs had an explicit strategy to tackle health inequalities, although a further fifth said that their strategy was subsumed within their HImp or HAZ Implementation Plan. Just over 40 per cent of HAs said that they were in the process of developing a health inequalities strategy, or a health inequalities component to their HImp, at the time of the survey. Twenty-two per cent of respondents said that their HA neither had a strategy nor any plans to develop one in the future. Not surprisingly, those HAs that gave health inequalities a high priority were more likely to already have a specific strategy to tackle them, while those that only gave them an average priority were most likely to not even be planning to develop one. HAs that are coterminous with their LA and those with long histories of partnership working were also more likely to have an existing strategy.

<table>
<thead>
<tr>
<th>Health inequalities strategy</th>
<th>Per cent of HAs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, health inequalities strategy</td>
<td>18</td>
</tr>
<tr>
<td>Yes, as part of HImp or HAZ strategy</td>
<td>20</td>
</tr>
<tr>
<td>Already have strategy but currently developing further</td>
<td>18</td>
</tr>
<tr>
<td>Currently developing one</td>
<td>23</td>
</tr>
<tr>
<td>No health inequalities strategy or plans to develop one</td>
<td>22</td>
</tr>
</tbody>
</table>

N=74

As well as examining in detail HAs’ strategies to reduce health inequalities, respondents were also asked about the factors that had shaped them. Table 2.13 shows that local needs, central Government policies and local partners, all influenced local strategies to reduce health inequalities.
Table 2.13 Key influences in developing priorities and programmes to tackle health inequalities

<table>
<thead>
<tr>
<th>Influenced by</th>
<th>To a great extent</th>
<th>To a reasonable extent</th>
<th>To a modest extent</th>
<th>Limited/not at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local needs</td>
<td>33</td>
<td>49</td>
<td>15</td>
<td>3</td>
</tr>
<tr>
<td>Partners</td>
<td>26</td>
<td>59</td>
<td>11</td>
<td>4</td>
</tr>
<tr>
<td>Government policy</td>
<td>26</td>
<td>59</td>
<td>9</td>
<td>7</td>
</tr>
</tbody>
</table>

N = 69

Partnership working

All HAs now work in partnership with LAs and others to promote health locally. On average, HAs reported working in partnership with their LAs to tackle health inequalities for nearly eight years. A history of partnership working to improve health was longest among those HAs that were coterminous with their LA - an average of nearly ten years - and lowest among those that worked with multiple unitary authorities. Twenty-three per cent of all HAs, and forty per cent of those working with two-tier local authorities, had only begun engaging in partnership working to tackle health inequalities in the three years prior to the survey, i.e. when Labour took office.

Some HAs have relatively simple partnership arrangements, mainly working with the social services department in their local authority and perhaps some voluntary sector groups, drawing on long established relationships around health care issues. Others have a much broader range of partners and work across many key departments within the LAs. Table 2.14 shows the range of partners that were involved in developing local programmes and priorities to tackle health inequalities, while Table 2.15 shows the key LA departments that respondents stated that their HA worked with for this purpose. It is important to note that some respondents simply replied: the ‘HImP partnership board’ or ‘statutory partners’, and in these cases it is difficult to assess who exactly was involved. Consequently, a greater proportion of HAs are likely to work with more key agencies than are explicitly listed in Table 2.14.

Not surprisingly, given the history of partnership working in the health service, the two key partners for the HA are LAs - mentioned by 86 per cent of HAs - and the voluntary sector - mentioned by 62 per cent of respondents. Slightly less than half of the respondents said that local PCG/Ts had contributed to developing local programmes to tackle health inequalities, and only one third said that their NHS Trusts had participated. This is worrying, given the leadership role that PCTs will have in tackling health inequalities in the future.
Table 2.14 Key partners involved in developing programmes and priorities to tackle inequalities in health

<table>
<thead>
<tr>
<th>Types of partners listed</th>
<th>Per cent of HAs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local authorities</td>
<td>86</td>
</tr>
<tr>
<td>Voluntary sector</td>
<td>62</td>
</tr>
<tr>
<td>Primary Care Groups/Trusts</td>
<td>46</td>
</tr>
<tr>
<td>NHS Trusts</td>
<td>33</td>
</tr>
<tr>
<td>Community groups</td>
<td>22</td>
</tr>
<tr>
<td>Community Health Councils</td>
<td>11</td>
</tr>
<tr>
<td>Police &amp; Probation</td>
<td>7</td>
</tr>
<tr>
<td>HIMP/HAZ Partnership Boards</td>
<td>28</td>
</tr>
<tr>
<td>‘Statutory partners’ or ‘health board’ only – no specific partners listed</td>
<td>11</td>
</tr>
</tbody>
</table>

N = 55

In relation to key departments within local authorities, Table 2.15 shows that 29 per cent of respondents said that their HA liaised most frequently with social services, while three quarters listed it within the top six departments they collaborated with. The chief executive’s office, closely followed by regeneration or economic development units, were the next most frequently mentioned as the key departments that the HA worked with to address health inequalities. However, when one examines the departments listed as the top six collaborators, education and housing become much more significant, being mentioned by at least three quarters of the respondents. Other departments that are clearly playing a significant role in partnerships to promote health and reduce health inequalities are environmental health, leisure and transport/highways.

It is important to bear in mind that different local authorities configure their departmental structures in different ways. So, for example, in some areas regeneration, Local Agenda 21 or community safety units are within the chief executive’s office. The low numbers of respondents mentioning these should therefore be viewed with caution.

HAs working with coterminous local authorities and two-tiered councils are most likely to rank social services departments as their key point of contact, while HAs working with multiple unitary authorities appear more likely to liaise with the chief executive’s office. Not surprisingly, social services is the department most commonly mentioned, no matter how long partnership working had been taking place locally. However, in addition, those with longer histories of partnership working tend to concentrate on collaborating with the chief executive’s office and regeneration contacts, while those who have begun working with LAs more recently have a much more widely spread distribution of collaborative departments.
Table 2.15 Key partners within local authorities

<table>
<thead>
<tr>
<th>Department</th>
<th>Per cent of health authorities who</th>
<th>Worked with most frequently</th>
<th>mentioned in top 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social services</td>
<td></td>
<td>29</td>
<td>76</td>
</tr>
<tr>
<td>Chief executive/corporate strategy</td>
<td></td>
<td>21</td>
<td>37</td>
</tr>
<tr>
<td>Regeneration/economic development/social inclusion</td>
<td></td>
<td>18</td>
<td>46</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td>13</td>
<td>76</td>
</tr>
<tr>
<td>Environmental health</td>
<td></td>
<td>8</td>
<td>51</td>
</tr>
<tr>
<td>Housing</td>
<td></td>
<td>5</td>
<td>78</td>
</tr>
<tr>
<td>Leisure</td>
<td></td>
<td>2</td>
<td>37</td>
</tr>
<tr>
<td>Health Unit</td>
<td></td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Community development</td>
<td></td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Environmental services</td>
<td></td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Community services</td>
<td></td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Transport/highways</td>
<td></td>
<td>-</td>
<td>31</td>
</tr>
<tr>
<td>Planning</td>
<td></td>
<td>-</td>
<td>19</td>
</tr>
<tr>
<td>Sustainability/Local Agenda 21</td>
<td></td>
<td>-</td>
<td>10</td>
</tr>
<tr>
<td>Youth services</td>
<td></td>
<td>-</td>
<td>8</td>
</tr>
<tr>
<td>Information/research</td>
<td></td>
<td>-</td>
<td>8</td>
</tr>
<tr>
<td>Trading standards</td>
<td></td>
<td>-</td>
<td>6</td>
</tr>
<tr>
<td>Community safety</td>
<td></td>
<td>-</td>
<td>3</td>
</tr>
</tbody>
</table>

N = 72

As well as examining ‘who’ health authorities worked with, the survey also asked about the extent to which they worked with local authorities on key activities. Table 2.16 shows the results. Over 80 per cent of respondents said that they worked with their local authorities to a ‘great or reasonable extent’ on a range of government initiatives, developing other joint strategies and submitting joint bids for funding. Slightly less, 71 per cent, were working together to develop the local community plan, while a much lower proportion - 34 per cent - were engaged in joint analytical work such as health impact assessment or equity audits. Perhaps, not surprisingly, given the complexities of working with two-tier councils, all of these kinds of activities were slightly less extensive in areas with such arrangements. Similarly, they also appeared less common in areas where HA and LAs had been working together for a limited period of time.
Table 2.16 Key activities between health and local authorities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Per cent of HAs saying working with LAs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>To a great extent</td>
</tr>
<tr>
<td>Government initiatives</td>
<td>50</td>
</tr>
<tr>
<td>Community Plan</td>
<td>33</td>
</tr>
<tr>
<td>Other joint strategies</td>
<td>30</td>
</tr>
<tr>
<td>Other joint bids</td>
<td>42</td>
</tr>
<tr>
<td>Health Impact assessment</td>
<td>7</td>
</tr>
</tbody>
</table>

N=73

What is being done?

In order to map the community health improvement process it is important to identify what key activities are being invested in to tackle health inequalities. From the analysis of the first wave HImPs, it was clear that within local partnerships a number of different strands of activities contributed to their approach to tackling inequalities in health. These included:

♦ tackling the root causes of ill health;
♦ promoting community capacity;
♦ promoting access to health lifestyles for communities and individuals;
♦ promoting equity of access to health and social care services;
♦ undertaking R&D to better understand how to tackle health inequalities locally.

However, given the very different levels at which individual HImPs were written, it is difficult to assess the relative investment that HAs and their partners were making in these areas to address health inequalities. While some HAs described programmes of work and specific initiatives in great detail others simply referred to other policy documents of the HA or the LA, or listed the names of projects and areas of work. In the survey, therefore, systematic information about what was being done to address health inequalities was sought in a number of different ways. First, respondents were asked to estimate the overall balance of effort that their HA made between the different strands of activities listed above. Secondly, they were asked to identify the top six priorities that the HA felt were most important locally to reduce health inequalities. Thirdly, they were asked to provide illustrative examples of particular initiatives under each of the headings. Unfortunately, this became too diverse to describe in detail here. Fourthly, respondents were asked about the extent to which their HA targeted particular groups, problems, or areas, as part of this approach to reduce health inequalities. Finally, respondents were asked for further detail about how their HA was trying to improve equity of access to health services.
Overall balance of activities

Figure 2.3 show a broad breakdown of the effort that respondents felt their HA put into these different activities. It is important to remember that respondents were asked for ‘guesses’ and hence too much emphasis should not be placed on these estimates. Respondents felt that just over one-quarter of their efforts to reduce health inequalities went into tackling the root causes of ill health and slightly more - 32 per cent - went on NHS activities. Slightly less - 19 per cent - of their effort went into promoting healthy lifestyles, while only 16 per cent of effort focused on building community capacity (including healthy living centres) and 7 per cent on R&D activities.

Overall, coterminous health and local authorities, and those with relatively new partnerships, reported putting the most effort into root cause activities. HAs working with two-tier LAs, or those that gave health inequalities ‘limited’ priority or who felt that it was ‘not a significant problem’ for them, put the least effort into these activities. Promoting community capacity to tackle health inequalities was highest among HAs that are coterminous with their LA, those with poor health but high inequalities, and those that thought health inequalities were only ‘of average concern’. It was lowest among those HAs working with two-tier LAs and those that felt health inequalities were of ‘limited’ priority. Efforts to promote healthy lifestyles were highest among HAs with good health and low inequalities, and among those that gave inequalities ‘limited’ priority. Such efforts were also lowest among HAZs and those HAs that said health inequalities were a ‘very important’ priority. NHS activities were highest among HAs that worked with two-tier local authorities, HAZs, those with reasonable health but high inequalities, and those who felt their HA only gave health inequalities ‘average’ concern. Efforts to use health services to tackle health inequalities were lowest among those with good health and low inequalities, those who had recently formed partnerships, and those that gave health inequalities ‘a limited’ priority or said it was only ‘of average concern’. Finally, investment in R&D
appeared higher among those HAs working with two-tier LAs and lowest among those with relatively new partnership arrangements.

Key priorities
Digging a little deeper, Table 2.17 shows the key activities respondents identified when asked what their HA’s top six priorities were to tackle health inequalities.

Over three quarters of respondents mentioned at least one priority associated with tackling the root causes of ill health. Contributing to local regeneration initiatives was the most commonly cited activity, followed by initiatives to prevent teenage pregnancy, or participating in SureStart initiatives. Nearly 40 per cent of respondents mentioned initiatives to promote the capacity of the community, through community development or community involvement activities, and by bidding for healthy living centre funds. Categorisation of the latter is slightly ambiguous, depending on its design and HAs’ perception of it, some labelled it as a ‘root cause’ activity, others ‘healthy lifestyle’, ‘NHS’ or ‘community capacity’.

Over half of the respondents mentioned at least one priority to promote healthy lifestyles to tackle health inequalities: reducing smoking, and tackling drug and alcohol addiction were the most commonly cited. Within NHS activities to address health inequalities most respondents simply replied ‘improve access to services’. A few specified the type of service on which they were focusing, those of particular concern appeared to be primary care, dentistry, community services, cardiac services and the uptake of screening.

As well as describing ‘what’ they were doing in their top six priorities, most respondents specified different kinds of foci. In the main, these were about particular geographic areas within their authority, specific health problems, and particular groups of the population. Table 2.17 also shows the different kinds of health problems and population groups that were cited as being priorities.

Not surprisingly, most of the key health problems mentioned are those that the Government has made a priority, such as teenage pregnancy, coronary heart disease (CHD) and mental health. It is perhaps surprising how little cancer features in this list given the clear social gradients that exist in it and the priority given to it by central Government.

Among the different population groups identified, children of all ages are the top priority for targeted efforts to address inequalities, while minority ethnic groups - and mainly within London, asylum seekers and refugees - are also important. Beyond these, very few other population groups were given systematic priority across HAs. Older people, for example, were only mentioned by nine per cent of the respondents. Given the level of morbidity among this group, the potential for reducing social inequalities in health by focusing more efforts on them is not really being exploited.

The final set of priorities mentioned by respondents focused on the processes that are required to support efforts to tackle health inequalities. The two main factors mentioned here included improving partnership working and finding ways of targeting resources at those most in need.
### Table 2.17 Key priorities to tackle health inequalities

<table>
<thead>
<tr>
<th>Priority</th>
<th>Per cent of HA's</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HA doesn’t have any priorities to tackle health inequalities</strong></td>
<td>3</td>
</tr>
<tr>
<td><strong>Social and economic problems</strong></td>
<td></td>
</tr>
<tr>
<td>Regeneration</td>
<td>41</td>
</tr>
<tr>
<td>Teenage pregnancy</td>
<td>36</td>
</tr>
<tr>
<td>SureStart &amp; support for parenting</td>
<td>27</td>
</tr>
<tr>
<td>Housing</td>
<td>17</td>
</tr>
<tr>
<td>Anti poverty, benefit uptake, credit unions</td>
<td>17</td>
</tr>
<tr>
<td>Education</td>
<td>14</td>
</tr>
<tr>
<td>Employment initiatives</td>
<td>11</td>
</tr>
<tr>
<td>Crime prevention (incl. domestic violence)</td>
<td>6</td>
</tr>
<tr>
<td>Physical environment</td>
<td>6</td>
</tr>
<tr>
<td>Transport</td>
<td>3</td>
</tr>
<tr>
<td><strong>Community capacity</strong></td>
<td>39</td>
</tr>
<tr>
<td>Community development</td>
<td>25</td>
</tr>
<tr>
<td>Healthy living centres</td>
<td>13</td>
</tr>
<tr>
<td>Community involvement</td>
<td>11</td>
</tr>
<tr>
<td><strong>Healthy lifestyles</strong></td>
<td>53</td>
</tr>
<tr>
<td>General</td>
<td>9</td>
</tr>
<tr>
<td>Smoking</td>
<td>25</td>
</tr>
<tr>
<td>Drugs and alcohol</td>
<td>19</td>
</tr>
<tr>
<td>Healthy schools</td>
<td>13</td>
</tr>
<tr>
<td>Access to food</td>
<td>11</td>
</tr>
<tr>
<td>Physical activity</td>
<td>5</td>
</tr>
<tr>
<td><strong>NHS</strong></td>
<td>39</td>
</tr>
<tr>
<td>General statement re reorganising/improving services</td>
<td>6</td>
</tr>
<tr>
<td>Improving access</td>
<td>27</td>
</tr>
<tr>
<td>Primary care</td>
<td>11</td>
</tr>
<tr>
<td>Dental care</td>
<td>6</td>
</tr>
<tr>
<td><strong>Health problems</strong></td>
<td>59</td>
</tr>
<tr>
<td>Sexual health (including teenage pregnancy)</td>
<td>39</td>
</tr>
<tr>
<td>CHD</td>
<td>28</td>
</tr>
<tr>
<td>Mental health</td>
<td>23</td>
</tr>
<tr>
<td>Cancer</td>
<td>9</td>
</tr>
<tr>
<td>Accidents</td>
<td>6</td>
</tr>
<tr>
<td>Diabetes</td>
<td>5</td>
</tr>
<tr>
<td>Respiratory disease</td>
<td>3</td>
</tr>
<tr>
<td><strong>Vulnerable groups</strong></td>
<td>75</td>
</tr>
<tr>
<td>Children and young people in general</td>
<td>53</td>
</tr>
<tr>
<td>Early years (pre school)</td>
<td>30</td>
</tr>
<tr>
<td>Ethnic minorities and asylum seekers</td>
<td>23</td>
</tr>
<tr>
<td>Older people</td>
<td>9</td>
</tr>
<tr>
<td>People with disabilities or who have a mental illness</td>
<td>9</td>
</tr>
<tr>
<td>People who are homeless</td>
<td>6</td>
</tr>
<tr>
<td>Prisoners</td>
<td>5</td>
</tr>
<tr>
<td><strong>Process</strong></td>
<td></td>
</tr>
<tr>
<td>General statement about need to target</td>
<td>16</td>
</tr>
<tr>
<td>Improving partnership working/develop joint strategies</td>
<td>13</td>
</tr>
<tr>
<td>Health impact assessment</td>
<td>5</td>
</tr>
<tr>
<td><strong>N=64</strong></td>
<td></td>
</tr>
</tbody>
</table>
Targeting

Table 2.18 shows the extent to which respondents felt that their HA was targeting its resources across a number of dimensions. Just over 70 per cent of respondents felt that their HAs targeted their efforts at least to a ‘reasonable’ extent on specific geographic areas. A similar proportion targeted particular health problems. Focusing efforts on demographic or socioeconomic groups was less pronounced, with just under half saying these groups were targeted to a ‘reasonable’ or ‘great’ extent. However, as a number of respondents made clear, geographic targeting was undertaken in order to prioritise socioeconomically disadvantaged groups and/or black and ethnic minority populations. For example, one HA, when asked to rank geographic, socio-economic and ethnic inequalities said ‘often comes to the same thing for us’. A nother, in their definition of health inequalities, said differences by ‘postcode = social class’. While geography is clearly a useful and simple proxy for such groups, research shows that this often misses more people living in disadvantaged circumstances than it captures (Fieldhouse and Tye, 1996; Joshi et al., 2000). Moreover, in some places there was a concern that plans to equalise services between areas would exacerbate inequalities, as the different needs of different places were not being taken into account. The ways in which HAs are improving access to health care is explored below.

Table 2.18 The extent to which HAs target their efforts to tackle health inequalities

<table>
<thead>
<tr>
<th>Per cent of health authorities targeting their efforts</th>
<th>To a great extent</th>
<th>To a reasonable extent</th>
<th>To a modest extent</th>
<th>To a limited extent</th>
<th>Not at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geographic areas</td>
<td>30</td>
<td>42</td>
<td>21</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Demographic groups</td>
<td>8</td>
<td>40</td>
<td>36</td>
<td>13</td>
<td>3</td>
</tr>
<tr>
<td>Socio-economic groups</td>
<td>13</td>
<td>28</td>
<td>36</td>
<td>18</td>
<td>5</td>
</tr>
<tr>
<td>Health problems</td>
<td>21</td>
<td>47</td>
<td>20</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>N = 65-70</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Improving access to health care

The final section of the survey examining what HAs are doing to tackle health inequalities explored, in a little more detail, their efforts to promote equity in mainstream NHS services in relation to need. Table 2.19 shows the extent to which respondents felt that efforts were being made to promote equity in NHS services in comparison to their assessment of how equitable services were in their area.

As can be seen, two-thirds of those places which were felt by respondents to have ‘very’ or ‘reasonably’ equitable services, were believed to be making a ‘great’ or ‘reasonable’ effort to promote equity, twice the proportion in places with less equitable services. Obviously it is impossible to say if the greater perceived equity in these HAs is a result of the greater effort or not. What is perhaps of significant concern is that a fifth of respondents that said local services were inequitable also said that their HA was making ‘little’ or ‘no’ effort to promote equity in the NHS.
### Table 2.19 Relationship between efforts to promote equity in the NHS and perceptions of inequalities in access to services

<table>
<thead>
<tr>
<th>Effort to promote equity in NHS services</th>
<th>Percentage of respondents who felt access to health care was</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Very or reasonably equitable</td>
<td>OK</td>
</tr>
<tr>
<td>Great or reasonable</td>
<td>69</td>
<td>36</td>
</tr>
<tr>
<td>Modest</td>
<td>23</td>
<td>36</td>
</tr>
<tr>
<td>Limited or none</td>
<td>8</td>
<td>29</td>
</tr>
<tr>
<td><strong>N=</strong></td>
<td><strong>13</strong></td>
<td><strong>14</strong></td>
</tr>
</tbody>
</table>

Finally, respondents were asked to describe what they were doing to promote equity in the NHS in more detail. The broad responses are shown in Table 2.20. It is important to note that less than half of the respondents replied to this question. Twenty per cent of these said that they were doing little more than beginning to recognise the problem. Fifteen per cent said that they were analysing data to ascertain the extent of the problem. In particular, respondents mentioned conducting equity audits as part of the CHD national service framework (NSF). Another fifth said that equity was considered as part of their policy review process for the HImP or SaFF. Some HAs had set up specific groups to undertake this review, while others had required all HImP sub-groups to do so. For example, one HA had recently established a group to ‘scrutinise’ all HA policy and strategies in order to examine their potential impact on equity issues. Another had an ‘Access to Services’ programme as part of its HImP process, while in another, all HImP strategic groups had to include objectives relating to inequalities in their three-year forward planning.

### Table 2.20 Ways in which HAs are trying to promote equity in NHS services

<table>
<thead>
<tr>
<th>Per cent of HAs</th>
</tr>
</thead>
<tbody>
<tr>
<td>General value/recognition of problem</td>
</tr>
<tr>
<td>Data analysis/equity audits</td>
</tr>
<tr>
<td>Some review as part of policy process</td>
</tr>
<tr>
<td>Influences some investment decisions (CHD, new buildings, targeting services)</td>
</tr>
<tr>
<td>Central criterion for all decision making</td>
</tr>
<tr>
<td>Plan to do something in future</td>
</tr>
<tr>
<td><strong>N=34</strong></td>
</tr>
</tbody>
</table>

A further fifth of HAs said that promoting equity was a criteria in some of their investment decisions. Key aspects mentioned here, were the location of new capital projects and primary care developments, and differential investment in key services by geographical location. For example, one respondent said that the HA ‘targeted approaches to addressing the main killer diseases e.g. CHD, cancer’. Others, however, said that while they were concerned about inequalities in access to services ‘responding to this is limited by resource constraints’.
Finally, a small group said that equity was a key criterion in all of their decision-making:

In all work of HA and considered in all decision making.

We have a financial deficit ... deciding how to solve that and modernise at the same time means using equity as a major criterion.

Summary

Many HAs are still in the process of developing their strategies to address health inequalities. Since health inequalities are often defined very broadly, strategies to tackle them can appear to include everything. While some HAs have developed a clear rationale to guide the HImP’s development in this respect, others appear to have ad hoc lists of activities with little coherence. More specifically, many HAs are engaged in activities with a range of partners to address the root causes of ill health and to build community capacity, although a few simply list what partners are doing and concentrate on activities within the NHS themselves. Efforts to promote healthy lifestyles are a key feature of many HAs’ activities, but, while improving NHS services is seen as important, there appears to be less emphasis placed on improving equity of access to such services. Given this overview of the community health improvement process across HAs, the next section turns to consider the progress that respondents felt their HAs had made in this endeavour.

Progress

Clearly, it is not possible in a survey to make an objective assessment of progress. Moreover, it is such early days in most HA’s efforts to tackle health inequalities that changes in the distribution of health outcomes would not be anticipated yet, rather, HAs have been establishing a framework for addressing health inequalities. To capture this, the survey asked about respondents’ overall perception of their progress. The overall results are shown in Table 2.21. Most respondents felt that their HA had made at least ‘average’ progress, with only 13 per cent feeling it was ‘poor’ or ‘very poor’. Respondents from HAs with poor health and high inequalities were more likely to say that they had made ‘good’ progress, while all of those respondents from HAs with good health and low inequalities reported ‘average’ progress. The group with universally poor health was most likely to report ‘average’ or ‘limited’ progress.

The survey also asked respondents to explain their progress. These responses have been categorised and are shown in Table 2.22.

| Table 2.21 Assessment of progress in tackling health inequalities over last year |
|---------------------------------|----------|
| Per cent of HAs                |          |
| Excellent                      | 5        |
| Good                           | 34       |
| Average                        | 47       |
| Poor                           | 12       |
| Very poor                      | 1        |
| **N=74**                       |          |
Nine per cent of respondents said that there was still no commitment in their HA and/or partnerships to tackling inequalities in health. Although most then went on to say that, despite this, some initiatives were happening on the ground, usually as a result of key individuals or other agencies taking the lead. For example:

We have good analyses, reasonable documents and some excellent specific initiatives - but I am not convinced that the HA and its PCGs really own the agenda.

I feel that although there is some good work happening on the ground supported by particular individuals in the HA, there is little corporate ownership or commitment to this work from the HA. The HA should have a role providing leadership to PCGs and the LA in respect to health inequalities. This is not happening.

**Table 2.22 Perceived progress in tackling health inequalities over last year**

<table>
<thead>
<tr>
<th>Per cent of HAs</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No commitment</td>
<td>9</td>
</tr>
<tr>
<td>Too difficult/too big</td>
<td>9</td>
</tr>
<tr>
<td>Other pressures dominant</td>
<td>29</td>
</tr>
<tr>
<td>On agenda</td>
<td>4</td>
</tr>
<tr>
<td>On agenda, mainly process activities &amp; capacity building</td>
<td>31</td>
</tr>
<tr>
<td>On agenda and action taking place</td>
<td>18</td>
</tr>
</tbody>
</table>

A second group of respondents said that little progress had been made because of the scale of the problem they faced, and/or the difficulty of tackling it. A number also said that tackling health inequalities really required national, not local, action. Those authorities with universally poor health mainly gave this response. An important point that a number of these HAs made was that, although they were making progress, more affluent places were also improving the health of their populations, and hence their relative position was not changing. For example:

Commitment [is] strong as is effort, but progress made locally can be overtaken by faster/better improvements in more affluent parts. Hence tendency to stay at bottom of ranks despite steady change at local level.

Nearly a third of respondents said that other pressures dominated their agendas. There were two broad dimensions to this, those that said that other Government-set priorities, such as waiting lists, etc., meant that health inequalities were always last on the list, and those that said that structural changes had hindered their ability to move forward. For example:

HA is engaging with partnerships but there are too many conflicting priorities and this work always seems to be bottom of the agenda.
tune of organisational change diminished resource available to devote to this issue.

One or two respondents mentioned local priorities that overwhelmed their agenda, such as particular acute sector issues. For example, one respondent reported that:

... commitment to tackle root causes ... has been high but reductions in expenditure by local authorities and cost pressures from acute sector have meant finding resources for implementation [is] difficult.

It is important to emphasise that all of the health authorities in the groups above do appear to be engaged in activities to address health inequalities, but the perception of key informants is that it is not a significant issue on the local agenda.

In contrast, 53 per cent of respondents felt that health inequalities were on the local agenda in a way they had not been until now, and that in different ways progress was being made. For some respondents, this was simply about getting some commitment to addressing inequalities. Others felt that they were beginning to get some of the necessary processes and foundations in place. Finally, some respondents felt that they have gained funds or developed strategies to address health inequalities that are now being implemented.

Much higher on people’s agendas.

Breakthrough on understanding, perceived way forward and partnership commitment.

Long-term process – progress is slow – setting foundations in place, development of a joint agenda to tackle health inequalities.

Good progress in partnership working with LAs and others in raising health inequalities in the context of community plans and other joint strategies.

Such statements about health inequalities ‘being on the agenda’ and the appropriate foundation stones being put in place were more likely to be made by those respondents whose HAs have poor health and high inequalities. Statements about implementing strategies, gaining resources or ‘doing things’ were less likely among respondents from HAs with the universally poor health, and entirely absent from those authorities with good health and low inequalities.

Summary

Most respondents felt that their HA had made good progress in addressing health inequalities. However, since this analysis is based on the perceptions of one individual within the HA, it is limited as a comparative measure of progress. The starting point is a specific individual’s perception of what represents ‘progress’, which clearly varies from place to place and between respondents. What is important, however, is that faced with the same national policy framework, some respondents felt that their HA was able to make progress in getting health inequalities on the agenda, while others felt blocked by other national priorities. The factors that distinguish these two groups
are crucial to an understanding of how to make progress in promoting action to tackle health inequalities in the future, and are explored further in the case studies.

**The way forward**

This final section examines the future direction of HAs’ strategies to tackle health inequalities. It explores how optimistic respondents were at the end of 2000 about the ability of HAs to address health inequalities in the future, what they saw as the next steps, and what factors they felt might facilitate or inhibit progress. It needs to be borne in mind, that when the survey was conducted few respondents expected their HA to merge in the near future. While the move to strategic health authorities means that the perceptions and plans of HAs as they existed in 2000 are on longer directly relevant to future efforts, the next steps and inhibiting and facilitating factors that these respondents identified, as discussed below, have been shown to be similar to those of PCG/Ts (Abbott et al., 2001).

**Optimism about the future**

As shown in Table 2.23, most respondents were ‘reasonably’ or ‘modestly’ optimistic at the time of the survey about their ability to tackle health inequalities in the future. Those HAs that had only recently formed partnerships to address health inequalities were the least optimistic about their future capacity to tackle this agenda, while those with long histories of partnership working were more positive about the future. HAs working with multiple unitary authorities were more likely to say they were not optimistic than those that did not. The higher the priority the HA attached to tackling health inequalities, the more optimistic respondents appeared to be about their ability to address them in the future.

**Table 2.23 Optimism in relation to future efforts to tackle health inequalities**

<table>
<thead>
<tr>
<th>Per cent of HAs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very optimistic</td>
</tr>
<tr>
<td>Reasonable optimistic</td>
</tr>
<tr>
<td>Modestly optimistic</td>
</tr>
<tr>
<td>Not very optimistic</td>
</tr>
<tr>
<td>Not at all optimistic</td>
</tr>
</tbody>
</table>

N=73

**Next steps**

The ‘next steps’, described by the respondents, suggested that they are still in the early stages of developing their approaches to tackle health inequalities. As with their description of progress to date, many HAs are still concentrating on establishing appropriate processes and frameworks locally for tackling inequalities in health. Table 2.24 shows the broad thrust of the three next steps described by respondents as crucial in their area to reduce health inequalities.
**Table 2.24 The three next steps identified**

<table>
<thead>
<tr>
<th>Step</th>
<th>Percentage of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Get commitment locally to tackling inequalities in health</td>
<td>31</td>
</tr>
<tr>
<td>Build effective partnerships especially with LAs</td>
<td>52</td>
</tr>
<tr>
<td>Work with PCTs to develop their approach to tackling health inequalities</td>
<td>26</td>
</tr>
<tr>
<td>Work with developing LSP on health inequalities</td>
<td>6</td>
</tr>
<tr>
<td>Work with community/build community capacity</td>
<td>9</td>
</tr>
<tr>
<td>Establish specific health inequalities post or groups</td>
<td>8</td>
</tr>
<tr>
<td>Develop joint public health function</td>
<td>5</td>
</tr>
<tr>
<td>Build equity into general framework/systems locally</td>
<td>11</td>
</tr>
<tr>
<td>Develop/review evidence base about what works</td>
<td>11</td>
</tr>
<tr>
<td>Develop/employ equity tools (HIA, equity audits etc)</td>
<td>20</td>
</tr>
<tr>
<td>Conduct need assessment or service review</td>
<td>19</td>
</tr>
<tr>
<td>Learn from own work and disseminate good practice</td>
<td>8</td>
</tr>
<tr>
<td>Develop strategy/agree priorities</td>
<td>28</td>
</tr>
<tr>
<td>Allocate resources to tackling inequalities in health</td>
<td>15</td>
</tr>
<tr>
<td>Develop performance management/accountability mechanisms</td>
<td>12</td>
</tr>
<tr>
<td>Set health inequalities targets</td>
<td>20</td>
</tr>
<tr>
<td>Implement specific strategies or initiatives</td>
<td>22</td>
</tr>
<tr>
<td><strong>N = 65</strong></td>
<td></td>
</tr>
</tbody>
</table>

The most common statement - mentioned by nearly half of respondents - was the need to continue to develop partnerships especially with their LAs. Linked to this, a number of respondents recognised the need to influence the LSP as it developed to ensure that health was a central part of its thinking, and to bring the HIImP and community plan closer together. For example, different respondents said their next steps were:

- Better partnership working with shared clear priorities.
- Continue close working with partners - be in at start of local strategic partnerships.
Developing community plan to which HImp is linked - including joint high-level meaningful targets.

Nearly ten per cent of respondents also mentioned the need to strengthen partnerships with community and voluntary groups or to place more emphasis on community development and community capacity building.

Another ‘next step’ that was mentioned by just over 30 per cent of respondents was the need to continue to create local commitment to tackling health inequalities. In some cases this was a general statement ‘to see health inequalities as a priority’, or to increase ‘the profile of inequality issues against the multiplicity of others faced by NHS and others’. Other respondents focused on the need to engage key organisations or individuals in the debate about reducing health inequalities. For example different respondents said what was required was:

**Greater understanding and commitment from chief execs and leadership.**

**Getting commitment to equity action plans from PCTs and LAs.**

**Ownership by PCGs at a local level.**

The need to work with PCG/Ts to develop their role in relation to tackling health inequalities was mentioned by one quarter of the respondents. Issues raised ranged from: simply beginning to involve PCTs; to transferring responsibilities to them; to supporting them to develop partnership working among themselves and with other agencies; and, to performance managing their actions.

**More strenuous action by PCTs to focus on health and health inequalities.**

**Ensure HImp approach to addressing inequalities is implemented by PCG/Ts.**

**Organising system for PCG/Ts to collaborate, share good practice and fund the work.**

Eleven per cent of respondents articulated the need to develop an overarching framework for tackling inequalities or for this to be built into all processes. A further eight per cent argued for specific posts or working groups to be established to tackle it. Clearly, different approaches are likely to be more or less appropriate, depending on the local policy and partnership context. For example, different respondents argued for the need for:

**Incorporation of inequalities across modernisation task groups.**

**Develop an overarching strategy, which underpins all policies and developments.**

**Make explicit in individual organisation and partnership plans.**
Others were taking a more focused approach:

Build sustainable inequalities team.

Appointment of modernisation manager with a specific remit for inequality.

Obviously these two approaches are not mutually exclusive - the last respondent quoted above also argued the need for ‘having social inequality as a cross cutting theme throughout the HImP’.

This last point links to another area that a significant number of respondents - 28 per cent - felt was an important next step - agreeing priorities, developing a strategy or refocusing the HImP on health inequalities issues. Associated with this, 15 per cent of respondents made the point that HAs needed to be able to allocate resources explicitly for this endeavour.

Underpinning the development of a strategy, a range of R&D activities were cited by respondents as being important next steps. These ranged from conducting traditional need assessment work and service reviews (19 per cent), to undertaking equity audits or health inequalities impact assessments (20 per cent). Eleven per cent of respondents mentioned the need to review evidence about effectiveness or ‘to identify what works/good practice to influence the myriad initiatives currently taking.

A related issue highlighted by a smaller number of respondents was the need to develop a joint public health function, or, more specifically, jointly accountable DPHs or jointly funded senior public health staff.

The next two sets of activities described by respondents focus on implementing action either in general, or in relation to specific issues. Most often cited was using public sector employment opportunities to tackle disadvantage and working more closely on regeneration issues in general. Within the NHS, respondents focused on improving primary care and targeting resources on those people and places in most need.

Finally, people were aware of the need to be held to account more explicitly for tackling health inequalities. Two specific ways of doing this were suggested: setting local health inequalities targets and building health inequalities more firmly into the performance management of a range of agencies. Within the latter, a number of respondents emphasised the need for joint accountability and performance management arrangements.

Inhibiting and facilitating factors

Respondents were asked which three factors would enable them to make progress in the future or hinder them from doing so. Table 2.25 shows the broad responses provided. The answers to the inhibiting and facilitating dimensions of this question have been merged as they were often the mirror image of each other. All of the issues raised here were also identified in the case studies, and are discussed in more detail in Part 3.

The key factor cited by over 60 per cent of the respondents was that health inequalities need to be a key national priority. A few respondents articulated this as continued commitment. However, the majority of respondents felt that there was a
need to **increase** the current national priority given to inequalities and put it on an equal status with other ‘must dos’. For example, one respondent wrote:

> A message from the centre that this ranks alongside waiting lists and winter pressures ... there are no other [enabling] factors.

Similarly, respondents believed current NHS policies were weak in relation to health inequalities, for example, some respondents said a key inhibiting factor was ‘the lack of priority within The NHS Plan’ and that ‘The NHS Plan – [was] incredibly weak on inequalities’. Another said that:

> Balance of the HiMP must swing from SaFFs and NHS Plan to inequalities. I know it is in theory, but no chief exec will get knuckles rapped for failing to deliver social inclusion.

The last point links to one made by 16 per cent of respondents who argued that health inequalities needed to be explicitly incorporated into ‘performance management at regional, district and local level i.e. “jobs will depend on it”’.

A further nine per cent of respondents said that there should be firmer joint accountability for tackling health inequalities. Current performance management systems were believed to be ‘misdirected’ if the Government was serious about tackling health inequalities. Instead, respondents argued that there needed to be ‘performance management on inequalities targets’, and for ‘joint performance management of LAs and NHS’.

Alongside a concern for the Government to provide consistent messages to local agencies, respondents argued for other aspects of the policy framework to tackle health inequalities to be more facilitative. In particular, respondents argued for less central control so that local agencies had more freedom and flexibility to respond to local needs, and less ‘short termism’ so that there was an explicit recognition by the Government of the need for ‘longer term strategies, timescales and funding’.

Funding was also seen to be a crucial issue. Thirty-six per cent of respondents said that they needed more resources to tackle health inequalities effectively. For example, one respondent said:

> Funding constraints – some of the services to tackle inequalities are already under funded and so it is difficult to make a difference without extra money.

A number made the point that they needed ‘resources for development’ or ‘money to kick start initiatives’. Sixteen per cent of respondents specifically argued that there needed to be ringfenced or earmarked resources to do this. For example:

> Ringfenced allocation of resources for health promotion/tackling health inequalities.

> Dedicated resources to focus and improve efforts.
A few respondents mentioned the need for specific funds. For example, several HAs within HAZs emphasised the need for ‘continued investment in the HAZ’. Some non-HAZs said they needed resources for ‘health impact assessment (HIA) and evaluation’, while others said that there was a need ‘to invest in primary care infrastructure’.

One final point made by a few respondents was the need for ‘the funding formula to accurately reflect local needs’. In the main, this point was made by respondents in London authorities, who felt that their HAs’ needs were inadequately reflected, either because of the issues around providing care for ethnic minorities and refugees, or because of the problems that they have as a result of having very mobile populations.

Table 2.25 Inhibiting and facilitating factors in taking forward the agenda to tackle health inequalities

<table>
<thead>
<tr>
<th>Inhibiting/facilitating factors</th>
<th>Per cent mentioned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Government commitment to health inequalities</td>
<td>63</td>
</tr>
<tr>
<td>Performance management of health inequalities</td>
<td>16</td>
</tr>
<tr>
<td>Joint performance management of local agencies</td>
<td>9</td>
</tr>
<tr>
<td>Local freedom and flexibility</td>
<td>10</td>
</tr>
<tr>
<td>Recognition of long term nature of solutions</td>
<td>12</td>
</tr>
<tr>
<td>Level of overall resources</td>
<td>36</td>
</tr>
<tr>
<td>Ringfenced/earmarked resources</td>
<td>19</td>
</tr>
<tr>
<td>Resource allocation formulae</td>
<td>3</td>
</tr>
<tr>
<td>Restructuring</td>
<td>37</td>
</tr>
<tr>
<td>Can PCTs lead on health inequalities?</td>
<td>6</td>
</tr>
<tr>
<td>Strengthening public health</td>
<td>18</td>
</tr>
<tr>
<td>National policy required</td>
<td>9</td>
</tr>
<tr>
<td>Joined up central government</td>
<td>5</td>
</tr>
<tr>
<td>Partnership working</td>
<td>30</td>
</tr>
<tr>
<td>Local commitment to tackling health inequalities</td>
<td>42</td>
</tr>
<tr>
<td>Champions</td>
<td>8</td>
</tr>
<tr>
<td>Evidence base</td>
<td>18</td>
</tr>
<tr>
<td>National targets</td>
<td>10</td>
</tr>
<tr>
<td>Local R&amp;D</td>
<td>21</td>
</tr>
<tr>
<td>Primary care</td>
<td>3</td>
</tr>
<tr>
<td>Integrated services</td>
<td>3</td>
</tr>
<tr>
<td>HA has no control over relevant local services</td>
<td>9</td>
</tr>
<tr>
<td>Local recognition of problem</td>
<td>5</td>
</tr>
</tbody>
</table>

N = 71

Following these sets of factors, the next most significant point – which was raised by 37 per cent of respondents – was that ‘constant restructuring’ and too many organisational uncertainties’ were hindering progress. In some cases respondents’
worries have subsequently been realised. For example, a number said that progress would be enhanced if HAs were 'not ... abolished' or there were 'no more mergers'.

As well as the process of reorganisation causing concern, some respondents were also concerned about whether PCTs were the right agencies to lead the health inequalities agenda in the future. For example respondents said:

- HA has become virtual – PCT is main player and is focused on services.
- Devolving resources/power/decision making to PCGs/Ts could distract from health inequalities.
- Service delivery agenda for PCTs will overwhelm.

A related concern was the future of public health and health promotion. Respondents felt that devolving these responsibilities to PCG/Ts has led to the ‘fragmentation of specialist health promotion’ and the ‘decentralisation of public health capacity’. Moreover, this was exacerbated in some places by the lack of clarity about future structures such that one respondent reported a local ‘battle for public health responsibility’ so that there was a need to ‘sort out who leads on public health in the community - LA or NHS?’ Such ‘turf wars’ were felt to be hindering action. Other respondents argued that they needed ‘more public health time’, and, to ‘ensure adequate specialist health promotion and public health knowledge and skills i.e. capacity and capability to reduce inequalities’.

At the local level the key factor mentioned by 30 per cent of respondents was partnership working. Issues raised ranged from the need to develop partnership working further to the problems experienced because of the lack of coterminosity with LAs or the general complexity of relationships that they faced. Other respondents focused particularly on integrating the role of HImPs and the community plan more closely. For example, respondents said:

- HImPs must be more clearly linked into LA consciousness. There is confusion about community strategies and HImPs and this waters down LAs involvement.

More specifically, a number of respondents made suggestions about ways in which partnership working should be developed, including joint budgets and appointments, as well as the issues mentioned above in relation to joint accountability.

Closely associated with issues around partnership working was the need to increase the commitment of other key players. For example, one respondent said that what was needed was ‘chief executive leadership in all sectors’ and another, the ‘engagement of LA chief executive’. To develop and support partnership working in this area, one respondents argued for ‘development work for chief executives and chairs’. Others argued for the need for broader local commitment ‘from the wider health community’, or for ‘a change in attitude among staff’ and for there to be an ‘acknowledgement from the population that inequalities exist’. Finally, as described above, in the ‘next steps’ section, some respondents felt that a ‘post to champion this objective and work in regeneration partnerships’ would enhance tackling health inequalities.
The final set of factors that were mentioned by a significant number of respondents were focused on the available evidence base and the need for more national and local work on this. For example, respondents said:

- We don’t really know HOW to do it.
- Examples of effective practice across ALL types of interventions.

Others pointed to more specific local activities that they felt would move them forward, such as:

- More robust evaluations/outcome measures
- Prospective health inequalities impact assessment.

Finally, ten per cent of respondents argued for national targets to tackle health inequalities, which have subsequently been produced.

Summary

Tackling health inequalities is a long-term agenda. To a greater or lesser extent most HAs have made some progress along the road. Key next steps identified were strengthening local commitment, developing partnership working, and working with PCG/Ts to ensure that tackling health inequalities was firmly built into their agenda. Crucial to all of this was central Government giving health inequalities greater priority and giving local agencies further resources to address them.

Summary

Considerable progress has been made by HAs in developing their local community health improvement process. All HAs are making some efforts to address health inequalities, but their definition of the problem was often very broad and goals vague, which makes devising a clear strategy difficult. This is exacerbated by many respondents feeling that they do not know ‘what works’. Moreover, addressing health inequalities requires partnership working across agencies and with communities, both of which need time to develop if they are to be effective. Commitment to tackle health inequalities has grown tremendously since Labour took office, but needs firmer and more consistent national support. There is concern that restructuring will distract agencies from pushing forward this agenda, and, perhaps more importantly, that PCTs are not committed enough to take the lead. Local champions have played a significant role in getting health inequalities on the agenda and are seen to be an important part of taking it forward. However, people recognise the need to create formal champions, particularly at chief executive level, in partner organisations, rather than rely on personalities. It was generally felt that making health inequalities a more central part of performance management would help to achieve this.
Key policy implications

- HA's should have a clearer definition of what they mean by health inequalities and what they are trying to achieve in this area.
- Stronger central Government commitment to reducing health inequalities would enable local agencies to devote more resources to this endeavour.
- Ringfenced funding for health inequalities would enable local agencies to put more effort into addressing them.
- Tackling health inequalities needs to be part of performance management systems across partner agencies.
- Improving equity of access to health care needs to be given increased importance across a range of ‘modernisation’ policies within health and social care.
- Tackling health inequalities needs to be made a more central part of PCTs’ agenda, and they need to be supported to develop the skills and capacity to address them.
- Continued effort needs to be made to raise awareness of the problem of health inequalities and to develop and to disseminate evidence about how to tackle them.
- The long-term nature of tackling health inequalities needs to be recognised explicitly, and built into policy agendas and target setting.
- Within a national framework to address health inequalities, there needs to be scope for local flexibility to address local priorities.
REGIONAL OFFICE FRAMEWORK

NHS Executive regional offices were expected to perform a variety of functions relating to the NHS’s role in tackling inequalities in health at local level. These included carrying out performance management, and providing a resource for local bodies working in public health as part of a national network of knowledge, information and surveillance (Cm 4386, 1999). Furthermore, Saving Lives made a commitment to establishing public health observatories in each of the regions, and envisaged them working together with a range of agencies including government offices for the regions, regional development agencies and the NHS Executive regional offices. At the time of interviewing, new guidance around strategic HAs and the plans for regional offices to be disbanded had not yet been made public.

This section explores the level and types of support offered to HAs from the regional level, and highlights some of the key issues that came out of both the regional office interviews and the interviews held in individual HAs. Types of support needed, the constraints under which regional offices work and the limits on their interventions at a local level are discussed. Since the fieldwork for this project has been completed, it has been announced that regional offices will be disbanded. Nevertheless, the issues that are identified below will be very pertinent to strategic health authorities as they take over the role supporting and performance management the efforts of PCTs to address health inequalities.

Support

In the regional office survey, respondents were asked what sorts of support was provided to HAs, and how they saw their role as contributing to HAs’ ability to tackle inequalities in health. Regional offices are engaged in a variety of support and performance management related activities at a local level. There was a marked difference between those who saw their role as part of the broad role defined by Saving Lives - as a public health resource for HAs and those regional offices that were strictly concerned with performance management. Of those regional offices providing a range of support and activities, four broad types of support were identified. These were:

♦ organising and facilitating inequalities-specific conferences, workshops and networks;
♦ offering support - for example in HImP, community plan and LSP development;
♦ sharing best practice – intra and inter regionally, assisting in the collection and dissemination of data/ R&D on a variety of issues pertaining to inequalities and developing guidance / briefing around policy documents;
♦ public health observatories.

Examples of these are given below.

Discussing the networks and conferences organised by their regional office, one respondent said:
We supported various conferences and workshops on this subject, and obviously through the different networks ... I have done about half a dozen different networks for the areas that I work in, we bring up health inequalities on those agendas.

The same respondent also highlighted a specific network that they supported around health living centres, looking at how best to target work and concentrating on health inequalities.

In terms of their development and support role around the HImP, which involves a number of different activities, another respondent said:

... we fund a number of development courses where the leads taking forward those [HImP] strategies go on and talk about the complexities of partnership working ... [there is also] a group of all the health improvement programme leads ... a meeting roughly every quarter where they discuss issues of concern to them or I tab le things which help in the development of those policies.

Also discussing HImP development, in relation to health inequalities in particular, another respondent said:

I have been helping the person that has [HImP responsibility] in particular to make sure that each of the HImPs has got a very clear focus on health inequalities and has got local strategies to address them.

There was also a range of examples offered to illustrate their roles in providing or synthesising good practice and other forms of data:

... keeping them up to date with ... developments like data ... one of the things people struggle with is obviously how to get hold of good quality robust data at the local level. So telling them about developments at ONS.

... primarily the decoding to a local level, from the regional health authorities, guidance from the centre, from the department of health and other central organisations that may have issues relating to inequalities ... providing guidance and briefing papers.

In terms of support we give, it is a question of sharing best practice and information that we have either from other health authorities or from other parts of the country as well, from other regional colleagues with whom we have a network established so that we can share best practice on the information as well.

And finally, discussing the role of their public health observatory, one respondent said:

We have got a public health observatory and the public health observatory has just completed ... a review on inequalities, they commissioned a review on inequalities in the [X] region. So that has provided a sort of
overview. They are also doing a piece of work looking at the health and poverty index.

While each of the regions has a public health observatory, at the time of interviewing there was little sense of substantial links between the regional offices and public health observatories. Only two respondents mentioned them explicitly when discussing the support that they offered. This could be in part because public health observatories are still in their infancy and not necessarily physically based at the regional office.

The observatory is still in its formative stage really, and it has established a work programme and established a few initial outputs, I don't think it would be honest or fair to suggest that the observatory is at the stage of specifically supporting health authorities or local authorities in trying to address inequalities in health.

Five regional offices reported that they were primarily engaged in performance management, and offered little other support to HAs around tackling inequalities. There were two types of reasons given for this. First - the most common reason - was that HAs would engage in tackling the inequalities agenda through meeting NSF targets and The NHS Plan ‘must dos’, and therefore the RO had little need to offer support other than performance managing them in this, as well as all other areas. They also felt that they lacked the resources to do so.

We have not got the resources to do that ... they know they have to deliver on certain aspects of the inequalities agenda and we expect that to be done.

I am not aware that the regional office here has run any workshops for HAs or inequalities in health and the kind of information on inequalities at district level, I would expect the HAs themselves to be aware ... probably more aware than we are in the regional office, I would not really expect us to be able to provide them with that information. Rather the other way around. I would expect them to provide us with that sort of info.

Secondly, on a more practical level, respondents spoke of the regional offices being constrained in their activities by being poor performers on NSFs and other targets, and in needing time to bed down as they were relatively recently formed.

We have taken quite a lot of time trying to get our own house in order but in the meantime we have also been linking as closely as we can with the government office. I think it will get better and better but we have made a good start.

Our region is performing extremely badly, on the waiting list and all of the other major agendas. We are a real outlier and I think probably that is our performance management main agenda.
While there was, in some cases, a sense of things getting better and that regional offices would provide increasing levels of support as it became more feasible, some respondents also suggested that this was not really their role.

**Performance management**

As discussed in the preceding section, all regional offices see performance management as one of the main functions that they need to carry out. Saving Lives (Cm 4386, 1999) states that regional offices are expected to set realistic but demanding targets for local achievement, and to monitor HA’s performance. There is scope here for the inclusion of targets that encompass tackling inequalities. Furthermore, The NHS Plan expressed a specific commitment to making improving access to health care and tackling health inequalities part of the NHS Performance Assessment Framework by 2001. Although this did not take place, the Government’s response to the Health Select Committee’s report (Cm 5242, 2001) made a commitment to doing this by April 2002.

However, from the regional office survey, conducted in March 2001, performance management still did not appear to assess what HAs were doing to tackle inequalities in health. Essentially, at the time of the survey there was very little in place to hold HAs to account around tackling health inequalities. As a result, when asked to what extent equity considerations were built into the performance management framework, their responses varied considerably.

There were, however, elements of broader NHS performance management identified that relate to inequalities, and some respondents cited these as their primary means for holding HAs to account. Most commonly, regional offices referred to the inequalities dimension within the various government policies, so for example if HAs were measured on NSFs or the SaFFs they would automatically also be held account to the inequalities element of the targets. There was also mention made of the new inequalities targets, with the implication being that they might be included at a later stage. Other processes included looking at inequalities within the HImP development and assessment but still not specifically around developing an inequalities framework.

One RO cited a regional evaluation of all the HAs in their region with a specific chapter on what they were doing about identifying and reducing inequalities.

**What do HAs want regional offices to do for them?**

There was a general perception from HAs that they received very limited support from their regional offices. However, there was also recognition of what the regional offices could potentially be doing.

A HA senior manager saw regional offices - government and NHS Executive - as influential in, among other things, LSP development and performance management, and it was felt that there was potential for cohesiveness and integration between NHS Executive regional offices and government offices for the regions that had not been realised.

I think regional government offices are going to become major players within the next 18 months, I mean they have already set out that they will
be determinants of whether or not there is a properly blessed local strategic partnership.

Regional offices were seen to be a critical element of an integrated regional public health function in the future, working together with other regional and local level bodies to bring about an effective overarching strategy, as well as integrating health organisations with other services that affect health. An HA executive director said:

I think there is plenty of scope for that integrated regional public health function, whatever that means – there is an intention to produce a regional health strategy as its in The NHS Plan.

Respondents saw real scope for significant efforts to address some of the determinants of health through more joined up government at regional level. The same respondent went on to say:

And it is what then you take up to the broad strategic level as part of regional development agencies and stuff at sub-regional level where you have still got the scope for pulling that together around transport, housing – all of those social exclusion type of issues.

Locally there was a sense that the regional office could, for example, play a much bigger role in ensuring accountability and in working with the HAs to develop appropriate performance ratings. There is a need at the regional level to draw on local knowledge and understanding, and this can come from HA/PCG level:

And I would like to see the … regional office making health inequalities and regeneration a very important part of the accountability arrangements of health authorities … now I think at the moment they probably don’t know what to put into these performance ratings. We would be very happy to help them, we have offered before.

You need to get people that have local knowledge feeding the system … there is going to be a regional taskforce for children, which feeds the national taskforce for children … we can lend our local learning to other areas too, rather than duplicate. We are all tackling the same problems by and large, let us share the experience.

Looking forward

As outlined in Shifting the Balance of Power within the NHS (DH, 2001a), the regional office functions are to be devolved to new strategic health authorities, and it is expected that the regional offices of the NHS Executive are to disappear over time. There will be four new health and social care directors, and regional directors of public health will be co-located in each of the government offices for the regions – the latter development being seen as a positive step in supporting the public health function. Government offices for the regions will be responsible, among other things, for LSP development and performance management.

Evidence from our surveys, suggests that both strategic health authorities and government offices for the regions must make greater efforts, both in terms of
supporting PCTs and LSPs in developing their strategies to address health inequalities and in holding them to account for their action, than most regional offices appear to managed to date.

This section has highlighted the need for regional support to be developed, beyond performance management, and beyond the health and social care agenda. Regional offices were limited in their capacity to provide support in this regard. Strategic health authorities and government offices for the regions must be enabled to provide a better balance between support and performance management for PCTs and LSPs to ensure that they take forward the health inequalities agenda effectively.

**Key policy implications**

- Government offices for the regions and strategic health authorities need both to support and to performance manage PCTs and LSPs to address health inequalities.
- The role of the regional directors of public health needs to be closely integrated into the government offices for the regions to ensure that LSPs are effectively supported and held to account in their efforts to address health inequalities.
PART 3

EXPLORING THE MECHANISMS TO GET HEALTH INEQUALITIES ON THE LOCAL AGENDA
INTRODUCTION

The aim of this part of the report is to examine the extent to which health inequalities are embedded in the local agenda, and what the inhibiting and facilitating factors local agencies have encountered in this policy process. The section is organised around the policy framework outlined in part 1, which identified the key mechanisms the DH employed to put health inequalities on local agendas. The ten mechanisms are divided into four groups as set out below.

A. Making health inequalities a priority

B. Restructuring the NHS

♦ Gave HAs strategic responsibility to lead on tackling health inequalities.
♦ Created PCGs to take over HAs’ commissioning role, as well as being responsible for improving health and developing primary care for their communities.

C. Working in partnership

♦ Placed ‘duty of partnership’ on NHS and LAs to work together to promote health (associated changes for LAs e.g. duty of well-being).
♦ Introduced health improvement programmes, 3-year strategy to integrate local action to promote health.
♦ Placed emphasis on the need to involve the public and to build community capacity.

D. Supporting and enabling foundations

♦ Plan to change funding formula so that it aims to ‘reduce avoidable health inequalities’.
♦ Changed the Performance Management Framework for the NHS to include equity and improving health and required local areas to set local inequalities targets.
♦ Increased recognition of public health within NHS and legitimised the social model of health.
♦ Emphasised the need for policy and action to be evidence based, and invested in research, development and dissemination to support action.

This part of the report is organised into these four broad groups and examines the effect of each of these ten mechanisms on local action to tackle health inequalities. To a certain extent, some of these issues have already been touched on in the preceding mapping section. However, it is important to examine these issues at these two very different levels. The mapping section gives some indication of how widespread issues concerning these mechanisms appear to be, across a representative set of HAs in the whole of the country. This section explores in depth how well they have worked in five particular contexts, and how people on the ground felt they could be enhanced to enable them to tackle health inequalities more effectively in the future. Drawing on the ideas of realistic evaluation and ‘theories of change’ it is assumed that the DH mechanisms will operate in different ways depending on the local context. Given this, before examining the mechanisms in more detail, it is important to develop a better understanding of the five places in which the study took place.
The case study sites

Boxes 3.1 to 3.5, set out a very brief outline of each of the five case studies’ strategies to tackle health inequalities using the framework described in Figure 1.1 – the community health improvement process. Drawing on interviews from the case study areas, the HAs’ HImPs and other strategic documents the boxes set out:

♦ the overall goals that the case study sites have set themselves to reduce health inequalities;
♦ their general context – the local economy, population characteristics, history of partnership working and initiatives to tackle health inequalities;
♦ the rationale that underpins their approach to addressing health inequalities;
♦ the key mechanisms or activities that they have adopted within this to achieve their goals.

Key informants in each case study area have verified these descriptions.

All of the case study areas included reducing health inequalities in their strategic goals. For some, these were very general statements, while one had adopted the goals as set out in The NHS Plan. Only one of the HAs had set itself a specific target to reduce health inequalities at the time of this fieldwork.

As described in Appendix 6, the case studies sites were chosen because they had either poorer overall health than the English average or higher levels of health inequalities. A number of the case study areas had witnessed the closure of much of their industrial base over the last few decades and were struggling to replace these major employers. Two of the case studies sites had extensive rural areas and associated problems with public transport making access to services difficult. Several of the case study areas had high levels of black and minority ethnic populations, and, two in particular, had high levels of refugees and asylum seekers. Three of the HAs worked with two-tier LAs, while the other two worked with multiple unitary authorities. Two had already moved to PCT status, and only two were anticipating their HAs merging in the near future. All of the case study areas were having problems recruiting staff, especially in primary care.

To differing extents, all of the case studies recognised that they needed to work in partnership to address health inequalities, although some of the partnership relationships were problematic for different reasons. Most of the case study HAs had adopted a social model of health. The extent to which health inequalities were incorporated into the local HImP varied considerably, as did whether or not they had made working with their local authorities to address the root causes of ill health a priority. All of the case study areas were involved in a range of partnership initiatives such as healthy living centres, SRBs, SureStart etc.

Given these broad similarities, and the differences, between the five case studies in the way they have developed their community health improvement process, the rest of this section examines the contribution that the DH’s mechanisms have made to ensuring health inequalities is central to this process, and the ways in which other factors in both the local and national contexts have inhibited or facilitated their progress.
**BOX 3.1: Place A’s approach to tackling health inequalities**

<table>
<thead>
<tr>
<th>Context</th>
<th>Strategy/Rationale</th>
<th>Key mechanisms with illustrations</th>
<th>Strategic goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>♦ High levels of social inequalities - a fifth of the population in the 20% most deprived wards in England.</td>
<td>♦ Acheson Report informed local approach to tackling inequalities and working in partnership. ♦ HIImP identifies local response to each relevant Acheson recommendation. ♦ Focus on partnership working to promote social cohesion and tackle social exclusion in order to reduce social inequalities in health.</td>
<td>♦ Focus in HIImP on partnerships with local government to promote health and social well-being - inequalities strategy included in this section. ♦ PCGs to address inequalities in health across the area - local action plans for each PCG that cover locally identified public health issues. ♦ Build on existing joint planning between social services and health and other partnerships (including ABIs) to develop integrated and holistic planning. ♦ Joint posts between housing and health, and social services and health, to tackle determinants and ensure joint planning and delivery.</td>
<td>To narrow the health gap in childhood and throughout life between socio-economic groups and between the most deprived areas and the rest of the country (targets to be added end of 2001).</td>
</tr>
<tr>
<td>♦ High levels of unemployment in some wards. ♦ High levels of teenage pregnancy. ♦ Poor history of services for children, especially those addressing root causes. ♦ Increasing pressure on services by refugees/asylum seekers. ♦ Significant numbers of looked after children. ♦ Previous bias towards older people/adult services. ♦ Shire county with political tensions between and within district(s) and county council. ♦ County council decision making controlled by Conservative Party members. ♦ Problems of recruiting staff to area, including GPs.</td>
<td>♦ HIImP identifies local response to each relevant Acheson recommendation. ♦ Social model of health. ♦ Focus on partnership working to promote social cohesion and tackle social exclusion in order to reduce social inequalities in health.</td>
<td>♦ Focus in HIImP on partnerships with local government to promote health and social well-being - inequalities strategy included in this section. ♦ PCGs to address inequalities in health across the area - local action plans for each PCG that cover locally identified public health issues. ♦ Build on existing joint planning between social services and health and other partnerships (including ABIs) to develop integrated and holistic planning. ♦ Joint posts between housing and health, and social services and health, to tackle determinants and ensure joint planning and delivery.</td>
<td></td>
</tr>
<tr>
<td>♦ HIImP identifies local response to each relevant Acheson recommendation. ♦ Social model of health. ♦ Focus on partnership working to promote social cohesion and tackle social exclusion in order to reduce social inequalities in health.</td>
<td>♦ Focus in HIImP on partnerships with local government to promote health and social well-being - inequalities strategy included in this section. ♦ PCGs to address inequalities in health across the area - local action plans for each PCG that cover locally identified public health issues. ♦ Build on existing joint planning between social services and health and other partnerships (including ABIs) to develop integrated and holistic planning. ♦ Joint posts between housing and health, and social services and health, to tackle determinants and ensure joint planning and delivery.</td>
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To narrow the health gap in childhood and throughout life between socio-economic groups and between the most deprived areas and the rest of the country (targets to be added end of 2001).
**Box 3.2: Place B’s approach to tackling health inequalities**

<table>
<thead>
<tr>
<th>Context</th>
<th>Strategy/Rationale</th>
<th>Key mechanisms with illustrations</th>
<th>Strategic goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>♦ Pockets of deprivation but generally affluent and healthy county.</td>
<td>♦ No overall HA inequalities definition (‘is by default the Acheson one’).</td>
<td>Structure of inequalities strategy&lt;br&gt;♦ The DPH highlights inequalities in annual reports.&lt;br&gt;♦ Inequalities strategy is one of 18 HIMPs programmes, each of which is led by multi-agency partnerships.&lt;br&gt;♦ The inequalities programme group was set up to develop and lead the implementation of their action plan (now disbanded).&lt;br&gt;♦ The inequalities programme is organised around the following groups or thematic areas:&lt;br&gt;  ➢ Sexual Health for gay men and ethnic minorities (and HIV/AIDS in general population);&lt;br&gt;  ➢ Health for ethnic minorities;&lt;br&gt;  ➢ General inequalities.</td>
<td>To achieve fairness in access to services based on the clinical needs of patients and to reduce variations in health across Place B.</td>
</tr>
<tr>
<td>♦ Small but growing black and ethnic minority population.</td>
<td>♦ National agenda being taken on locally over time.</td>
<td>The type of work carried out includes:&lt;br&gt;♦ Outreach work/schemes with gay men in urban area;&lt;br&gt;♦ Developing the use of interpreters, and providing appropriate accessible health service information;&lt;br&gt;♦ Community development and capacity building in ethnic minority and faith communities;&lt;br&gt;♦ Collecting data on ethnic minorities including take-up of services and make-up of population;&lt;br&gt;♦ Compiling a community development database of local and national initiatives;&lt;br&gt;♦ Health needs assessment in a town ward;&lt;br&gt;♦ Conducting research into social factors affecting the health of older women;&lt;br&gt;♦ Improving access to neurology services.</td>
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<tr>
<td>♦ Problems associated with large elderly population.</td>
<td>♦ The HIMP partner organisations are working towards the development of a county strategy to address health inequalities.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>♦ Rurality a problem in terms of access and quality of services offered.</td>
<td>♦ LSP and PCTs to take forward agenda – current PCGs have developed (or are in the process of developing) individual HIMPs.</td>
<td></td>
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</tr>
<tr>
<td>♦ Public transport is limited.</td>
<td>♦ History of partnership working – ‘Alliance for Health’ set up in late 1980s.</td>
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<tr>
<td>♦ Lack of higher educational facilities.</td>
<td>♦ Lack of coterminosity and tiered council structure can make partnership working difficult.</td>
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<tr>
<td>♦ Health promotion historically has not looked at inequalities.</td>
<td>♦ NHS priorities – HA does not do much on health inequalities agenda or tackling root causes.</td>
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<td></td>
</tr>
<tr>
<td>♦ Inequalities part of HIMP but not a priority overall.</td>
<td>♦ Problems of recruiting staff to area, including GPs.</td>
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</table>
### Box 3.3: Place C’s approach to tackling health inequalities

**Context**
- Deprived area with growing inequalities.
- Relatively homogenous deprived population – young age group, large black and ethnic minority population.
- Growing numbers of refugees and asylum seekers.
- Access to NHS care is not very equitable.
- Not coterminous – covers two local authorities, and tends to work more effectively with one of them.
- There are affluent wards within each LA – one LA is more affluent than the other.
- HA is in deficit – acute sector, health and social care targets prioritised – root cause action historically seen locally as LA responsibility.
- History of some partnership working, with ABIs and LAs in the area.

**Strategy/ Rationale**
- The HA is working towards working in partnership to tackle inequalities by planning to address the root causes of ill health and to improve equity of access to services in the area.
- The inequalities strategy is part of the HImP, as well as the primary aim of an externally funded inequalities specific programme of work, which is carried out in addition to the HImP and HA mainstream.

**Key mechanisms with illustrations**
- Inequalities form a significant part of the DPH’s annual report.
- The HImP is implemented in partnership with local agencies and non-statutory bodies.
- There is also previous joint finance money – now the partnership fund, which has an inequalities focus. Work includes a partnership and root causes approach to acute sector redevelopment.
- Joint health unit planned to bring public health & health promotion and partnership working under one umbrella.

**Strategic goal**
- Improve health for everyone and tackle inequalities in health and health social care that exist in this area.

<table>
<thead>
<tr>
<th>Context</th>
<th>Strategy/ Rationale</th>
<th>Key mechanisms with illustrations</th>
<th>Strategic goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>♦ Deprived area with growing inequalities.</td>
<td>♦ The HA is working towards working in partnership to tackle inequalities by planning to address the root causes of ill health and to improve equity of access to services in the area.</td>
<td>♦ Inequalities form a significant part of the DPH’s annual report.</td>
<td>Improve health for everyone and tackle inequalities in health and health social care that exist in this area.</td>
</tr>
<tr>
<td>♦ Relatively homogenous deprived population – young age group, large black and ethnic minority population.</td>
<td></td>
<td>♦ The HImP is implemented in partnership with local agencies and non-statutory bodies.</td>
<td></td>
</tr>
<tr>
<td>♦ Growing numbers of refugees and asylum seekers.</td>
<td>♦ The inequalities strategy is part of the HImP, as well as the primary aim of an externally funded inequalities specific programme of work, which is carried out in addition to the HImP and HA mainstream.</td>
<td>♦ There is also previous joint finance money – now the partnership fund, which has an inequalities focus. Work includes a partnership and root causes approach to acute sector redevelopment.</td>
<td></td>
</tr>
<tr>
<td>♦ Access to NHS care is not very equitable.</td>
<td>♦ Joint health unit planned to bring public health &amp; health promotion and partnership working under one umbrella.</td>
<td>♦ ♦ Jobs and training – refugees and asylum seekers, youth, community business and training and employment;</td>
<td></td>
</tr>
<tr>
<td>♦ Not coterminous – covers two local authorities, and tends to work more effectively with one of them.</td>
<td>♦ ♦ Capacity building – strengthening voluntary organisations;</td>
<td></td>
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</tr>
<tr>
<td>♦ There are affluent wards within each LA – one LA is more affluent than the other.</td>
<td>♦ ♦ Management and publicity – including evaluation and feasibility;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>♦ HA is in deficit – acute sector, health and social care targets prioritised – root cause action historically seen locally as LA responsibility.</td>
<td>♦ ♦ Public health – drugs awareness, health promotion and socio-economic and environmental;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>♦ History of some partnership working, with ABIs and LAs in the area.</td>
<td>♦ ♦ Access to primary care – young peoples health, integrated customised care and gateways to care.</td>
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</tr>
</tbody>
</table>
**Box 3.4: Place D’s approach to tackling health inequalities**

<table>
<thead>
<tr>
<th>Context</th>
<th>Strategy/Rationale</th>
<th>Key mechanisms with illustrations</th>
<th>Strategic goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>♦ Large county with rural areas – creates problems of access to a range of services and opportunities.&lt;br&gt;♦ Poor public transport exacerbates this.&lt;br&gt;♦ Scale creates additional problems for providing services.&lt;br&gt;♦ Significant unemployment due to closure of coal mines and other industries.&lt;br&gt;♦ Poor housing stock in some parts.&lt;br&gt;♦ High levels of crime and drug misuse.&lt;br&gt;♦ Significant levels of domestic violence.&lt;br&gt;♦ High accident rates.&lt;br&gt;♦ High levels of teenage pregnancies.&lt;br&gt;♦ High levels of obesity.&lt;br&gt;♦ HA works with multiple district councils and, is only part of the area covered by a county council.&lt;br&gt;♦ HA is in deficit.&lt;br&gt;♦ Problems of recruiting staff to area, including GPs.</td>
<td>♦ Acknowledged need to meet the national agenda but with local flavour.&lt;br&gt;♦ A ction to reduce inequalities underpins all of HImp, plus significant sub - programme of it.&lt;br&gt;♦ A ction to reduce health gap can only be successfully achieved by well co-ordinated action from all agencies.&lt;br&gt;♦ Key to this is locality-based partnerships, which benefit from coterminosity between PCTs and district councils – these will become LSPs.&lt;br&gt;♦ Focus on investing in particularly disadvantaged wards.&lt;br&gt;♦ Opportunistic – seeing ways of giving health inequalities focus to range of other initiatives.</td>
<td>♦ Emphasis on working in partnership to address all root causes – role of health agencies within that:&lt;br&gt;  ➢ contribute to developing bids for funds and integrated plans;&lt;br&gt;  ➢ ensuring regeneration, housing, activities etc are designed to improve health of disadvantaged areas;&lt;br&gt;  ➢ health facilities used as site for welfare rights advice, etc.&lt;br&gt;♦ Provide information that enables healthy lifestyle – e.g. one-stop shops, including health issues in education on wide range of vocational courses e.g. nursery nurses.&lt;br&gt;♦ Ensure equitable access to services appropriate for needs of minority groups (black and ethnic minority groups, men who have sex with men, people with disabilities).&lt;br&gt;♦ Improve access to services in rural areas – through contributing to community transport strategy.&lt;br&gt;♦ Draw HImp and community plan together, focus on health and crime.&lt;br&gt;♦ Strategy to promote health and welfare of children &amp; young people focuses on most disadvantaged and build on current successes &amp; models of good practice in areas such as SureStart, healthy schools programme, drug misuse, review role school nurses.</td>
<td>Reduce inequalities and promote health.&lt;br&gt;Range of specific outcome targets aimed at improving services, health and social outcomes, mainly for people living in the 10 most deprived wards.&lt;br&gt;Key target to reduce health gap is:&lt;br&gt;20 per cent reduction in all cause SMR for people aged 15-64 in 10 wards with highest SMRs by 2010.</td>
</tr>
</tbody>
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**Community strategy**

| HA works with multiple district councils and, is only part of the area covered by a county council.<br>♦ HA is in deficit.<br>♦ Problems of recruiting staff to area, including GPs. | ♦ Acknowledged need to meet the national agenda but with local flavour.<br>♦ A ction to reduce inequalities underpins all of HImp, plus significant sub - programme of it.<br>♦ A ction to reduce health gap can only be successfully achieved by well co-ordinated action from all agencies.<br>♦ Key to this is locality-based partnerships, which benefit from coterminosity between PCTs and district councils – these will become LSPs.<br>♦ Focus on investing in particularly disadvantaged wards.<br>♦ Opportunistic – seeing ways of giving health inequalities focus to range of other initiatives. | ♦ Emphasis on working in partnership to address all root causes – role of health agencies within that:<br>  ➢ contribute to developing bids for funds and integrated plans;<br>  ➢ ensuring regeneration, housing, activities etc are designed to improve health of disadvantaged areas;<br>  ➢ health facilities used as site for welfare rights advice, etc.<br>♦ Provide information that enables healthy lifestyle – e.g. one-stop shops, including health issues in education on wide range of vocational courses e.g. nursery nurses.<br>♦ Ensure equitable access to services appropriate for needs of minority groups (black and ethnic minority groups, men who have sex with men, people with disabilities).<br>♦ Improve access to services in rural areas – through contributing to community transport strategy.<br>♦ Draw HImp and community plan together, focus on health and crime.<br>♦ Strategy to promote health and welfare of children & young people focuses on most disadvantaged and build on current successes & models of good practice in areas such as SureStart, healthy schools programme, drug misuse, review role school nurses. | Reduce inequalities and promote health.<br>Range of specific outcome targets aimed at improving services, health and social outcomes, mainly for people living in the 10 most deprived wards.<br>Key target to reduce health gap is:<br>20 per cent reduction in all cause SMR for people aged 15-64 in 10 wards with highest SMRs by 2010. |
Box 3.5: Place E’s approach to tackling health inequalities

(HA works with two unitary authorities, most of the HA’s work is conducted with each LA separately e.g. separate HiMPS, separate health and care partnerships etc. so this summary is based on one locality’s approach)

<table>
<thead>
<tr>
<th>Context</th>
<th>Strategy/Rationale</th>
<th>Key mechanisms with illustrations</th>
<th>Strategic goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>♦ Ex-mining, ex-manufacturing area.</td>
<td>♦ Recognise that health is not sole preserve of the NHS but is affected by the activities of a much wider range of organisations and individuals. ♦ Deal with most important health problems for population and take into account the Government’s priorities. ♦ Tackle inequalities by targeting action on those who are worst off, in social, economic and health terms, who are concentrated in same areas. ♦ HiMPS does not have a specific section on health inequalities, the main vehicle to address these is through health settings.</td>
<td>♦ Needs assessment being carried out based on large health survey of population. ♦ Focus on healthy settings: healthy communities; healthy schools; healthy workplaces. ♦ SRB funds for healthy neighbourhood initiative. ♦ Community development projects in particular disadvantaged areas. ♦ Healthy living centre bids based in most deprived parts of the borough. ♦ Physical activity strategy – focus on inequalities by influencing provision of facilities and by targeting development work on particular vulnerable groups. ♦ Adopted an ethnic health strategy. ♦ Food poverty initiatives e.g. ‘cook &amp; taste schemes’ in disadvantaged areas. ♦ Emphasis on prevention and targeted work in implementing CHD NSF. ♦ Crime and Disorder partnerships.</td>
<td>To secure the maximum improvement in the health of the people in place E. This includes: promoting health minimising ill health reducing disability - addressing inequalities in health.</td>
</tr>
</tbody>
</table>
SECTION A: MAKING HEALTH INEQUALITIES A PRIORITY
MAKING HEALTH INEQUALITIES A PRIORITY

In their first term in office the Labour Government made health inequalities a national priority for the NHS. As Part 1 highlights, in a range of different policy documents and priorities guidance, tackling health inequalities was given considerable prominence. The aim of this section is to consider the extent to which this national guidance has resulted in health inequalities moving up the local agenda.

Central Government priority

As with respondents to the survey, virtually all of the people interviewed in the case study areas felt that the priority and the attention given to tackling health inequalities by central Government had been transformed since Labour took office. As a result health inequalities were a much more significant part of local thinking. The people interviewed emphasised how important this change of perspective by central Government had been in changing the local approach.

I think the impact of current government policy cannot be underestimated. It has been fantastic in getting health inequalities on the agenda as a legitimate part of health authority and partnership working.

At one level this change in central Government’s perspective had changed the environment in which local players operated to enable them to think and to speak in a different way. People felt ‘released’ by this. They were now allowed to talk about ‘inequalities’ rather than ‘variations’, and to acknowledge the link between poverty and health.

... it is good that we have got such clear guidance, what’s good about this Government is that they have linked health and poverty, whereas the Conservative Government didn’t link health and poverty.

Well yes if you talk about health inequalities it wasn’t even on the agenda – we had a code word for poverty – probably do still a bit – but you know the change has been phenomenal.

More substantively, people felt that government prioritisation of tackling health inequalities legitimised local efforts to get them on the agenda. In particular, specific aspects of the national priorities guidance had enabled them to shift local resources into relevant priority areas within the SaFF process.

In the past people were very aware of issue around pregnancy but ... because of all their other priorities, weren’t necessarily that geared towards doing anything about it, and the national guidelines on teenage pregnancy have made a huge difference because I have been able to go to the SaFF and say you need to do this, this is not a choice, this is a national priority, these are national guidelines, and we need to look at how that fits in with what you are doing.

I think on the whole national policy over the last few years has enhanced the work because it has been very mindful of the issues of social
inequalities and social inclusion so though that has sort of been a broader agenda and though it hasn’t always been absolutely clear how that joins up, I felt that overall it has contributed.

Inadequate support and commitment to tackle inequalities in health

While many people were happy that health inequalities have been made a more significant priority they felt that this was insufficient to achieve change, and that further guidance was needed. People felt that tackling health inequalities was a massive agenda and were often unclear about where to begin:

... I think the challenge for me has been, that because it is the flavour of the month everybody is doing it now and I think everybody is doing it quite badly.

... we know health inequalities is a massive agenda, and certainly, without sounding at all political, since the ’97 election and Labour coming in, a whole range of issues have come and seem to alleviate the difficulties around health inequalities ... there is a clear agenda from the centre that social inclusion, social exclusion, health inequalities are on the agenda that need to be dealt with, but we have found it difficult to get a grip on this locally.

Perhaps more importantly than this, it was questioned whether central Government had really made reducing health inequalities a priority. There was a general sense that there were far too many priorities. As an executive director of an acute trust reported:

I think the general view among health service managers is that there are far too many priorities, the danger is if everything is a priority, then really nothing gets done properly.

As a result there were seen to be first - Government ‘must dos’ - and second order priorities. Although there was universal acknowledgement that the Labour Government had made tackling health inequalities a priority, there was similarly a general agreement that it was only a second order priority, and that other issues were much more important to the Government.

It is a fetish ... reduction in the waiting list has preoccupied people’s minds and energy and money to a point where this [inequalities] agenda is just on the periphery.

... and the targets upon which we lose or draw are not primarily based on equity or health inequalities issues, they are based on other issues, I think, now, in an academic sense you can always draw some obscure hyperlinks from these things to another, but they are not really about those sorts of targets.

As discussed further in the sections below on funding and performance management, the people interviewed argued that the lack of overall resources available meant that they could only address ‘central’ priorities or ‘must dos’, which did not include
reducing health inequalities. In addition, given that it was not part of the NHS’s performance assessment framework, little was actually done in relation to it. As one HA executive director said:

... you can’t avoid the focus on central priorities. If you had loads and loads of money that wouldn’t matter, but we don’t even have enough money to achieve the central priorities, and therefore anything else is entirely peripheral and just doesn’t get the attention... there is no money for it, the view is why waste time on it.

This issue was linked to the perception, shared by many of the people interviewed, that the priority given to health inequalities had fallen in the last couple of years. In particular, some people felt that The NHS Plan had marginalized health inequalities.

You know, there has been a HIMP focus at the beginning of the government and an NHS focus at the end of the government, and the NHS end of it with social services actually ... getting what is in The NHS Plan - very little about inequalities - a couple of pages.

A similar general sentiment was expressed in a review of primary care organisations and their health improvement role (Abbott et al., 2001). Interestingly however, other respondents here felt that the way in which The NHS Plan and (even more so) NSFs had integrated reducing health inequalities into core business was helping to put the issue on the local agenda in ways that had not previously been possible.

The NHS plan and priorities and planning guidance is so much health and social care, so the older people’s issues, you could if you wanted to, just say it is intermediate care ... but what we try to do for the older people’s action teams is to bring their housing, fall prevention and all sorts of issues that we need to address, and then when the NSF comes along and says ‘those are important’ that is quite a help.

... but when Our Healthier Nation first came out, it wasn’t good, but now, what was in Our Healthier Nation has been integrated, and not kept separate, into national service frameworks ... and I think that is what I like, I think what they have done is integrate inequalities into the national service frameworks and that is really, really positive ... it has been mainstreamed more.

Overall, therefore, while the new status of inequalities under the Labour Government was acknowledged and appreciated, there was a strong feeling that the Government could do more to make reducing health inequalities central to the NHS’ agenda. The general welcoming at the local level of the Government’s agenda to address health inequalities has been found in other studies (Exworthy et al. 2002). Similarly, however, this study also found that other national imperatives still dominated local priorities. Hence, although health inequalities are much more visible on the policy agenda, they remain very much a second order priority.
Translating central government priorities into local priorities

The greater national priority attached to reducing health inequalities did not always translate into it becoming a local priority. Although this was partly a result of the issues discussed above, local contextual factors were also significant. Many of the respondents identified the vital role that individuals played in the overall success of agencies, of partnership work, and, crucially, of getting health inequalities on the agenda. In particular, the relative power of people who acted as champions for health inequalities, or those who, for different reasons, blocked it was seen as significant. Champions were seen as important to get health inequalities onto the local agenda, to keep it there, and to implement subsequent policies and initiatives.

Unless you have committed people doing the work it isn’t going to work, so you have to have champions and I don’t think they have had enough champions … in health to be able to take this agenda forward.

The most effective champions are those who have a combination of tenacity, power and respect, backed up by national policy and commitment. A champion was not thought of as someone you could create, or as someone that you could necessarily go out and recruit per se. Often respondents cited examples of progress being made only through the dogged work of particular committed individuals who have fought to get issues addressed and worked relentlessly to make initiatives succeed. A voluntary sector executive director said that:

... but most of those things have been fought for, it has always taken people of great determination and not a little patience on that to really hold out and say you know, you may think people don’t want this but the reality may well be very different and in nearly all cases, the reality has been completely different.

While there was recognition of the need for ‘champions’, there was a concern about leaving responsibility to key individuals, and relying on their personal commitment and willingness to push issues forward.

I think you need a local champion, or champions, in a sense just to keep it on the agenda, but again what you have to do is manage that and understand that it cannot be the sole responsibility of that one champion.

I am pulled in about 100 different ways - and it has taken every hour of the day to put as much time and energy into it, and if I personally was not committed to it, it would not be happening. I think a lot of it is very dependent on people’s personal commitment and doing that bit extra in order to make things happen - in your own time, a lot of it.

There was seen to be a need to gain a more general commitment to tackling health inequalities and, in particular, to ensure that senior figures were engaged in the agenda. Without this, the efforts of local champions were limited.

... and all the HImP programme groups ... have all been chaired at chief executive or very senior management level. The idea behind that was -
well, there will be a lead from the top, the great and the good will gather round the table and that usually kicks off these things.

... if we have senior people, and there are a few of us here who understand health and are taken seriously by the different partnerships, then we can get them to understand health ... and get influential ... because that is an opportunity.

There was a concern however that while relying on individuals could be very successful it could also be very vulnerable, as much depended on individuals’ own personalities. This was particularly important in influential roles. A key issue here is that of power. Individuals and organisations that hold power can have a very positive or a very negative effect on the process. A powerful champion or a championing organisation could have a huge impact on getting inequalities on the agenda, and on promoting partnership working and developing accountability and co-operation. On the other hand, there was also concern about those people who had power, either within the organisation or specific partnership, who would not engage or co-operate. ‘Blockers’ used their power to block or to impede processes, or to divert processes to fit their agendas. Both individuals and organisations were seen to be potential blockers. Blocking behaviour was often understood as being part of an outmoded or rigid organisational culture that had yet to change.

And then you are still fighting a battle with a medical consultant then, on what they think should be the priorities that are taken forward, so I think that there is still a value change here that has to happen.

When discussing the future role of PCTs with respondents, there was some concern over GPs and their ability to champion, or their potential to block, ways of working. A senior manager from a local authority said:

Well that is one of the difficulties, what will they focus on first? Because they [PCGs] have been very strongly GP led, and GPs haven’t been champions for children’s services, in fact quite the reverse.

The lack of enthusiasm of GPs for the health improvement agenda more generally was also identified in a study of the health improvement role of primary care organisations (Abbott et al., 2001). The study by Abbott and colleagues also emphasised the need for senior support for the health improvement agenda at Board level, and that without this, even where champions did exist, they would find it impossible to bring about change.

**Summary**

While it was almost universally acknowledged that inequalities were higher on the agenda than ever before, juggling priorities and objectives in an environment overloaded with competing targets and agendas was an altogether different reality. Within this tackling inequalities in health was only seen as a second order priority and hence marginalized. The policies and frameworks to which HA’s and other agencies were expected to work were not always felt to be the most effective way of getting inequalities on the agenda. Furthermore, the need locally for a range of senior
champions locally to push the agenda forward amidst a formidable set of ‘must dos’ was stressed, and support in this regard is crucial.

Key policy implications

♦ Tackling inequalities in health needs to be a high priority – an imperative ‘must do’ along with the others.

♦ Make chief executives champions, in tandem with policy changes, so that the efficacy of champions is not impeded by a lack of power, or by competing priorities.

♦ Develop local and national ways to recognise, reward and support local champions.
SECTION B: RESTRUCTURING THE NHS

The restructuring of the NHS, which began with The New NHS White Paper (Cm 3807, 1997) established key new roles for both HAs and PCG/Ts in tackling inequalities in health locally. As described in Part 1, HAs were given responsibility for providing overall strategic leadership while PCG/Ts were required to focus on the needs of their local community. This section examines the experience of the case study areas in developing those roles to date.
THE ROLE OF HEALTH AUTHORITIES

The strategic leadership role of HAs in relation to tackling health inequalities has two dimensions. First, they need to develop an overview and to facilitate partnership working on the HiMnP to identify key priorities for tackling health inequalities and to implement strategies to address them. Secondly, they need to support and to manage local PCGs’ contribution to this agenda to enable them to develop their own strategic approach within their communities. Although they have needed to do all of this with the threat of mergers hanging over them, at the time of the fieldwork, only two of the HAs studied expected to merge with nearby HAs in the coming year. As highlighted elsewhere, towards the end of the fieldwork, Milburn (2001a) launched the Shifting the Balance of Power agenda, which made it clear that all HAs would merge into larger strategic authorities by April 2004. However, the main policy documents were not released until after the fieldwork was completed. As a result many respondents assumed their HA would continue in its current form. This is reflected in the comments below.

HAs as strategic leaders for health

The opportunity that being ‘freed up’ from commissioning gave HAs to lead local partnerships to address health inequalities was clearly seen as positive by many of the people interviewed in the case study areas. It was felt that once PCGs locally had grown into their role as PCTs, HAs could focus on providing a strategic enabling function, which co-ordinated efforts to tackle health inequalities for that area. As two HA executive directors said:

I think there is more chance of a strategic coherent co-ordinated approach in an area if it is a body like a health authority, where their role will not be commissioning any more, I think there is more chance now than there has ever been for there to be a proper co-ordination of the health agenda.

... as health service ... commissioning ... is increasingly shifting to the PCTs and the health authority has a strategic role in enhancing health ... the health authority has that role and it has got the time and opportunity to do it.

All of the HAs were active in local partnerships, leading HiMnP development, and engaged to greater or lesser extent in different community capacity building and regeneration activities locally. One HA executive director described their role:

... we have a leadership role, we have a role in terms of health inequalities, understanding them, finding out what can be done effectively about them and trying to encourage, cajole, persuade, whatever ... facilitate, catalyse others to do something about them, and that includes obviously communities as well as statutory agents.

Another HA executive director described how she saw the health authority as needing to make the right connections between a range of activities and policies taking place in the external environment. This may be strategically developing initiatives or opportunistically encouraging other actors to shape what they are doing in order to maximise the benefits to health, even if this is not their ultimate aim.
I think being in the right place at the right time, pulling some of these things together. I have seen that as the main health authority contribution to trying to address health inequalities so people out there don’t necessarily see it as health inequalities but the outcome you eventually want you know will have an impact on addressing or redressing health inequalities.

A senior manager saw the HA’s role as using its leverage over the local public agencies and businesses that it worked with to encourage them to adopt good employment practices and equal opportunities policies. Perhaps more importantly, the HA needed to lead by example in these areas and to exploit their potential as an agent for local economic development.

... the other thing about root causes, is that the NHS locally has always said, “oh that is the local authority, we don’t do that” ... but we have got a role ... in economic regeneration ... through the health service, they could be looking at how they tender their services like laundry, whether they invest in the local economic infrastructure ... at how their purchasing behaviours around food and services affect the local economy ... there is huge potential.

Although all HAs were beginning to take on their role to lead local approaches to addressing health inequalities, not all HAs were seen to be succeeding in this at the time of interviewing. For example, one senior manager in a health authority described a workshop to examine how the HA could address health inequalities, which concluded that:

... if we were going to take up health inequalities seriously the health authority was going to have to change its whole reason for being ... that unsettled people because I think they realised that the majority of work they did they wouldn’t be doing any longer ... so I think the health authority, not backed away from it, but recognised you cannot necessarily do something about it like that.

A second case study area was also struggling to turn the HA into a leader for health inequalities. A senior manager said that it lacked ‘a vision around reducing them’ and while individuals within the organisation itself were concerned with health inequalities, the organisation did not provide leadership: ‘we’re a barrier, to be honest, as an organisation, not an enabler’. One explanation for this was the lack of power of public health within the organisation, which was echoed by one of the local partners who said:

... the health authority ... is very much immersed in the medical model of health ... and I cannot think of one example ... that the health authority led in terms of the social model of health or in reducing health inequalities.

Furthermore, it was felt that organisationally, many HAs were starting off from a poor position, and that if they have poor partnership or networking abilities, this will limit their effectiveness:
... so things like strategic things, is where we fail, to be honest, neighbourhood renewal fund and other things like community development, we just don’t seem able to influence or get a way in and it’s organisational, I’m sure.

A key part of the HA’s strategic role was to work in partnership with other agencies to develop and to implement the HImP. These dimensions of their role are discussed in more detail below. However, a further part of the HA’s strategic role was to provide support to PCGs as they developed, and to hold them to account for their actions.

**Supporting PCG/Ts**

It was clear that at present much of HAs’ energy was still directed at providing a supporting role to PCGs as they made their transition to PCTs. As discussed below, in many places the PCG/Ts’ responsibility to tackle health inequalities was the least well developed of their three key obligations. There was a clear sense in all of the HAs that they need to be much more focused on enabling this, both in terms of providing more support, but also by beginning to hold them to account for it. PCG/Ts were particularly seen to need to develop their role in local partnerships and their role in local health improvement.

Respondents from a number of different HAs identified the need to encourage PCG/Ts to broaden and strengthen their partnership relationships and public health perspective.

... it has been very difficult to get them [PCGs] to concentrate on the external agenda. One of my main roles in the next six to nine months will be to bring them up to speed so that they can engage properly with others.

I think that is part of my job, to make sure locally that the PCTs take on the public health agenda ... you know, the way different people have approached it, to link public health consultants or specialists into the PCT, now to me that is missing the point ... the main thing is to basically make PCTs public health agencies.

... as a Director of Public Health I’d like to ... look at the effectiveness of their relationships with local strategic partnerships, developing their public health practitioner role amongst their staff and really put some quite testing objectives down for them ... there is a lot of work to be done on that.

Some of the ways in which HAs were doing this included providing public health and partnership working training, encouraging job shadowing and developing learning sets for senior PCG managers. However, more crucially, there was universal agreement that HAs needed to performance manage PCTs on this agenda. Many respondents felt that HAs needed to develop accountability systems so that PCTs were answerable for their role in tackling health inequalities as well as in developing primary care and commissioning services.
This is where the health authorities’ role ... needs to be really beefed up ... they do have a very strong monitoring and challenging role for PCGs, and PCTs as well, because I think if that is not in place, and they don’t have that clout, then the PCTs [are] going to take us back to the bad old days in terms of the wider position of health issues.

Of particular concern to many respondents was whether PCTs had the necessary public health skills or perspective to take on this agenda. The issues in relation to this are discussed in Section D below.

Another important role for HAs was seen to be ensuring equity in commissioning of services between PCTs in their area. As one HA Director said:

I think there needs to be a ‘ringmaster’ ... being able to stand back and just make sure we are not developing more inequalities between PCTs, I mean that would be our role, that sort of performance management and making sure that across the patch, there is equality.

There was considerable debate between respondents about whether the locality focus would enhance efforts to tackle inequalities, or actually create inequalities between localities, as discussed below.

**Looking forward**

While many people recognised that HAs in the future would be leaner and more strategic, there were mixed feelings about whether much larger geographic authorities would be beneficial for each location. One respondent was excited by the idea of the strategic authority as it would enable the current HA area to benefit from a stronger commitment to, and longer experience of, tackling health inequalities than existed at present. Others, however, were concerned that strategic health authorities would be too large to focus on the needs of that particular place.

I think the most important thing of all, is for there to be a co-ordination for any particular area, now I think a health authority area [current] is probably ideal ... I think there needs to be a critical mass of skills that support efforts in other organisations, helping them to see the whole picture on the jigsaw and helping each organisation to see which part of the jigsaw they are and making sure they are all working towards common goals in the same way.

However, an acute trust director felt that this strategic function was more appropriate at a sub-regional, or regional level.

... if you have got primary care groups and they are commissioning all the services then you don’t need a health authority to do that part of it ... many of the other functions have been taken over so we will need a more strategic approach, and obviously one that fits in with other areas of regional government.

A second concern expressed was whether now was the right time to move to strategic health authorities, as PCG/Ts had not really had a chance to find their feet.
My view is we should let the PCGs develop, become secure and get the experience, and get the health authorities to get these policies in place and firmly bedded in before we move on.

On the other hand, in another case study area the HA was described as a ‘ghost organisation’. A number of senior executives had left and were not being replaced as people waited to see what future organisational structures would emerge. This created problems; both for staff morale within the organisation and for other agencies trying to work with them. For example, an executive director of a voluntary organisation said that:

... the health authority has been torn apart by all the changes, and I feel very sorry for the people that work there because it is [difficult] - and for us - trying to build a relationship with them.

Similarly, an executive director of an acute trust reported that:

... it is a big organisational issue, and people are distracted at the minute by - people who should be doing that [inequalities work] are distracted by - am I going to be merged? Are we out of a job? Is my career going? Can I pay the mortgage? It takes your mind off important things.

Clearly, the direction of Government policy in relation to the future structure of the NHS is now set. Nevertheless, the problems of motivating staff in these difficult times needs to be borne in mind. An HA senior manager said:

... it is very difficult when you come down to the actual people that are working in any organisation within a changing agenda, to ask them to see this as an exciting opportunity, to try and look at how they might impact on some of the issues like inequalities, when [what] they are actually worrying about [is] will I have a job when all this reshuffling is finished?

Summary

HAs have begun to develop their strategic role in relation to tackling health inequalities and are beginning to think about how to enable and to support PCG/Ts to do the same. There is real concern in some places that losing the strategic perspective at this level will be damaging for local efforts to address health inequalities, over and above the destabilising nature of the structural changes themselves. In other places, however, a locality basis was felt to offer real potential to take forward tackling health inequalities. As HAs merge and become more strategic bodies, they will need to continue to provide support to PCTs in developing their role to address health inequalities, but also to hold them to account for it more effectively than is currently the case. A bbt and colleagues (2001) made a similar recommendation in their study of the health improvement role of primary care organisations.

Key policy implications

- A n agency needs to take strategic responsibility for co-ordinating action to tackle health inequalities and for ensuring that the right links are made to
fully exploit opportunities. There is uncertainty about what the best level for this strategic perspective should be.

- There is still significant development work to be done to ensure that HA s and PCTs become ‘public health organisations’.
- PCTs need to be performance managed on their efforts to engage in broad local partnerships and to address health inequalities, as well as their other functions.
- All health and other public agencies need to be much more active about using their roles as employer, developer and purchaser, to promote local economic development and to set an example to others in this way.
THE ROLE OF PRIMARY CARE GROUPS/TRUSTS

PCG/Ts were given three broad responsibilities under The New NHS: to improve the health of their communities and to reduce health inequalities; to commission services; and, to develop primary care. In each of the case study sites PCGs’ development had taken place. However, in only two of the case study areas had the local PCGs become PCTs. In the others, none had yet achieved PCT status and at the time of the interviews, they were consulting about the appropriate PCT structures and boundaries.

There was considerable difference of opinion among respondents from all organisations about whether or not PCTs were able to take forward the health inequalities agenda. A number of issues were raised. First, whether PCTs could develop a health improvement perspective or whether they were too immersed in service issues and the medical model. Secondly, whether PCTs have the capacity and the skills to tackle health inequalities. Thirdly, whether the local level was the right scale at which to address health inequalities. Finally, however, whatever people’s views on the preceding issues, there was significant agreement that PCTs offered the best hope for improving access to care locally, and many examples were given about innovative ways in which this was being done.

The health improvement role

To differing degrees, all of the people in PCG/Ts that were interviewed believed that they should act to improve health and to address health inequalities. For example, one PCG chair said:

... address health inequalities ... that is the single most important thing we do, should be doing, it is fundamental ... So the PCGs [here] have that at the forefront of their minds all the time.

However, this view of their approach and commitment was not held universally across their partners. As one LA respondent observed:

... you are seeing one or two of the primary care groups and embryonic trusts looking to make appointments to look after health inequalities ... but that is not common across the area ... I think it will be down to the level of leadership and interest ... you will find different approaches in different areas ... at least partly because of the knowledge and interest in health inequalities.

A lack of interest in health improvement and health inequalities was seen as a real problem, particularly as a result of GPs taking such a significant role in setting the PCG/T agenda. As one PCG chief executive said:

... the GPs - most of them probably - you know, they are not young, new doctors and I think trained in a traditional mode, I think it would be fair to say and this is an assumption ... they appear less interested in that aspect of our work, they are more interested in primary care development and hospital admissions.

While a senior manager in a LA observed that:
... despite the fact that PCGs and PCTs have tackling health inequalities at the top of the list of what they are there to do.. I think that [they] have probably not been able to ... generally speaking, I find that PCTs have focused on more kind of primary care issues and that is understandable, up until now the boards have been GP run.

And an HA executive director said:

... the problem with basing it in a health care delivery organisation is that all the resources will get subsumed to health care, it always has, it always will.

Whether or not PCG/Ts saw their health improvement role clearly, there was considerable agreement among most respondents that they currently had far too full an agenda for health inequalities to get much attention. This was partly seen to be a result of the change agenda they had to manage as they themselves were only just coming into being. One HA director said:

... the concept of PCTs was a very good one ... but the capacity to do that, it is a long haul for PCTs to actually understand what their responsibilities are. I think there is a long way to go ... so it [restructuring] is a sort of hindrance, and all these changes take time ... ok yes services go on ... but in terms of actually changing cultures, vague things like health inequalities, it gets in the way.

But other respondents felt the lack of priority given to health inequalities by PCG/Ts was simply a general reflection of national priorities, as discussed above. For example, one HA director said:

... some PCGs are really quite keen on their health inequalities responsibilities, encouragingly so ... but what will happen of course is that their priorities will also be national priorities despite their very best endeavour, I don’t think they will find much time to spend on health inequalities work.

Summary

These findings are reflected in a study of the health improvement role of primary care organisations, which found that PCG/Ts found it difficult to priorities their health improvement role among other pressing priorities (Abbott et al., 2001). The lack of national priority given to this role was reinforced locally by a lack of interest on the part of most GPs, and without senior support on boards little progress could be made in pushing health inequalities up the agenda. In addition, the transition to PCT status created a huge organisational burden that had overshadowed other activities. Similarly, the national longitudinal tracker survey of primary care organisations found that improving health improvement and reducing health inequalities was the least well-developed objective of PCTs, although some foundations for it had been put in place (Gillam et al., 2001).

There is a general sense, across this study and others, that until new structures had been given time to settle in and, more importantly, the Government made tackling
health inequalities a key priority for local agencies, it will remain on the ‘back burner’.

**Capacity and skills**

Many respondents felt that considerable work was needed to turn PCG/Ts into public health agencies. HAs saw this as a key development process that they now needed to address. There were five dimensions to this that respondents felt to be important.

First, there was a need to encourage the whole PCG/T to take a broader public health perspective ‘because at the moment I think that what we are woefully lacking in PCG land is the public health dimension’. There was a need to ensure that all members and all staff had a better understanding of public health and their health improvement role. As one HA director said:

... the main thing is to basically make PCTs public health agencies and actually get, say, both members and the staff trained in public health so they actually think in public health terms, and that is the crux of it.

Secondly, some respondents felt that there was a need for a stronger broader public health presence on the boards of PCTs. While some PCTs did have public health consultants as their directors of public health, and hence members of their executive committee, it was the public health specialists who led on the wider efforts to address health inequalities, and their perspective was often felt to be lacking at the highest level of PCG/Ts. While some PCGs felt that their lay members and social service representatives were interested in such topics, others felt that these mechanisms were inadequate. For example, one local authority respondent felt that only having social services representing LAs on PCT boards was a mistake as they ‘are not necessarily members who have got enough of a broader view to tackle the wider issues’. Similarly, some people felt that including community nurses on the board would broaden the perspective, but others felt that there was still a danger that ‘it will adhere to a medical model’.

Thirdly, the need for public health resources to be devolved to PCG/Ts in order to promote their health improvement role was seen to be crucial. There was significant unhappiness among a number of the PCGs and PCTs interviewed that their HA had ‘hung on’ to the public health resource. There was also considerable debate about whether public health resources should be devolved to PCGs/Ts at all, as discussed in Section D.

Fourthly, many respondents saw that a key opportunity for PCG/Ts to develop their approach to health improvement was through the role of community nurses, such as health visitors or district nurses. The capacity and commitment of community nurses to take on this role is discussed below, here we focus on the alternate perspectives about whether this was a sensible way forward. One HA executive director argued that it was vital to ‘resurrect’ the public health role of such staff, so that a significant workforce has a public health perspective, which:

... means linking up with other agencies, it means health visitors talking to local authorities about how we can create safer or more adequate play areas for children, that kind of thing.
Without disagreeing with the idea that community nurses could make a much more effective contribution to public health, another HA director was concerned that this would be seen as the only way in which PCG/Ts should lead on health improvement.

I think there is huge potential for health visitor in their daily jobs ... there is just a range of stuff that they can be doing, but most of it is one to one or with families and most of it is opportune, there is no way you can co-ordinate tackling root causes through health visitors.

Finally, while PCGs were seen to have the potential to tackle health inequalities though partnership working, they were struggling:

... at the moment they just haven’t had the resources. They are presenting an exciting place to be for the future around tackling inequalities, and the important place to be, and they are going to be leading the discussions with social services about inequalities or with education, not the health authority in the future.

There was universal agreement that PCG/Ts needed to develop their partnership working and networking more widely, so that health inequalities did become a more natural part of their agenda.

There is a lot more growing up to do ... on the inequalities stuff, it needs to become more sophisticated and more developed, so I’d like to see that networking side developed, the partnership structure having health on its agenda more.

However, most of the PCG/Ts themselves felt that they did not have the resources to engage effectively in partnership working. As one PCG chief executive said:

... the nub of looking at health inequalities, social inequality and that can only be done by working together with the local authority and the local community, it is hard work ... in my PCG there is only myself and my deputy who can do that.

A different set of concerns were worrying local authority partners. This was the increase in transaction costs as PCTs took primary place in partnerships instead of health authorities. Where local authorities had previously dealt with one or two health authorities, they might now be in the position where they have to work with a large number of PCTs. This was illustrated by senior managers in different local authorities:

... so there is the obvious difficulty that instead of working with two health authorities, we could potentially be working with eight to ten primary care trusts and that will make for some issues.

I think it is going to be very hard to engage at locality level, and certainly for people like me, it is impossible for me to go to seven [PCTs].
This respondent saw the answer being for the county council itself to move to a locality-based style of working itself so that it could actively engage with PCTs in the future. Some PCGs were experiencing similar problems in reverse, as one senior manager said:

... where PCGs cut across at least two and even three district councils, it is messier, it is more difficult to get things done.

Summary
Developing the PCTs as public health organisation is clearly central to their role to address health inequalities. It is clear that much still needs to be done in this respect. This reflects the findings of studies of primary care organisation (Abbott et al. 2001; Gillam et al., 2001). For example, in their study of the health improvement role of primary care organisations, Abbott and colleagues (2001) identified a similar range of issues that needed to be addressed, including the need for stronger senior support for the health improvement role, great support to individual staff engaged in activities to address health inequalities and more effective development of public health skills and resources with PCTs

**Locality basis is best?**
Many respondents, particularly those in PCG/Ts, felt that the locality level was the most appropriate scale to address health inequalities. In part this was because many PCG/Ts were coterminous with district councils so that partnership working on the root causes of ill health would be relatively straightforward. However, more significantly, PCTs were seen to be embedded in their local communities. This gives more power to frontline staff who could use their local knowledge to ensure services were provided in ways that would meet local needs on the ground. As a result many people felt that ‘the locality focus is actually the best way to deal with health and social well-being’.

On the other hand, some people were concerned that shifting to a locality focus might lose strategic input and could actually create inequalities by developing local strategies and services that may reflect local need but may vary considerably from place to place. The extent to which the shift to a locality focus may benefit efforts to tackle health inequalities or hinder them, remains to be seen.

**Improving access to care**
It was clear in some PCG/Ts studied that they saw their main role in tackling health inequalities as improving access to primary care, rather than taking a broader health improvement perspective. Studies that have examined the role of primary care organisations more directly, have also found this to be the case (Abbott et al., 2001; Gillam et al., 2001). To a lesser extent PCG/Ts also recognised their ability to try to improve access to secondary services.

I think it is improving primary care, what goes on in general practices will greatly improve access and reduce inequalities. I think that is our greatest thing.
Many of the case study areas were suffering recruitment and retention problems in primary care. Often they had areas of their patch, which had significant numbers of single-handed GPs or GPs near retirement age. They were looking at a range of initiatives to tackle these issues. A number had established Personal Medical Services pilots and employed GPs to provide services in under-doctored areas or for ‘problem’ patients. Others were trying to improve practice premises, training and development for GPs and other staff to attract people into the area. Where it was not possible to attract additional GPs, other PCG/Ts were employing extra practice nurses or other related staff, and thinking more imaginatively about the distribution of work responsibilities. As well as focusing on improving the fabric and increasing the staffing of primary care, other PCGs were conducting audits and staff appraisals to improve the quality of professional practice.

There was concern that little had been done to date to examine equity in PCG/Ts’ commissioning practices. One PCG chief executive said that since they commissioned services ‘for people who take them up’, they could actually be ‘increasing the health gap’. PCGs and PCTs were beginning to scrutinise their referral patterns and to develop care pathways to address this. They were also experimenting with a range of clinical outreach schemes and walk-in clinics, as well as transport schemes and home visiting, as ways of improving access to a range of services for their population.

All PCG/T respondents felt that they were only just beginning to scratch the surface of what could be done to improve access to both primary and secondary services.

**Summary**

PCGs, and even more so PCTs, are relatively young organisations that have yet to find their feet. Nor have the relevant processes been established to support and to hold them to account for their responsibilities. Not surprisingly, therefore, there were very different perspectives on the extent to which PCG/Ts had addressed their responsibility to reduce health inequalities. Similarly, there were different views as to their capacity to develop this role in the future, and what resources were appropriate to do this. Since the Shifting the Balance of Power agenda very clearly states that PCTs must lead local action to tackle local inequalities in health, ways of developing their strengths and improving on their current limitations need to be found. These are discussed further in Part 4.

**Key policy implications**

- Encourage and support the efforts PCG/Ts are already making to improve equity of access to primary and secondary care.
- Develop the role of PCTs in relation to tackling health inequalities.

This requires:
- a stronger national commitment to tackling health inequalities, which is translated into local ‘must dos’;
- support and training for PCT senior managers, members and other staff, in partnership working and in public health awareness and skills;
- sufficient resources for PCTs to carry out these roles;
♦ clear performance management of PCTs in relation to health improvement, improving access to services and reducing inequalities in health;
♦ members of the board of PCTs must include people with a broad public health/health improvement perspective;
♦ developing the public health role of community nurses, but emphasising that this is a useful part of the PCTs public health role, but it is only one of a number of strands that are required.
SECTION C: COLLABORATION

As outlined in Part 1, the Government believed collaboration was a core foundation for better services in general and efforts to address health inequalities in particular. In order to ensure that local players worked in more collaborative ways, the DH established three broad mechanisms to encourage them to do so:

- a duty to work in partnership was placed on HAs, initially with LAs but expanded to other NHS agencies (Cm 3807, 1997);
- HAs were required to develop HiMPS, three year strategies to improve health and health care, again in partnership with LAs and other agencies (Cm 3807, 1997);
- community involvement in governance and service planning is increasingly viewed as a core principle for all local agencies (Cm 4818-I, 2000; DH 2001f); building community capacity is seen as an essential prerequisite for this, as well as a way of promoting community health more directly (Cm 4386, 1999; SEU 2001);

This section reviews the way in which the case study areas approached these three mechanisms in relation to reducing health inequalities, and what helped and hindered their progress.
PARTNERSHIP WORKING

Partnership working between local public agencies is seen as the key to addressing health inequalities locally. In *Saving Lives* the Government was very clear:

... the goals of this health strategy will be achieved only by a joint effort. This means individuals taking steps to improve their own health, and on new directions and new more effective partnerships formed at local community level between the NHS, local authorities and other agencies.(Cm 4386, 1999, p. 119).

Similarly, across all of the case study areas, there was recognition that health inequalities could only be addressed if local agencies worked together. This was because of the general recognition that most of the causes of health inequalities lay outside of the direct control of NHS agencies.

I like to think that people will realise firstly that the health service hasn’t been a health service, it has been an illness service, it has got to start being a health service and the input of the local authority in terms of education, transport, community development and social deprivation in terms of turning that around.

Furthermore, partnership working, while still beset by problems, is generally seen to have improved since Labour took office in ways that were promoting the public’s health.

... but I think now there is certainly recognition between the health authority and the local authority that they can - it is better for them to work together than separately.

... the health authority [is] working really close with the local authorities to look at the wider impact of environmental issues, etc., access, transport, all of that has its impact on health, so I think there is quite a shift.

As the above quotes suggest, the key partnership relationship for promoting health was seen to be the link between LAs and HAs. In addition, however, HAs are required to work with other NHS agencies to promote health, and as Part 2 shows, also to engage with other public agencies such as the police and the probation service, and to a limited extent, local businesses. While respondents in HAs could see the clear benefits of working with some of these agencies for reducing health inequalities, they often struggled to engage with them in any systematic way.

A range of commentators have identified key requirements for effective partnership working to promote health (e.g. Nutbeam, 1994; Funnell et al., 1995; Higginbottom and Simpson, 1996; Costongs and Springett, 1997; Nuffield Institute for Health, 1997). These include:

♦ clarity of purpose and benefits for each partner;
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- dedicated project leadership and senior commitment from all organisations;
- the development of mutual respect through inter-agency teambuilding, balanced with achieving tangible benefits in the short term to maintain enthusiasm;
- clear management structures and delineation of responsibilities;
- time to allow partnerships to develop;
- consistent or joint accountability;
- dedicated resources.

Similar issues were identified within the interviews in these case studies, and a number of them are discussed elsewhere in this report. The focus here is on the particular issues that were raised in relation to working together to address health inequalities. Specifically, the difficulty of engaging particular partners in this endeavour, and more general problems resulting from a lack of ‘joined-up’ government in Whitehall, with the consequent policy overload, combined with limited capacity on the ground.

Engaging partners to address health inequalities

HAs were required to work with LAs and other NHS agencies to tackle health inequalities. The extent to which they were succeeding in doing this varied across the case study areas and the particular agencies concerned.

Local authorities

As the opening quotes of this section suggest, there was general agreement that LAs were vital to local efforts to tackle health inequalities. While some of the local authorities in the case studies were very committed to this agenda, others appeared less so. For example, respondents in two different HAs reported:

I think [X] council, I think as an example, they are really strong and ... are very interested in health inequalities.

Well, personally, I don’t know of any explicit work that is doing that. The only thing I can say that I am trying to do is, within the coronary heart disease NSF, the preventative side of things, where there is role for a local authority, I have been trying to get in touch with somebody who might feel they have a role.

A number of explanations were put forward to explain this lack of engagement and the poor working relationships between the NHS and LAs. These included:

- limited resources on the part of the LA;
- poor history of partnership working locally, especially at senior levels;
- cultural differences between HAs and LAs, particularly in relation to working with local politicians;
- poor inter-departmental working within LAs, and/or between district and county councils;
misaligned geographic boundaries between HAs and LAs.

Coterminosity between LAs and HAs is often cited as being crucial for effective partnership working (e.g. Calman, 1998; Exworthy and Peckham, 1998). In many respects the respondents in the case studies agreed with this. However, a number argued that a much bigger problem was working with two-tier councils. A number of reasons for this were put forward. First, the additional transaction costs of dealing with different agencies for different aspects of local government. Secondly, in some places it was suggested that there were often poor relationships between the county and the district level, and between the different districts within an area. Thirdly, there were not only cultural differences between the NHS and LAs, but within different parts of local government itself. One senior manager from a county council said:

I think that there are also dangers around different organisational approaches and you know we are all working as best we can to the partnership mantel and we are all working to very different cultures. Not only actually to be honest with you with different organisations, but also within our own organisations.

Finally, a particular problem, cited in relation to working with county councils, was the distance of council offices from particular localities within their borders, making it difficult for staff to understand local needs in detail or engage effectively in local partnership activities.

All of these issues made it difficult for other agencies to develop strategies that encompass issues that cross the boundaries of different organisational responsibilities as well as geographic ones.

Acute Trusts

While acute trusts were seen as key members of local health partnerships, the extent to which they felt that the health inequalities agenda related to them varied considerably. However, even those that wished to engage in efforts to address health inequalities felt constrained by their own agendas. The acute sector is engaged in the delivery of service, under much local and national pressure to meet targets and ‘must dos’, more so than the rest of the health economy. An acute trust director said:

... oh within the trust, we all have a will for it, but you get driven out by the imperatives. You get driven to do the short term and miss the long term in a whole range of areas. You don’t get time to deliver the basics before somebody wants a result so you don’t develop the basics right.

Many HA respondents, however, questioned whether the acute trusts did have this ‘will’ to engage.

... so it is actually quite difficult ... it still is to a certain extent getting clinicians involved from the acute trust unless they see from the health improvement programme – we are going to have another cardiologist, they are not interested. The majority ... will say ‘we understand the broader issues – yes – if you manage to reduce smoking out there that will
make a big impact and you need to go and do that, but I still want another half time cardiologist to deal with the impact of people out there smoking’.

Given their huge agendas, acute trusts were reluctant to see resources diverted into community projects be it to promote health, or to provide community-based care. Furthermore, many of the current Government’s ‘must dos’ focus on acute sector deliverable, and these factors make it very difficult to invest in action to address health inequalities locally. This is discussed elsewhere in this report.

In terms of their own role in reducing health inequalities, there were mixed views among respondents from the acute trusts. Some were working with PCG/Ts to identify ways of improving access to services through a range of outreach schemes, developing care pathways, and integrating hospital and community services, etc.. Others viewed their job as being simply to treat those ‘who come through the door’. A similar division of responses was apparent in relation to using their role as a developer, employer and purchaser to promote the health of people in the local community.

Other partnerships who come into us and say right - well we are trying to develop local employment, what can you [acute sector] do as an employer to make sure that you fit in with return-to-work campaigns or whatever. So you get a group of organisations across society, both employers and public organisations working together to tackle those problems in common.

However, on the whole there appeared to be limited acute sector involvement in the regeneration and inequalities agendas within the case study sites which reflects the general pattern across the country as shown in Part 2.

Levels of partnership working
Across the range of partners that the NHS was engaging with to address health inequalities, many respondents from the case studies felt that partnerships worked well on the ground or in specific projects, but became more problematic at senior strategic levels.

My perception is that one of the breakdowns in partnership working is where the chief execs go ... My perception is that those chief execs don’t even know what is going on in their own organisation ... so that weakens partnership working at different tiers, and it means it is not very well informed. So I reckon at the field level, it is getting better.

I think we are very good at partnerships on an operational level ... I think strategically it is not so good at all.

Given the importance of clear leadership for partnership working in general, and more specifically, the need for senior figures to champion health inequalities issues, this is of particular concern. A number of ways of tackling these problems were put forward by respondents including:

♦ teambuilding development activities for senior managers in particular partnerships;
job shadowing and secondments;
• joint appointments at a senior level to co-ordinate partnership activities;
• include partnership skills in basic management training courses and ongoing professional development activities;
• more general training and awareness-raising for all staff in relation to partnership working.

**Joined up agendas**

Crucial to partnership working to address health inequalities is for local partners to have shared agendas, incentives, and the capacity to work together on relevant issues. The current Government has introduced a wider range of partnership initiatives, with and without their own funding streams, to encourage or to require local agencies to work together in this way. While many respondents welcomed the Government’s emphasis on tackling social exclusion, others were overwhelmed by the range of initiatives that had been introduced.

I do find it difficult even as a planner or policy analyst working in the field to actually get my head around you know, how the whole thing fits together.

There was considerable concern that although partnership based, many of the initiatives were led by individual Whitehall departments, which resulted in different lines of accountability and funding. One senior manager in an HA said:

... but unless there is some integrated thinking around core funding down to regional level between government departments at the top you will always get conflicting ‘must dos’.

While a director of an ABI argued for a rationalisation of such initiatives:

... because we are always hearing about joined up thinking, and I agree with the need for it, we all wanted to sing from the same hymn sheet, but we have already got a huge raft of different funding sources and initiatives, and if that could be rationalised, that would be a huge step in the right direction.

The Government has recently acknowledged some of these problems in a number of policy documents. LSPs are being established both to provide an umbrella organisation which draws all partnership working together, reducing duplication and enhancing synergy, and, in time, to actually rationalise the number of partnerships locally (DETR, 2001b, SEU, 2001). Bringing partnerships together into a local framework in this way was welcomed by many respondents, who organisationally, and individually, struggled to engage with the range of partnerships activities that are relevant to reducing health inequalities. As one HA senior manager said:

... we are a small team and yet to be in strategic places of influence requires you to have three times as many people as we have got, because we have got other parts of the job to attend to.
However, there were differing views about the extent to which LSPs, as they were emerging in the different case study areas, would address these issues. For example, while one respondent could see really opportunities as partnership structure began to be drawn together, another felt that there was a danger of creating yet another layer of partnership meetings to attend.

I do, I think the LSP is actually a good opportunity to do something differently, I mean it is already changing the landscape of the partners that we work with.

... I must say I am a little bit uncertain about the local strategic partnerships, now, you know, I mean, I know what that is, but the whole point is we are into a situation where there are too many people trying to do too many things and you know, the same people meeting several times... to talk about the same subject. But then the groups have got different names and the end products are different documents.

Current structures for LSPs were still being developed at the time of the interviews, but many people were hopeful that they would bring some order to the current multitude of local partnerships. However, the extent to which health inequalities were seen to be an integral part of the LSP agenda varied. In NDC and neighbourhood renewal areas, reducing health inequalities is one of the targets that LSPs have to demonstrate that they will deliver (SEU, 2001). However, in other areas, unless this target is adopted as part of the voluntary PSAs, health inequalities do not have to be on the LSP’s agenda. Whether it is on the agenda in such places will depend on the strength of the public health lobby within the LSP. Two issues were of concern here. First, that PCTs will now be the main NHS link within LSPs. As discussed above, respondents were concerned about whether they would act as champions for health inequalities. Secondly, there was a concern about the extent to which sub-structures of LSPs would engage with each other to address cross-cutting issues such as reducing health inequalities.

Most LSP structures that had been proposed while the fieldwork was being carrying out had adopted a ‘hub and spoke’ model, with health as one of the strategic ‘spokes’. A number of respondents were concerned about the limited connections between the health partnership and other partnerships that were responsible for significant determinants of health, e.g. housing, economic development, social exclusion.

We have got these wonderful strategic partnerships but they are still in silos.

At the time of the fieldwork, few LSP proposals had developed plans for how to address cross-cutting issues, or how to ensure that different sub-partnerships worked effectively together. A number of places did however recognise that this was an important next stage of their development. Clearly, this needs to be addressed by central Government if LSPs are to be a key vehicle for ensuring that the root causes of health inequalities are addressed as it proposes (Cm 5242, 2001; DH 2001c).
Looking forward

There was a general perception from the case studies that partnership working had improved under Labour in some respects, but that in others the agenda was so overloaded that there was a danger that nothing would be achieved. The principle of LSPs, to simplify these local arrangements, was therefore appreciated by most respondents. However, at this stage, some people were concerned whether health inequalities would indeed be a priority for LSPs, and in particular, if the cross-cutting nature of the strategy needed to tackle them would be considered.

Key policy implications

- Consistent priority to address health inequalities needs to be given to all relevant organisations.
- Central government policy needs to be better co-ordinated so that local agencies have common, rather than conflicting, agendas.
- Acute trusts, and other agencies, need to take more account of the effect that their roles as employer, developer and purchaser, can have on the local economy and hence on health promotion.
- Partnership working needs to be improved at very senior and strategic levels, for example, by developing teambuilding activities by encouraging job shadowing and secondments and by including partnership skills in general management training schemes and ongoing professional development, etc.
- Ways of providing support for local areas to promote effective partnership working need to be enhanced.
- It must be ensured that LSPs, which are not involved in NDC or neighbourhood renewal schemes, are held to account for addressing health inequalities.
HEALTH IMPROVEMENT PROGRAMMES

As outlined in Part 1, HImPs were introduced by The New NHS (Cm 3807, 1997) White Paper as three-year local strategies to improve health and healthcare. More importantly here, they were seen as a core part of the Government’s overall strategy to tackle health inequalities (Cm 4386, 1999). HImPs were expected to show how local partnerships would deliver on national priorities, but also to identify local needs and to develop action to address them. This combination of meeting national targets and reducing local needs was seen to be a crucial part of the Government’s approach to addressing health inequalities (Cm 4386, 1999). HA’s were required to take lead responsibility for delivering the HImP, but HImPs were intended to be ‘genuine joint enterprises with local authorities and others’ (Cm 4386, 1999, p.124), including other NHS agencies, local businesses, voluntary bodies, community groups and individuals. The HImP was, therefore, as much a process for engaging with partners and the community, as it was a strategy for health improvement (Aroroa et al., 1999, Hamer, 2000).

From this perspective, three aspects of the HImP appear to be significant for local action to tackle health inequalities:

♦ the HImP as a strategy for action to address health inequalities;
♦ the HImP as a balance between central and local priorities;
♦ the HImP as a process for partnership working and community involvement (although an HA responsibility).

This section examines how these three dimensions operated in practice at the local level in the case study areas.

HImPs as strategy for action to address health inequalities

As described in Part 2, HImPs have been developed in very different ways and there is huge variation in their scope and structure, and the level of detail they contain. In part this reflects the nature of HImPs as local statements of priority, which should vary according to local needs. However, at the local level this was also felt to be a result of a lack of national guidance on what the HImPs should contain. Although guidance was produced (DH, 1998b), this was felt to be ‘too little, too late’, and the HDA review of HImPs recommended a range of areas that required stronger guidance and development support in the future (Hamer, 2000).

More generally, the broad remit of the HImP at the local level was to seen to be both positive and negative in the case study areas. Some respondents saw this breadth as a useful tool in tackling inequalities, and in getting inequalities on the agenda, as it provided a strategic ‘umbrella’ under which work could be arranged and prioritised. As one HA executive director described their HImP:

...lots of these initiatives – how do they all fit together, and in a sense the HImP has been quite useful for that because you can try and show those relationships between them and that ... they are existing under a strategic ‘what works’ sort of umbrella in terms of addressing inequalities in health, determinants of health, and then really how do you get that into practice through inputting the partnerships and how do you get some good ideas off the ground by enabling and trying to get a bit of money towards them.
In contrast, others felt that they had struggled with developing the HImP as a result of this breadth – which bits of work count as contributing to health improvement and which do not? A n LA senior manager explained this dilemma:

... well I think the difficulty is always going to be that you have got ... the core business of the county council in all its different aspects ... and it all has an impact on the health of the people ... it is quite difficult to see how you isolate ... the bits of work and it makes it quite difficult ... and that is the trouble with HImPs so it has always been well what goes in and what goes out ... so where you draw your line and your boundary is always open to difficulty.

Given these contrasting views about the scope of the HImP, it is not surprising that people’s perceptions of how health inequalities should be built into it also varied significantly. As already noted in Part 2, some HAs asserted that reducing health inequalities was an overarching aim that underpinned their whole HImP strategy and therefore did not include a specific section on it, while others produced specific HImP chapters to describe their particular local problems and action to address them. These dilemmas were apparent in the case study areas. One senior manager in an HA explained:

... I think we struggle with that a bit in the HImP and ... we put in a specific chapter on addressing health inequalities, because it runs through all the rest of it. At the end people said they wanted a specific chapter didn’t they, which is fair enough.

In this case study area in particular, reducing inequalities was seen to be a theme of their plans throughout the HImP, with each priority area also identifying particular aspects that would reduce health inequalities. Nevertheless, in HImP consultation events, people were very clear that reducing health inequalities needed its own chapter to demonstrate that it was a clear priority for the partnership, and that something was being done. In another case study however, having health inequalities as a chapter in the HImP was seen as an abdication of responsibility. As a senior manager in a community trust described:

... there is not an overarching philosophical statement that says this HImP is around the district inequalities ... it is not, it does not inform the HImP really, it is just a chapter within it ... and I do not think it encompasses the whole thing.

On the other hand, not having specific structures or sections of the HImP focused on health inequalities was seen in other case study areas to mean that it was not a priority. A voluntary sector executive director said:

... in terms of the structures that exist, I think that it is telling that although there are a number of HImP groups in existence ... there isn’t one for health inequalities.

This sentiment is perhaps reflected in another HA, where the HImP inequalities group, which had been one of a number of programme groups, was disbanded earlier
in the year, because of dwindling attendance and perceived limited efficacy of the group.

Another key distinction among respondents’ perceptions of the HImP strategy was the extent to which it appeared to drive the local agenda. In several of the case study areas, the HImP was seen as ‘wish list’ or only an ‘aspirational’ document. In others, however, it was seen to have established clear priorities that were now driving the local agenda forward. An HA project worker said:

... in terms of setting priorities ... I think through the HImP which drives it, to which everyone contributes, we actually started to set key priority areas.

While in another area, a voluntary sector director said:

... the HImPs have been very good ... any ideas for example to do with children and young people go to the children and young people’s HImP and that is where all the priority is and all the funding and everything is sorted out.

Finally, however, a number of respondents made a note of caution about judging HImPs too quickly. The size of the task to develop an effective HImP should not be underestimated: time is required to establish partnerships, to agree priorities, to develop a strategy to meet them, to implement it and to review the processes and learn from it.

I just think it is one of those things that you can’t - to be fair you can’t expect [them to] all get together and produce a plan that is going to change the world tomorrow - it does take time to bed in.

**HImPs as a balance between central and local priorities**

A key requirement of the HImP has always been to demonstrate how national targets are to be met, at the same time as developing local priorities (Cm 4386, 1999). The challenge for local partnerships is to achieve an appropriate balance between them. While some HImPs reviewed in Part 2 did have clear local priorities in relation to health inequalities, others simply ran through the priorities articulated in the national priorities guidance to demonstrate that they were taking action in relation to them. As described above, many respondents felt that it was impossible to do anything other than the central Government’s priorities, as there were so many of them. The challenge then was to deliver on national targets in ways that were appropriate for local needs.

The trick is to try and make sure you actually deliver the national objectives within a framework of local agreement about how to actually achieve those objectives which meet particular needs and circumstance, so how you actually reduce coronary heart disease and the way you tackle it may be entirely different here from say in West Wales or somewhere like that, but everybody is, I think, really focussed on the national must dos.
Whatever the ‘rhetoric’ about establishing local priorities was, the reality was felt to be rather different.

One thing about that is that the priorities ... which you are expected to build into your HImP and there is relatively little leeway when it comes down to what your HImP chapters need to be and what your key areas need to be ... what you are going to address isn’t really up for debate.

This was not seen to be simply a function of the HImP process, but a of broader issue around much of the policy for the NHS. Respondents felt that strategies such as the NSFs, while helpful in many ways, reduced local flexibility to determine their own priority areas. As one respondent noted however, this had always been a tension within the NHS:

The NHS traditionally has been very much a centralised top down bureaucracy, historically, professionally led, and driven from the centre.

The idea the priority given to tackling health inequalities by central Government was ‘dashed’ locally by other central Government ‘must dos’ was also a key finding of the study of local implementation of the health inequalities agenda by Exworthy and colleagues (2002).

Many respondents, while welcoming the emphasis by central Government on reducing variations in standards and in services across the country, wished that they could be given more flexibility to prioritise the needs of the local population.

The NSF is very good in lots of ways but it does mean that with it there are very clear needs to find ways in which money ... is spent on the national ‘must dos’. And I think that gives us less flexibility than we had in the past to fund broader health agenda projects, which were about health and well-being as opposed to health services.

Often respondents felt that the only way in which they could create the flexibility for themselves to support more development-orientated or health-promoting projects was to seek external funding. This, however, brought other constraints and demands with it, as discussed in Section D.

**H1mPs as processes for partnership working and community involvement**

Local experiences of partnership working and of community involvement are discussed in general elsewhere in this section. Here the focus is on the role of the HImP as a vehicle for achieving both of these.

**Partnership working**

In principle, the HImP was viewed as being a useful way of drawing together partners, and the community, to agree local priorities for action. In practice, however, local experiences of both of these processes within HImP development were mixed. The extent to which local HAs had been inclusive in developing the HImP varied considerably. In one case study a senior manager in the HA said:
... local groups feed into the health improvement programme when it is being written they can comment on it and so forth, a vast raft of individuals.

In contrast, a voluntary sector executive director in another case study area described how the HImP had been entirely written within the HA.

... the involvement in developing the health improvement plan has been non existent ... a group of individuals wrote it for 2 years within the health authority the first time ... we never actually get to asking anybody outside the organisations - how do you see health can be improved? What do you want?

The HImP development was seen to be a closed process even within that HA, with respondents in public health also feeling that they were not involved at all.

Even in more inclusive places, key partners felt that the development of the HImP was not a truly shared responsibility. In some places this was a consequence of having to get the structures and the systems of engagement up and running. People described how they had been excluded from the development of the first wave HImP but that the processes had improved since then. Nevertheless, there was still a sense that the HImP ‘was presented as a partnership process’ but in fact the HA was leading, and had greater responsibility for, and control of, it. While partners understood that the HA was accountable for delivering the HImP, and hence needed to ensure that it was produced, it was felt that they could be more facilitative and less controlling in the way that they did this. An LA respondent said:

... and giving HImPs as the main focus to health [authorities] makes it quite difficult for us to see where we fit in, ... and because of their performance management framework, then it is difficult for them [the HA] not to see HImPs as something that they have to do ... they are performance managed on it.

This was a particular issue in relation to PCG/Ts. In some areas their involvement had simply been to consult about the local implementation of the HImP, rather than being actively engaged in its development for their locality. In other places, however, the HA had devolved responsibility for developing the HImP to them, as an explicit mechanism for addressing local inequalities.

I think that is one of the reasons why we have pursued the local HImP approach is that it does give us an opportunity to redress that imbalance [inequalities] to some extent, partly because of local involvement of primary care and partly because of the ability to focus in on more discrete communities than some of the other more top level, county wide and planning arrangements do.

Community and voluntary sector involvement
Voluntary sector and community involvement in the development of the HImP was also felt to be problematic.
It is very, very poor voluntary sector involvement in that as far as I am concerned ... there isn’t enough voluntary sector involvement at that level but we are working on it.

In another case study area a respondent argued that this was because there were limited resources to develop the local groups and structures that would enable people to engage effectively.

There are not sufficient resources to engage people in that process, to enable people at grass roots level to be heard you need to have local groups and there is not the structure to do that to enable that to happen.

Engaging the community was found to be particularly problematic among more disadvantaged groups. More generally, while some areas had succeeded in involving communities at operation level, this was harder to do strategically.

Unfortunately this is difficult I mean at the level the government would like them [the community] to be engaging in contributing at a strategic [level] ... those people were not particularly interested in going to some type of HImP type meeting or contributing to strategy.

The national evaluation of HAZs also found that HAZs struggled to actively engage their communities in strategic decision making (Barnes, et al., 1999).

Looking forward

Since the fieldwork was conducted the Government has launched the Local Modernisation Review (LMR) process. This requires the NHS to work with partners to undertake a risk assessment of their ability to deliver on all of the targets in The NHS Plan, including those relating to health inequalities. The assessments will identify developments that are required to meet the targets, and will form the basis of future three to five year local action plans. They will be taken forward in a new planning process for the NHS based on health improvement and modernisation plans (DH, 2001g), which will be led by PCTs and replace HImPs. Health improvement and modernisation plans will need to link into the community plans being developed by LSPs, and the best value reviews of local councils.

A key issue for the case study areas at the time of the fieldwork was how to bring the HImP into closer alignment with the local community plans.

It may be an issue about how we blend the HImP and community plan together will be a key issue for us and so we avoid doing things twice over or we have huge bits of the community plan in the HImP and vice versa.

Many people saw value in this, for two broad reasons. First, close partnerships between the local NHS and LAs were vital in addressing the causes of health inequalities. Secondly, there was a general feeling that the community planning process would be more effective at engaging with communities than the HImP process had been. However, while some respondents felt that the HImP and the community plan could become the same document, others were wary of this.
I just think that we have talked about the HImp being subsumed within the community plan and that kind of frightens me ... you do actually need your separate thematic plans which then feed into the main plan and the main plan feeds back to them, ’cause we can’t be all things to all people within the community plan.

The way in which the new health improvement and modernisation plans and community plans link together will crucially depend on how well PCTs integrate themselves into LSP structures and ensure that both health and health care feature prominently on its agenda.

**Key policy implications**

- More guidance is required in relation to how reducing health inequalities can be built into health improvement and modernisation plans in a meaningful way.

- Boundaries need to be clarified for both the health improvement and modernisation plans and for strategies to address health inequalities; without a clearer focus they could become everything to all people and hence will not be capable of driving the agenda forward.

- Crucial to this will be establishing clear connections between the health improvement and modernisation plans and community plans.

- In all of this, explicit recognition is required that both time and support are needed to develop the processes, to agree priorities and strategies, and to implement them effectively.

- In particular, more effort needs to be put into finding effective ways of engaging communities in developing future strategies and action plans.
COMMUNITY INVOLVEMENT AND BUILDING COMMUNITY CAPACITY

Community involvement in decision making and building community capacity, both to facilitate this, and to promote individuals’ well-being, are increasingly features of Labour’s social inclusion strategy and its commitment to tackle the determinants of ill health (CM 4386, 1999; SEU, 2001). This section examines the experience of the case studies in addressing both of these activities.

Community involvement

Gilles (1997) suggests that community participation is required to ensure effective intersectoral collaboration capable of tackling the underlying causes of health inequalities, and to ensure that the population’s needs are met by the local healthcare system in an equitable manner.

Most people that were interviewed did acknowledge the need to engage with communities as a way of effectively designing and evaluating services. However, the way in which this was done varied across organisations and case study sites. A range of different approaches to involving the public were employed by the case study areas, including public meetings, surveys and panels, leaflets and consultation documents. A number of respondents also cited local or community forums as ways of engaging with their local communities.

Also we have various local area forums - not committees, but forums made up of local people and with these we try to have a health focus but it is one among many, many other themes.

We have begun to experiment with what we call locality reference groups within some client groups so that we can engage the public carers and users of services.

Many respondents did believe that their agencies were getting better at community involvement, nevertheless they found that engaging the ‘community’ was a difficult and challenging task. People were understood to have neither the time nor the inclination to get involved unless they, or someone they were caring for, were ill. A local authority project worker said:

... well people had the option to be involved but I am not sure it is something that people choose to be involved in. I don’t think that just by ... offering the documents and saying please respond, you actually get genuine ... community involvement.

... so in a way it is finding ways of getting to communities - you would find more difficult to reach and you have to be very creative about it. I mean they may not read leaflets, they may not read the papers, you just have to think it through how you might access.

Furthermore, those who are most in need and most excluded are by definition the least easy for the statutory and non-statutory sectors to locate or to engage with. As a
result, inequalities can be exacerbated, as it is the people who are least in need who are most likely to engage in community involvement activities in various ways. Given the difficulties experienced in relation to community involvement, some areas are increasingly recognising the need to build community capacity in order to enable local communities to engage in decision-making processes.

**Building community capacity**

Saving Lives acknowledges the need to build community capacity in order to involve communities in local planning.

Real change can only come from the local community itself by harnessing the energy, skills and commitment of local people in setting clear objectives for change and forming new partnerships for action. Sometimes certain individuals - “social entrepreneurs” - are particularly effective in focussing community action to secure change (Cm 4386, 1999, p. 126).

In addition, it also notes the positive effect on health of engaging with people to build their self-esteem and strengthen social networks.

Russell with Killoran (2000) suggest capacity building is required at three levels:

♦ the individual;
♦ the group;
♦ the community infrastructure.

Community development projects are often aimed at the first two levels, while efforts to develop the voluntary sector are seen as crucial to developing the community infrastructure more generally. In addition, Russell with Killoran (2000) argue that there is also a need for capacity building and staff development with mainstream agencies, to enable organisations to ‘become more community friendly’ and to work effectively with local groups. Some of the key issues from the case study areas in relation to community development and building voluntary sector capacity are highlighted below.

**Community development**

All of the case study areas were involved in community development projects to promote health in their most disadvantaged areas. Many of these initiatives were cited by respondents in the particular case study as key examples of how they were tackling health inequalities. Such projects were focused both on geographic communities and communities of interests, especially women and children. Illustrative initiatives include: a young people’s community cafe, community-run need assessment exercises, community educators development programme; refugee professional accreditation schemes; food co-ops; cook and taste events; and, mother and toddler groups. Project managers could often point to initiatives that had achieved positive outcomes for the individuals who had engaged with them. Many of these initiatives described the key to their success as having the ability to allow the community to shape the initiative themselves, and being able to support them in doing so. For example, the manager of a young person’s cafe said:
And what I find really exciting is it really focussed on the young people themselves. Its focus was very ... led by what young people themselves say they want and see for the future.

Many respondents outside of the projects cited the crucial importance of the commitment and the tenacity of key workers in identifying multiple sources of funding to keep projects running. Funding of community development projects was difficult in all of the case study areas. It was seldom an activity that mainstream services supported. A voluntary sector executive director said:

... and its hard - in a lot of places, there are community development units or at least some resource going into general or pure community programmes, but there isn't in this borough and people are quite reluctant.

Even where such units exist, they were seen to be underfunded. A community development worker based in a LA said:

... because what happens at the moment there is just not sufficient resources to do it [community development], and therefore it doesn't get done and so you don’t get proper consultation.

The requirement of central Government to undertake community development projects in various policy domains - for example the CHD NSF - was seen to be slowly creating change on the ground.

... until very recently there was no community development in the local authority. Leisure services have changed only in the last couple of years and they recruited a community development co-ordinator and then changed a lot of their workers into community development workers ... so that is the first formal community development side of the local authority ... so no there isn’t a huge understanding of that area of work, I would say they are learning hand over fist and a lot of it is being driven by the fact that it is required by national government.

In addition, some PCTs have recognised the benefits of taking a community development approach for both community involvement and health promotion activities. In some places they were taking over the core funding of projects that had been reliant on short-term project funding until now. Similarly, many community development activities were being built into healthy living centre bids, as well as community planning. As a result, there was a sense that such activities were on the rise in all areas and were beginning to gain some mainstream acceptance. Nevertheless, more effort was required in this respect.

Strengthening the voluntary sector

A second way of building community capacity is to develop the community infrastructure. Voluntary groups are seen as crucial to this. The Government has developed a number of policy initiatives to increase recognition of the role of the voluntary sector and to improve support for it. For example, the Compact on relations between the government and the voluntary sector (Cm 4100, 1998) sets out a
framework for improved ways of working together. In the National Strategy for Neighbourhood Renewal, a Community Empowerment Fund has been established to support the involvement of voluntary and community groups in the LSPs (SEU, 2001).

As with community involvement, it makes sense to engage with the non-statutory sector to gain a real understanding of the needs and priorities within user groups and the wider community. The voluntary sector are both service providers, with a real understanding of the issues and the needs and the resource gaps within their field, and also representatives of those users. The voluntary sector has a long history of engaging with the multi-faceted determinants of ill health.

Many voluntary sector agencies could be seen as working towards tackling inequalities, they just may not label or understand it in that particular discourse. Hence there is a huge untapped resource of good and effective work within the voluntary sector. A voluntary sector executive director said:

I suspect that the label of health inequalities means very little to most voluntary organisations or community groups, ... however it is probably what all voluntary groups do, more than anything else.

Another voluntary sector executive director stated that:

... there is a huge ability out there in the voluntary sector - potential, but it is actually not being maximised.

Not being aligned to any statutory agency is an important feature of the voluntary sector’s success in gaining the community’s trust and in engaging with them. Thus, while being recognised as a legitimate strategic partner with statutory agencies was not always straightforward, the voluntary sector did have, in many cases, unparalleled access to communities. One health authority project worker said:

... very often people who are at the margins of society will not accept a health visitor or will not accept a statutory body but they will accept a volunteer who goes in, in a completely non-judgemental [way, with] no ... agenda but just to be along side them.

Voluntary sector involvement varied across the case study areas in terms of breadth and depth, and also in terms of which individual agencies they managed to engage with. Some council for voluntary services umbrella groups had core funding from their local HAs, while others had none and had to bid for, and manage projects, in order to secure funding for core staff. A number of respondents commented that while it was relatively straightforward to gain funding for innovative projects, it was much harder to get agencies to support core staff. Voluntary sector organisations struggled to keep pace with the multiplicity of sources from which funding could be obtained. Many specific projects or groups had to fund their activities from a number of different sources, which multiplied the bureaucracy with which they had to engage; both in bidding for resources and in providing monitoring and performance management information. Some council for voluntary services organisations were trying to streamline these systems locally, as well as to provide information on potential sources of funding.
Voluntary sector engagement in local partnerships was mixed. Some council for voluntary services directors were actively engaged at the centre of strategic partnerships, or they were leading, on behalf of the partnership, on large SRB and healthy living centre bids and projects. In other places however, there was considerable scepticism about whether the voluntary sector were being involved as key players, or only to secure funding:

... you know the special money that is coming round, they have to show very clearly that they have voluntary sector partners and it is no good getting artificial partners.

As a result, in some areas, the voluntary sector still felt ‘out in the cold’ completely, with little or no significant involvement. In some places as well, there was considerable debate about the legitimacy of voluntary sector representatives being on strategic boards. It was questioned whether they were suitable representatives of the community at large and, given their provider roles, whether it was appropriate for them to be involved in commissioning decisions.

Looking forward
Community planning and local strategic partnerships offer the potential for engaging communities in more effective, inclusive ways. While the benefits of community involvement are acknowledged, and enshrined in policy, insufficient effort has been focussed on community development and building capacity. Neighbourhood renewal and the Community Empowerment Fund will hopefully strengthen existing efforts to build community capacity and cohesion, but only in the selected 88 local authorities. Similar efforts are needed elsewhere.

On the whole, despite some dissatisfaction with the form and the speed at which voluntary sector involvement was taking place, it was generally felt that they were increasingly involved in many initiatives and partnerships. While this obviously varied between and within case study sites, it was believed that where it was improving, it allowed for more effective, inclusive and transparent planning.

Key policy implications
- Need to continue to build community capacity at all levels in order to promote health and to enable effective community involvement.
- Rationalise voluntary sector funding processes and broaden funds to support core staff as well as innovative projects.
- Organisational and staff development needs to take place in local agencies to increase their awareness of community development approaches and to better enable to them to work with community and voluntary groups.
Health inequalities: a priority at a crossroads

SECTION D: SUPPORTING AND ENABLING FOUNDATIONS

As discussed in Part 1, the DH strengthened and reorientated a number of underpinning foundations to encourage, manage and support local action to address health inequalities, including:

- funding;
- performance management;
- public health;
- developing an evidence base.

The way in which these have operated in the case study areas are described below.
FUNDING

Three broad issues were raised in the case study interviews in relation to resourcing efforts to address health inequalities:

- the overall level of funding;
- the basis of current funding allocation and the pace of change;
- the benefits and the problems around ringfenced money and short-term funding initiatives.

Overall levels of funding

All of the statutory agencies in the case study sites felt constrained in their actions by limited overall resources. This meant that they felt that they could only focus on central priorities. The following quotes from executive directors in different case study areas illustrate this concern in a health authority, an acute trust and a local authority respectively.

You can’t avoid the focus on central priorities. If you had loads and loads of money that wouldn't matter, but we don’t even have enough money to achieve the central priorities, and therefore anything else is entirely peripheral and just doesn’t get the attention ... there is no money for it, the view is why waste time on it.

But if you look at the resource position versus the targets we have got to achieve, there isn’t enough resources for the bare minimum targets we have got to achieve, so there is very little discretionary funding or whatever you want to call it for us to be able to say well actually this is our local need to do X, Y and Z.

I think one of the biggest problems that local authorities around the country have and it is certainly the case here, is the resourcing, it is hard enough to resource the core functions, and I think health promotion as it is seen does not seem to be a core function.

Some respondents made the point that this problem was exacerbated by HAs, and hence their successor organisations PCTs, being in deficit, which meant any new resources, including those identified as health inequalities funding, went into what was seen as core business – responding to the ‘must dos’. Clearly, these points relate to the more general issue that has been discussed elsewhere, that health inequalities were not seen to be a central priority on the local agenda. The implication is that if reducing health inequalities was given a higher relative priority nationally, it would get a different share of the pot, no matter how large or small that is seen to be.

Current funding formula

Several case study areas identified concerns with the current formula for allocating hospital community health services resources to health authorities. Three concerns were expressed. First, that the formula, based on weighting average levels of ill health and deprivation, did not take into account the extent of variations within health authority areas. There was a concern that areas with average levels of morbidity and
mortality but high levels of ‘hidden’ inequalities between their wards were not adequately funded to address the needs of their disadvantaged populations.

Secondly, there was a concern that areas with particular population groups were not receiving sufficient funds to cover the additional costs of providing services to them. Two groups were of concern: minority ethnic groups, where the current formula weight was felt to be inadequate, and refugees and asylum seekers, which are not included in population counts and hence not taken into account in either the formula or the allocations.

Finally, one of the case study areas, which was ‘under target’ in relation to their hospital and community health service resource allocation, felt that the pace of change towards target was too slow. It felt that crucial to its capacity to address local health issues was to move its actual allocation to its target share as quickly as possible.

Clearly, each of these specific issues are true for other places beyond the case study areas, and the current review of funding mechanisms needs to address them.

**Additional monies for health inequalities**

All of the case study areas discussed how they had received or bid for additional monies to support their efforts to address health inequalities. Two kinds of monies were important. First, hypothecated or ringfenced money that had been allocated to all or some agencies for specific purposes, for example, the Children’s Fund or the health inequalities adjustment. Secondly, short-term money for which local partners had to bid from a range of different funders. People welcomed these additional sources of funding because they enabled them to address health inequalities in ways that were not possible within core resources.

We access different pots of money ... neighbourhood renewal ... SRB money ... European money ... we see this as part of a shared pot of money to which together we can implement joint planning policies to improve people’s health and well-being.

The role of these additional sources of develop monies was similarly identified as a crucial factor in primary care organisations engaging with the health improvement agenda (Abbott et al., 2001).

However, there were also concerns among respondents that using external funds meant that the mainstream services were not having to address health inequalities issues.

I think what you will find is that it is all on new monies, it is all on bids ... and for me that shows the attitude ... we will deal with inequalities in health if we get extra funding but if we don’t we can only focus on the old ways of behaving and the old ways of doing.

I think the other challenge has been to try and extract the money from mainstream budgets to recycle some of that money but with all the other
pressures on them, new drugs and acute services stuff, that is even more difficult ... I think than it was a few years ago.

The short-term nature of funding associated with many area-based initiatives was seen to be particularly problematic. Such initiatives were seen to have little effect on the mainstream, with all of the valuable learning from them lost when they ended. Hence, as ways to address long-term problems, they left much to be desired.

Ringfencing mainstream resources therefore was seen as a way of addressing some of these concerns. An executive director of an acute trust suggested that:

... some ring fenced money is always valuable, now there is a lot of money coming round community development, its coming from so many different sources ... there should be a way of simplifying it...if they said we require that you spend one per cent of your money on health promotion or five per cent of your growth money in this area ... and some indication of where the money needs to be targeted.

Another benefit of ringfenced money has been to enable local areas to support development and innovation.

We received a national adjustment to our allocation for inequalities, we have already been supporting what we can [with] our partnership fund ... [it] will go in there ... and one of the benefits of the partnership fund is that it enables us to pilot schemes, to learn from experience and say we didn’t quite get that right, so let us do something else or yes that worked, let us now find ways of core funding.

However, even when money is labelled as being allocated for inequalities, without careful central guidance and accountability, it can be subsumed into general mainstream activities.

A further concern about earmarked funding was that when a range of different funding streams begin to engage into such processes it can make things on the ground very complex, so a simpler approach is required.

This hypothecated money is brilliant but it is complex and some of it is just unhelpful and it needs to be simplified and rationalised and we are finding that one government [department] doesn’t clearly always know what the other department is doing.

**Summary**

Adequate funding is obviously vital to address health inequalities. Ringfenced money was seen to be very helpful in getting issues on the table and in providing development funds to begin to address them, provided agencies were held to account for how they were used. The danger is that this implies that the mainstream services then do not need to tackle them.
Key policy implications

♦ Need to ensure that tackling health inequalities is given central priority so that it gets its share of the cake.

♦ The new funding formulae needs to address a range of issues to ensure that local needs in relation to health inequalities are taken into account.

♦ Ringfenced mainstream resources may help to ensure that appropriate resources are spent on improving health and reducing health inequalities in the face of competing priorities, provide appropriate accountability mechanism are built in.

♦ Short-term funding provides a useful supplement to mainstream resources to enable areas to address particular issues. However such initiatives need to build in ways to mainstream learning and to take account of the long-term nature of the problems that need to be tackled.
PERFORMANCE MANAGEMENT AND ACCOUNTABILITY

At the time the interviews were conducted, health inequalities were not part of any performance management system. Although the national inequalities targets had been published, these did not seem to have yet made a significant impact at local level. Moreover, a range of issues was raised about how the current performance management system detracted from efforts to tackle health inequalities. In particular, respondents felt that the key issues were:

♦ local areas were not being performance managed on health inequalities;
♦ the current approach to performance management worked against tackling health inequalities in a number of ways;
♦ issues that needed a joint response needed joint accountability.

Health inequalities as part of the performance management system

As discussed in Section A, reducing health inequalities was seen to be a ‘second order’ priority in comparison to ‘must dos’, such as waiting lists. The fact that it was not part of the performance management system emphasised this distinction, and many of the people interviewed felt, therefore, that it was not possible to invest in tackling health inequalities. This point was made frequently across all organisations and all places, as illustrated by the quotes below, from an acute trust executive director and a senior manager in a local authority, both from a different case study area.

The overall performance management regime within which we function is quite tight, is quite driving, is quite focussed – it is only going to get more so, I should think, and the targets upon which we lose or draw are not primarily based on equity or health inequalities issues, they are based on other issues ... you can always draw some obscure hyperlinks from these things to another, but they are not really about those sorts of targets.

If you look at the accountability arrangements for a health authority ... there are performance reviews on a range of different things ... health inequalities and regeneration were barely mentioned and unless work is seen to be rooted at high levels where accountability counts, then people like me are not going to get the time or be given the time to put the energy into it that it needs.

Limitations of the current performance management system

Other respondents felt that even if health inequalities were part of the performance management system, this would not help unless the overall approach changed. Four issues were raised here.

First, people felt that the overwhelming number of targets made tackling anything but the top handful in a meaningful way impossible. As two acute trust executive directors in different HA areas said:
... the other problem is that I think the general view among health service managers is that there are far too many priorities, the danger is if everything is a priority, then really nothing gets done properly.

... if they are going to use, and I think it works reasonably well, the HIMP and SaFF process as a way of targeting, then they need to take out some targets and put in some around health promotion and make those real... we have counted the targets, there are 126, now there is no way someone is going to monitor us on 126 targets they are going to monitor us on the key 10 ... so what you have got to do is actually find some way of measuring inequality, inequity and target some change in.

Secondly, the current performance management system was felt to detract from acting to tackle health inequalities by focusing on the short term. Given this, people felt they were always chasing short-term targets and hence not looking forward as to how they might achieve more public health-oriented, long-term outcomes such as reducing health inequalities.

We are just making the books balance, and sometimes that feels very much at odds with the work we are trying to do around inequalities ... and I think that is the dilemma at the moment with national policy, it is really very number sensitive, time sensitive targets which have a much shorter time span that the work you need to do to tackle inequalities.

Another concern expressed about the current approach in terms of tackling health inequalities was that a focus on common targets across the country might not be meaningful everywhere. There was a desire to be able to respond to local variations and inequalities more effectively, through more meaningful local, tailored, target setting.

It is alright hitting the Government targets, but if people at the lower end of the income scale or living in poor housing or come from different community backgrounds, their relative position isn’t changing ... we are not actually reducing health inequalities at all.

Given this focus on reducing national inequalities in health, there was a concern in some places that already had reasonable overall levels of health, that the new national targets were not relevant to them. This was an issue because they still had significant levels of disadvantage within their borders, but the targets did not consider these. This concern was also raised in the study of the health improvement role of primary care organisations (Abbott et al., 2001).

Finally, people were concerned about whether the general approach to performance management led to meaningful activity. Instead of generating sustainable, concerted work around tackling inequalities in health in a substantive way that permeated the whole organisation, it was felt that:

... priorities shift when you have to have ticked boxes, ... rather than actually delivering quality pieces of work, based on evidence, based on good practice, based on experience we are forced to fulfil other people’s
agendas and so even though we might know what the best way might be, it often gets compromised.

Again, these concerns are echoed in other recent reports of local agencies efforts to improve health and reduce health inequalities (Abbott et al., 2001; Exworthy et al., 2002).

The idea that local agencies should have to demonstrate a more substantive approach to tackling health inequalities, rather than focus on a specific target, was echoed by a number of respondents. Some people felt that local agencies needed to be held to account for their overall approach to tackling health inequalities, rather than focus on the detail of what was being done. Others felt that there should be a specific ‘protocol’, which set out performance measures across a range of dimensions, such as community capacity building or partnership working. Supporting these kinds of ideas, a number of respondents suggested local need for process targets and milestones to get things moving in the right direction. Other respondents also suggested that a ‘best value’ approach to audit would be more productive than the current ‘numbers focused’ approach.

The national health inequalities targets were felt to be rather broad goals, and some respondents argued that there needed to be a much more focused set of indicators to make targets more meaningful locally. A number of respondents felt that what was needed was a common minimum set of local health inequalities indicators, which health authorities could work towards. Others suggested that to ensure that investments were made to improve the health of specific disadvantaged groups, these common indicators should be pinned down locally to outcomes and activities for those targeted groups.

A difficult balance therefore needs to be struck between holding agencies to account for their approach to tackling health inequalities, as well as to achieving outcomes. Such a conclusion echoes the findings of one of the reviews of Health of the Nation (Fulop et al., 1998), which argued the health strategy needed to be much more firmly embedded in the performance management framework, including markers of both process as well as outcomes. Furthermore, it was felt by respondents here that getting the balance right in performance management is vital. If performance management were too ‘light’, then nothing would get done, and if it is too ‘heavy’, then people would resent it and it may become onerous.

Despite the many problems and issues cited around performance management, it was felt that it does serve a useful purpose. A senior health authority executive director said: ‘we have all hated it, but it has been a very good discipline’. In this sense it could be an effective tool, most notably if it incorporated measures around processes or outcomes related to tackling inequalities in health. Being performance managed on The NHS Plan ‘must dos’ means that this is where energy is focused, so clearly it is important to build efforts to tackle inequalities into that process in some way.

Consistent performance management

Linked to the idea of a broader perspective on the performance management of tackling health inequalities was the need to have joint accountability across agencies because many of the necessary actions required partnership working. Unfortunately,
at present, as a number of respondents described, targets were still perceived to be in organisational silos.

I think these boundaries are always going to be there as there is this thing that we work to our health targets and the police work to their Home Office targets and everybody works to their own targets, and maybe what needs to happen, which probably is this thing of coterminosity, is that you can say ‘our’ targets are - and we share them.

A key issue which a number of respondents raised was that a range of partners needed to engage in activities, for example to develop the HImP, but at present only health authorities were held to account. This made it difficult for there to be real ownership and shared commitment across the different players. Those agencies that were not held to account for their contribution to the HImP felt that they could not make it a high priority as they had to focus on those things on which they were specifically performance managed. HAs were seen, albeit understandably, to be keeping a tight control on HImP development, as they needed to demonstrate its delivery, thus reducing the capacity for genuine partnership working.

It was argued that a greater consistency was required in accountability and performance management arrangements between the county council, LAs, NHS Executive regional offices, and health agencies, to enable them to work together more effectively. An acute trust executive director said:

... give people a common language and a common understanding and of course some elements of consistency of targets and approach between the programmes of county council and regional government and the health and social services to be able to truly attack that together.

An associated problem was the variety of different performance management systems to which individual projects needed to respond when they had multiple funders. There is some scope to avoid duplication, or in some cases, to avoid having to complete a number of different sets of performance management and monitoring requirements, by standardising the process across funders and agencies. One case study area was attempting to develop a common approach to controls and monitoring in line with SRB criteria for the rest of its partnership fund work, but so far this much needed rationalisation seems to be locally rather than nationally driven.

... what we are trying to do is ... have common service level agreements and a common monitoring ... but just to make things easy from everybody’s perspective. It is easier if you are filling in the same thing for a variety of people, than marginally different things.

More thought needs to be given to how agencies can be jointly held to account when they are working towards common goals, particularly in relation to issue such as health inequalities, which require such complex responses from a range of agencies.

**Summary**

Performance management was seen to be a useful tool to ensure that local agencies delivered on key priorities. However, at present, it was felt the system failed to
support local action to address health inequalities. Again, this finding echoes the conclusions of one of the reviews of Health of the Nation (Hunter et al., 1998), which argued for a performance management framework that set out clearly each agency’s specific roles and responsibilities but emphasised joint targets and monitoring.

**Key policy implications**

- Health inequalities need to be a more central part of performance management systems than is currently the case if local agencies are to put more effort into tackling them.
- Such performance management needs to be consistent across the different partner agencies that need to work together to reduce health inequalities.
- The system needs to recognise the need to balance working towards longer-term outcomes as well as meaningful short-term outputs. This could perhaps be achieved by combining audits of different partnerships’ approaches to tackling health inequalities with a basket of local targets.
- There also needs to be a balance between reducing national inequalities and ensuring local agencies focus on reducing local variations.
PUBLIC HEALTH

As highlighted in Part 1, in a whole range of policy documents (Cm 3852, 1998; Cm 4386, 1999; Cm 4818-I, 2000) the Government has argued that public health and prevention need to become much more central to the role of the NHS. In part this is about having a broader concept of public health and bringing that to the centre stage of local agencies activities. It is also about strengthening the public health role of the three different sections of the workforce identified in the Chief Medical Officer’s (CMO) report (Donaldson, 2001):

♦ most public sector managers;
♦ professionals who engage in public health practice (e.g. health visitors);
♦ public health consultants and specialists.

Concerns about these issues were identified by respondents and are briefly highlighted below. In addition, there was widespread concern and debate about where the public health function should be located in the future. Subsequent to this fieldwork the Government clarified their plans for this as part of their Shifting the Balance of Power agenda. The implications of this are discussed in Part 4. The following discussion reflects respondents’ concerns and aspirations at the time that they were interviewed.

Making public health a central part of the NHS

Local players welcomed the increased importance given to tackling health inequalities and the recognition of a broad social model of health. The lack of a broad perspective on health was one of the key criticisms identified in one of the reviews of Health of the Nation (Fulop et al., 1998). However, at a more practical level on the ground, whether or not promoting health and reducing health inequalities was being taken more seriously was judged by the flow of resources into it. In some case study areas, money was being set aside as part of the SaFF process, for the first time, for prevention and health promotion activities, which was seen as a significant achievement.

The PCGs have agreed to put £150,000 out of the SaFF process and allocate that purely to sort of ‘health promotiony’ bits of the NSF, so the bits that are around inequalities, so that is a big achievement.

More generally, however, there was a feeling that health promotion had been marginalized for a long time and that little had changed. A health authority executive director stated:

... one of the reasons that you have got very poor health promotion departments in a lot of areas is because the money has been gradually been siphoned off when things have got tight in health care.

A senior manager in the same authority made a similar point about investing in efforts to promote equity:

... the only agenda is financial balance. It is a tremendously difficult environment in which to work, and I don’t see it changing, I think the
Board can only nod in the direction of equality to the extent that it doesn’t involve any financial risk. They cannot even think about the fact that it actually might save them money to offer people a service that stops them becoming ill later.

One problem that frequently came up in the case study interviews was that groups of professionals or managers who hold considerable power in local partner agencies do not see the value of investing in prevention.

If you are a hospital consultant you will clearly bark for what you can get, your slice of the cake for your particular developments in your hospital setting ... it is very difficult for a hospital consultant to see the health relevance [of] investments like SureStart.

In contrast, in another case study area public health itself was seen to be marginalized in decision-making processes.

I think public health isn’t strong enough within this organisation, for example we don’t write the HImP... there are other health authorities ... that are public health led and I think those ... probably have a much more strategic approach to addressing health inequalities.

It is clear, therefore, that further efforts are required to ‘change hearts and minds’ so that prevention and public health are seen as a more central part of the NHS. One way of doing this is to try to expand the public health perspective across a wide range of managers and other professionals.

**Expanding public health**

Respondents identified two groups of actors in local partnerships who, in different ways, needed to develop a public health perspective. First, it was argued that all managers and health care professionals needed a better understanding of public health. One executive director of an acute trust argued that there is a need to find ways:

... to encourage our most competent managers to spend at least some of their time in health promotion and [the] community, rather than dashing for the sexy jobs in hospitals.

While another argued for an even broader approach:

... taking some sort of public health and wider determinants of health, education, understanding, awareness, sensitivity amongst all aspects of organisations that the government feeds or funds that affect health inequalities ... this sort of idea of providing a common syllabus element for the various professions allied to medicine and in medicine.

This view is supported by a range of studies that have argues for the need to include public health in core courses and to promote multidisciplinary education to address these kinds of issues (Blackman, 1993; Doyle and Thomas, 1996; Daykin and Naidoo,
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1997). The CMO’s report on strengthening public health (Donaldson, 2001) made similar recommendations.

Secondly, and more substantially, it was argued by a wide range of people that professionals, who have what the CMO described as a ‘public health practice role’, need to develop the public health dimension of their jobs. In the case study areas a number of attempts had been made, or were planned, particularly with health visitors and community nurses, to promote their public health role. This was seen as a very positive opportunity.

Previously public health has been the preserve of people with public health professional labels attached to them, mostly people working at fairly strategic levels in health authorities, what we have now got is the opportunity for people such as health visitors and district nurses who, historically would always say they had a strong public health role, haven’t actually been able to exercise that role.

While a senior manager in health promotion said:

I think particularly for community nurses, there is a huge opportunity to work in a public health kind of way and actually putting those agendas both on their training and also in the way they deliver services to the general public, they have a huge educational role, which is totally missed.

However, a number of specific initiatives that were described had hit stumbling blocks, although this was often because of limited or inadequate staffing levels. There was a sense of fear that public health work would detract from the vital delivery role that health visitors and nurses already play, with limited capacity and resources. A senior manager of a PCG discussed this issue, outlining their progress thus far:

...[to] take forward the public health function of the primary care and part of that was to try and get about 20 per cent of the nurses’ role, 10 to 20 per cent of the nurses role into looking at broader public health issues, and I failed dismally ... trying to get them to change their role into something else is stopped at management level.

On the other hand, some respondents asserted that nurses and health visitors were already managing to perform a broader, public health function, and were engaged in developing wider links with the community, and that this role needed to be fostered.

School nurses are not just looking at doing checks at certain stages in childhood, they are looking at much more the public health way, what they can do in a community development way... I think we have some very good practitioners... who are working differently.

Clearly, while there is obvious support for developing the role of such practitioners, there are some practical issues to overcome.
I would like to see the nurses take forward the public health agenda, they are the right people I think they are overworked, but I do think they are the right people, but that also needs Government commitment.

It was recognised that the Government had introduced a range of initiatives in this area (Cm 4386, 1999). However, these were not felt to have been given sufficient priority to transform the situation for most community nurses on the ground.

**Broadening the public health function**

As well as developing public health understanding in the wider health community, a number of public health and health promotion respondents also discussed the need to broaden and to strengthen their own roles. Again, this is an issue identified in the CMO’s report on public health. Non-medical practitioners in public health and health promotion workers felt undervalued. For example, a specialist in public health in one case study area said:

...the Government has said public health specialists should be there and leading on the inequalities agenda, but we are second class citizens to the medical consultants and more often than not they have got medical consultants managing us.

While a health promotion manager in another area said that they felt:

...health promotion is very marginalized, [both] our kind of role and as a profession.

Crucial to both groups was the need for a clearer career path. Again, this was something highlighted in Saving Lives and the CMO’s report. Nevertheless, respondents on the ground felt that very little progress had been made:

...if they could stop faffing around and get on and we could get a proper career structure developed.

Here again, giving priority to implementing the recommendations of the CMO’s report (Donaldson, 2001) would address many of the concerns on the ground, and improve staff morale tremendously.

**The location of public health**

There was much discussion about where public health should be located in the future. Different respondents, depending on their own organisational loyalties, alternatively argued that it should be with PCTs, local authorities or strategic health authorities. The Government’s response to the Health Select Committee’s report on public health, made it clear that public health should remain within the NHS (Cm 5242, 2001). Nevertheless, many staff from local authorities and some community organisations felt that the local authority was a more appropriate home for leading the health improvement agenda.

In a sense, what the LAs do already tackles inequalities, there just needs to be a greater awareness of how and why they do it, and how best to raise health’s profile and to maximise the health benefits of their work. It was felt by some respondents that
the LAs would be more able to pursue action to tackle the root causes of ill health, as
they were not constrained by performance management around health service
delivery. One local authority executive director said:

I can’t help thinking that the majority of preventative health work and
what really affects people’s well-being are provided by - not necessarily
provided, governed by the local authorities rather than health authorities,
and I think we have a bigger stake in the services that can produce good
health... and I would dearly love to see a non-health authority directed
strategy... the lead I think comes from community governance, which is
the local authorities.

While a director of a voluntary sector umbrella group said:

... they talk about public health moving back to local authorities and some
of me supports that... I am feeling more and more that public health and
the whole health improvement agenda perhaps needs to be met some
where else - I’ve spent 25 years - head banging - trying to change
cultures within health services and I suppose I have come to that
conclusion and I know there are drawbacks to it.

However, responsibility for the health improvement agenda does not necessarily need
to equate with moving the public health function to local authorities. A number of
respondents argued that public health experts were not necessarily the best people to
lead on partnership working and regeneration issues. Others felt public health staff
were exactly the right people to take the lead in this area.

Given that the Government has made it clear that public health will remain in the
NHS, the issue then becomes where it should be located within it. There was still a
significant debate taking place in the case study areas at the time of the interviews
around whether public health should be located at the HA or the PCT level. Chief
executives and chairs of PCTs and PCGs were eager for public health resources to be
moved to them so that they could focus more on improving the health of their
populations.

I think public health people should actually be in the PCTs ... proposals
are that it should all go into one big health authority...I don’t know it
doesn’t give a local flavour ... it is public health people who have made
the biggest changes to health ever ... I think they should be local.

My PCG has three staff, right, that is all really, and we had some difficulty
in getting [the] health authority to realise that - that we might have lots of
ideas about what could and should happen, but without public health
resources, we couldn’t possibly do them ourselves ... so we haven’t had
the staff to do.

There was significant bad feeling in a number of the case study areas that HAs had
kept the public health resource rather than transfer it to the PCGs. Those PCGs then
felt that this had hindered their ability not only to address the health improvement
agenda but also to improve commissioning.
However, many other respondents were concerned that devolving public health and health promotion to PCTs would lead to fragmentation, with isolated and unsupported staff working on their own. This was voiced by an executive director at a health authority:

... the public health resource would be fragmented so much that you lose people that have been there before and have got a memory of what actually happened.

While in a PCT, a public health respondent said:

... at the moment having one individual in each of the PCTs, it is pointless, you can only just keep chipping away.

It was felt that public health needed a critical mass to perform effectively. Not only did dividing them between PCTs isolate individual staff members, but also current HA areas could end up with a number of ad hoc pieces of work. This could lead to the duplication of effort in different localities so that, overall, the resource had little impact on the populations’ health. Moreover, there were still a number of public health functions at the HA level which required resourcing. This could mean that public health staff had to divide their time between PCGs and HAs, although this too was seen to be problematic.

A number of study areas were developing public health networks to try to overcome these problems, with directors of public health and health promotion remaining at the HA with a small staff to provide an overview of the patch. This also meant that there were independent lines of professional accountability as well as staff support and development. In most places this network was virtual. However, in one case study area they had proposed developing a joint health unit. The unit would include a range of staff from public health, strategy, health promotion, and others, to provide support to all local agencies as a way of ‘strategically underpinning’ local efforts to tackle health inequalities. The Faculty of Public Health Medicine (Griffiths et al, 2001) have put forward a model of ‘managed public health networks’, to link and co-ordinate multidisciplinary professional groups across organisational boundaries that are aiming to improve the health of the population.

**Summary**

It is clear that the DH has advocated a much broader perspective on public health in its policy documents and this is universally welcomed locally. At the same time a number of initiatives to broaden and to strengthen public health have been introduced. However, they were not seen to have been given sufficient backing to really create change on the ground. Although the Government is clear about the future location of the public health function, feelings on the ground are more mixed. Yet as PCTs take over lead responsibility for tackling health inequalities locally, it is crucial that they have strong public health input. Unless real investment is made in public health and the Government are seen to place more value on it, staff morale will remain low.
Key policy implications

Many of the issues identified in the case study areas, support the need to implement the recommendations of the CMO’s report (Donaldson, 2001). These included the need:

- to improve public health awareness and skills across a wide range of public sector managers and professionals;
- to develop the public health role of community nurses and other practitioners;
- to broaden the public health function to encompass the range of skills necessary to promote health improvement;
- to enhance the role and the value of non-medics in public health and health promotion professionals by providing better career paths.
EVIDENCE BASED POLICY

Across all areas of health policy the Government has placed considerable emphasis on developing evidence-based policy - reducing health inequalities and promoting health is no exception (Macintyre et al., 2001). For example, at the national level, within months of taking office, the Prime Minister announced an independent review of evidence to support policy development to tackle inequalities in health, chaired by Sir Donald Acheson (1998).

The Government also introduced a range of initiatives to develop the public health evidence base. Central to this was the transformation of the Health Education Authority to the Health Development Agency (HDA) as a new resource for those local bodies working in public health. Its role includes developing an evidence base for effective public health action, capacity building for public health across the NHS, local government the private and voluntary sectors, and developing standards for multi-sectoral public health action, linked to other government initiatives.

At the local level, agencies are encouraged to use an evidence-based approach to policy, the extent to which this was happening in the case study areas varied considerably.

The existing evidence base

A number of respondents spoke of how their organisations had used what evidence was available to them nationally to develop their HImPs and to substantiate their policy making across a range of services and strategies.

Clearly we took all of the national and local evidence that made clear [how] the issues of access to acute services impacted directly on inequalities, both in health and in social care provision, and that is why we are now reconfiguring our acute services, based on proximity to our deprived communities.

I mean children is relatively easy, because I think we have a lot of national evidence to draw upon and there are all sorts of research papers and indeed the government’s own needs assessment framework that I think has been extremely helpful.

A frequently mentioned resource was the Acheson Inquiry (1998), which provided a base document for many HAs to define and to develop their approach to, and understanding of, inequalities. In many ways this Inquiry was seen to have legitimised a focus on tackling root causes to reduce inequalities in health and, both inter and intra agency, partnership working. An HA senior manager, describing their HImP, referred to its inequalities section, saying:

... which was a digest of Acheson and an analysis of Acheson to see which elements of it had local applicability ... so there was a paper produced ... which in a sense looked at Acheson and said these are the local issues and reviewed what progress had been made.

Despite the mention made in the interviews of national R&D and support to inform and to develop evidence-based policy, there was a real sense of the need for more
support. This is echoed in other studies. For example, Hamer (2000) in her review of HImPs, identified an 'emerging theme is the gap between research and development'. She argued that there was a need to provide strategic support to authorities, regions and emerging public health observatories and to disseminate examples of current good HImP practice, and to mainstream innovative approaches to public health development through HImPs, HAZs and community strategies.

Respondents in the case studies echoed this. For example, they argued for the need to share HAZ learning more effectively. There was thought to be a regional role in developing networks and in sharing learning. A respondent said:

One of the things we tried in this department was to involve higher educational institutions and universities locally to work with us to evaluate some of our projects, but they haven’t got the resources to do that, but if there was an agency, even if it was centrally operated from London, where they could give us that support to evaluate things much more effectively, then it would be very good.

These sorts of structures and processes could be implemented at government office for the regions or NHS regional levels (new strategic HA) level.

More locally, many respondents suggested there was not enough sharing of good practice and lessons, or dissemination of information or data between groups, or between agencies. On the other hand, perhaps as a caveat, one respondent pointed out that just because an initiative worked in one place does not mean it will elsewhere.

What we need to learn from that as a health authority is that just because something works well, you can’t automatically replicate it and expect it to work well.

Such a concern has been echoed nationally in a number of commentaries on evidence-based policy (Klein, 2000; Davey Smith et al., 2001).

Nevertheless, there was a strong sense that communication about good practice - intra and inter organisational - needs to be more effective, and that information and data need to be a lot more accessible. It was felt that lessons and information ‘goes down sub-group pathway and gets lost’, and that lessons simply do not get learnt. Without effective communication, the continuum and momentum of improvements in delivery is lost.

**Local research and development**

There were many examples of topic-based surveys and studies, papers, working parties, or data collected through monitoring procedures for HImP groups or ABI-funded projects, either in-house or done externally. However, these were limited to specific issues, for example, sexual health, and there was little sense of good baseline data being collected, good practice being shared and disseminated, or studies that reflect the holistic and interdependent nature of health.

Locally, three broad areas of support were identified:
Co-ordinated data collection and sharing of good practice

Most respondents discussed the need for better baseline data to enable them to develop more effective and meaningful strategies to tackle inequalities in health. However, there was felt to be limited resource or capacity for effective R&D to do this. A number of respondents were engaged in trying to co-ordinate databases within their areas, but also indicated the need to share data, learning and good practice nationally, regionally, and locally.

The availability of baseline data for needs assessment, monitoring and evaluation was often inadequate, for example, a voluntary sector senior manager said:

... one of the problems relating to that is the lack of baseline function. One example of that is I am doing an evaluation of a home safety project, trying to get a coherent baseline information around accidents is a nightmare - we need it to do an effective baseline.

A number of respondents pointed specifically to the need for better, or for more developed databases, providing a comprehensive listing of both provision of services and need in their areas. This was recognised as being central to effective planning and delivery. One HA has set itself a milestone to amalgamate the databases of services and activities across its area, as there was considerable duplication and a number of gaps. It is felt that only by co-ordinating current data sources and future data collection, will strategies become more effective.

Everybody has had different databases, then everybody was missing somebody at some point, so through that we have actually set ourselves a task of actually having one ... database of organisations that are involved in care.

One LA had tried to develop a database of partner agencies’ activities in order to map strategies, initiatives and good practice, and had found it very difficult to gather information from organisations. This was thought to be partly because of time constraints, but also because of a protective approach to what they were doing, where they had achieved success and where they had failed. This response is not difficult to understand, given the strict performance management and target setting at a national level.

Needs assessment

Respondents felt that projects and programmes would be more effective if there was a greater understanding of the local needs. While in part this comes from good, detailed baseline data, there is also a requirement for support and resources to establish a more qualitative understanding of the communities’ needs through a variety of methods. This can be done using a range of consultative and inclusive strategies, however, it is a resource-hungry exercise.
Funding becomes a lot more accessible if there is a real understanding of local problems so that agencies have a strong case to put forward. Public health data were therefore seen to be useful for bids, and data were collected for ABIs or similar initiatives to substantiate the proposals and to target efforts. However, this was less common in mainstream activities, where good data in relation to need are equally important.

I think part of the problem is that we need health needs assessment of local populations, now that can either be as small as you like ... then come to you and say, within this ward, we have this, on this ward we have that, and if you hold the purse, I am going to be asking you why you do not release the purse to achieve.

A more recent development was the use of health impact assessment, which was seen as a potentially useful and effective tool by some respondents. Its role in developing a more robust understanding of the potential impact of initiatives on health – good and bad – was recognised. Cave and Curtis summarise the aims of HIA as follows:

to propose ways to promote and record the beneficial health outcomes, and also to monitor potential negative impacts with a view to reducing, or mitigating their effects (2001, p.2)

Issues raised around HIA however relate to the fact that it can be a demanding procedure if it is to be carried out in a meaningful and rigorous way. More worryingly, it could also become a mere token exercise if it becomes a standard requirement for agencies to fulfil:

... otherwise there is the danger of what happens in other health authorities ... to say when we do something new health impact should be assessed and all that would happen is that we would have paragraph 56 of the report ... ‘this project will improve the health of the area’.

One respondent was emphatic that there has to be meaningful community involvement in needs assessment and in HIA if they are to be effective. Their belief was that the communities themselves need to be involved in identifying the possible pros and cons of initiatives, and their views have to be taken into account. Moreover, HIA is in part a community involvement tool, and can be used as such. Cave and Curtis (2001) suggest that ‘HIA can also provide a participatory way of examining a project and its potential for affecting people’s health’.

Local evaluation and monitoring
A key feature of policy development should be consistent and effective monitoring and evaluation of work to assess where the strengths and weaknesses are, and how lessons can be incorporated into new ways of working. However, despite its widely recognised importance, there was little indication from the respondents that sustained and overarching monitoring and evaluation was taking place, specifically with regard to activities to address health inequalities. There was some evaluation being carried out for area-based initiatives and other small externally funded initiatives, but this was not the case for mainstream activities. As a result there was no real sense of understanding if, and how, inequalities were being tackled.
Summary
While Government’s commitment to supporting evidence-based policy was appreciated at the local level, but much more needs to be done. Key areas of support were highlighted around developing baseline data, sharing good and bad practice, and conducting needs and health impact assessment. While much of this work can be carried out at a local level, national support, in line with its Saving Lives commitment, needs to be more effective. The foundation stones laid by the Labour Government when it came into office around public health observatories, the new HDA, the Acheson Inquiry and range of other initiatives need to be built upon and extended, developing local, regional and national links.

Key policy implications
- Support local and national needs assessment and health impact assessment.
- Incentivise and guide the dissemination and sharing of good and bad practice, and baseline data between and within areas.
- Allow time for local lessons to be extracted and learnt, and for local flexibility to incorporate these into strategies.
- NSFs and the NHS Plan as potential sources of data for local areas need to incorporate more appropriate levels and forms of cross cutting health and health inequalities data.
PART 4

TACKLING HEALTH INEQUALITIES: THE WAY FORWARD
INTRODUCTION

As the fieldwork for this project, and Labour’s first term in office, drew to an end, the Government announced a significant reorganisation of the NHS, which meant that HAs as studied here would cease to exist. Instead, PCTs will lead on tackling inequalities locally, and will be the key link with LSPs, which will increasingly coordinate local efforts to address the root causes of ill health. It is within this framework that consideration is now given to the policy lessons derived from this project that will help to promote local efforts to tackle health inequalities in the future. This section therefore begins by briefly describing the new policy framework for the NHS and what it means for local efforts to reduce health inequalities. Many of the key mechanisms introduced in Labour’s first term will continue to be significant, albeit in a different context. Hence key lessons for improving those mechanisms are discussed below.

NEW POLICY FRAMEWORK

As Labour moved towards its second term it announced a sweeping reorganisation of the NHS (Milburn, 2001a). Although building on the changes set in train under The New NHS (Cm 3807, 1997) and the policy direction set up by The NHS Plan (Cm 4818-I, 2000), the future looks radically different. Shifting the Balance of Power within the NHS (DH, 2001a) makes changes at every level of the NHS. This, together with the general development of intersectoral action at all levels of government, has contributed to the emergence of a new policy framework to tackle health inequalities locally.

What is unfortunate from the perspective of tackling health inequalities is how little prominence it is given in Shifting the Balance of Power within the NHS (DH, 2001a). While there are repeated references in the main text to different agencies contributing to ‘improving health’ in general, the requirement to reduce health inequalities is not mentioned until Appendix 1 (p. 41) in the description of roles and responsibilities for strategic health authorities. It does not appear in relation to PCTs until Appendix 2, which describes the future structure of the public health function. Crucially perhaps, it is not listed as one of the ‘critical targets in key priorities’ for the revised performance management system (DH, 2001a, p.28). Similarly, Alan Milburn makes no mention of it in his first statement announcing Labour’s priorities for their second term (Milburn, 2001b).

Nevertheless, a range of policies have been put in place that aim to promote local action to address health inequalities. The key mechanisms within these, as part of the new policy framework established by the DH for Labour’s second term, are illustrated in Box 4.1, and are described in more detail below.

At the local level, all remaining PCGs will move to PCT status in April 2002, and all current HAs’ functions will be devolved to PCTs as soon as possible. The local modernisation review guidance emphasised the need for the NHS to address the root causes of ill health and to ‘improve NHS access for all by placing health inequalities in the mainstream of the service’ (DH, 2001g). PCTs will be the key point of contact between the NHS and local government, and must play a full role in the national strategy for neighbourhood renewal and LSPs. PCTs will be required to produce annual health improvement and modernisation plans, which replace HImPs (DH,
2001c) to take forward the action outlined in the LMRs. Work is underway to ‘align activities for health improvement and modernisation plans with LAs’ community planning process’ (Cm 5242, 2001, p.26). In time, as PCTs develop more integrated services with local government, they may wish to merge with social services to become Care Trusts. All NHS organisations will be expected to use their role as employers, developers and purchasers, to support the local economy and local communities in ways that improve health.

At the intermediate level, current HAs will be merged into much larger strategic authorities in April 2002. These will act as the bridge between the DH and the local NHS; they will set the strategic direction of, and performance manage, both PCTs and acute trusts. The NHS Executive regional offices will be abolished, with strategic health authorities taking over many of their functions. Instead, four regional directors of health and social care will oversee local developments.

At the national level a number of policies are continuing to be developed. For example, the review of resource allocation mechanisms is still underway (Milburn, 1997). National health inequalities targets have been set and are part of the Public Service Agreement between the DH and the Treasury. In August 2001, a consultation document was published to examine how these national health inequalities targets can be met. This identified six priorities for action (DH, 2001c):

♦ providing a sure foundation through a healthy pregnancy and early childhood;
♦ improving opportunity for children and young people;
♦ improving NHS primary care services;
♦ tackling the major killers: coronary heart disease and cancer;
♦ strengthening disadvantaged communities;
♦ tackling the wider determinants of health inequalities.

The final strategy is still under consideration.

Underpinning these specific responsibilities are a number of foundations that are continuing to be developed. In relation to performance management, in its response to the House of Commons Select Committee on Health’s Second Report on Public Health, the Government said that ‘the new systems will need to give due weight to health improvement and reductions in inequalities’ (Cm 5242, 2001, p.32). Similarly the guidance for the LMRs, states that one of the three themes of The NHS Plan is:

... reducing inequalities and improving access to health and social care. It is intended that these themes should be reflected in everything the NHS does, and in every part of the NHS performance management and planning process (DH, 2001g).

However, nearly all of the access targets contained in the LMR guidance focus on improving waiting times i.e. the speed of access rather than equity of access between different groups or places. The targets ‘to improve public health and reduce health inequalities’ do include a number of distributional outcome targets as well as others focused on improving healthy lifestyles.
More broadly, the role of public health will provide vital support at all levels of the NHS in its efforts to address health inequalities. Shifting the Balance of Power in the NHS (DH, 2001a) sets out a new framework for the public health function. At the local level PCTs will need a stronger public health team than most currently have, including representation on the executive board, to support their health improvement and service development roles. It was recognised that some endeavours may be too specialised for one PCT to support and in such circumstances they are encouraged to pool resources. A director of public health with a small support team will be part of the strategic health authority and will be required to create local public health networks and to performance manage public health in PCTs. At regional level, directors of public health will co-locate in each of the nine government offices for regions, to ensure that health concerns are built into regional regeneration plans. This will be particularly important as government offices for the regions are required to support and to performance manage the work of LSPs, including their action to address health inequalities, where appropriate (see below).

**Cross-cutting** developments are taking place across a range of broader policy initiatives to build tackling health inequalities into local, regional and national agendas. At the national level a cross-cutting spending review is taking place that will examine how the whole Government can better focus on health inequalities (Smith, 2001). At the local level reducing health inequalities is explicitly being built into a range of partnership efforts, including New Deal for Communities (in 39 disadvantaged neighbourhoods), the National Strategy for Neighbourhood Renewal (in 88 disadvantaged LAs) and the voluntary local public service agreements (SEU, 2001). In such places, the emerging LSPs will provide leadership for all of these initiatives and will therefore need to build tackling health inequalities into their community plans. The NHS Plan makes it clear that the NHS must play its full role in LSPs; Shifting the Balance of Power states that PCTs will be required to lead on this. Within the reforms to the NHS, to local government and to regeneration initiatives, there is an increased emphasis on the role of community development and on the need to strengthen the role of the voluntary sector and the public in local partnerships and planning processes.

Overall, therefore there are mixed messages about the centrality of reducing inequalities in health to the local policy agenda. Some policies, such as the health inequalities targets, or including inequalities in regeneration programmes, are very helpful in putting the issue on the local agenda. Others, such as only mentioning health inequalities in the appendix Shifting the Balance of Power in the NHS and not at all in the priorities for the NHS for the second term, are a backwards step. Nevertheless, this is the new policy framework that local agencies must work within, over the next few years. The next section, therefore, explicitly identifies the key implications of our findings within the new policy framework.
<table>
<thead>
<tr>
<th>Context</th>
<th>Key mechanisms</th>
<th>Overall aims</th>
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| ♦ Increased devolution of decision making to local NHS structures to respond better to local needs.  
♦ Major organisational change in the NHS.  
♦ Health inequalities were built into a range of policy structures during Labour’s first term.  
♦ Popular perception that the Government is not delivering on the NHS in relation to waiting times, hospital services etc.  
♦ Increased investment in, and prioritisation of, health care agenda.  
♦ Conflict between long-term agenda of tackling health inequalities and short-term imperatives to deliver improvements in the NHS. | Local level  
♦ PCTs are to lead on health improvement and on reducing inequalities locally.  
♦ PCTs will be the key link with local government and represent the health economy on LSPs.  
♦ Emphasis on local agencies using their role as employers, developers and purchasers to support local economic development and hence improve health.  
♦ Commitment in a range of ways to strengthen community development, the role of the voluntary sector and public involvement. | To narrow the health gap in childhood and throughout life between socioeconomic groups and between the most deprived areas and the rest of the country (Cm 4818-I, 2000). |
| | Intermediate level: providing an overview  
♦ Strategic health authorities will provide overall direction and performance manage local primary care and acute trusts. | All NHS organisations to tackle the inequalities between the more and less deprived areas and communities within their boundaries, not just the fifth of HA s with the lowest life expectancy at birth (Cm 5242, 2001, p.6). |
| | National level  
♦ Health inequalities remain a priority for the NHS, and reducing them is part of the DH’s PSA with the Treasury.  
♦ National targets have been set to reduce health inequalities. A delivery plan has been produced for consultation, which provides a framework for tackling health inequalities.  
♦ The DH is still completing the review of resource allocation to incorporate reducing health inequalities into its criteria. | All levels: underpinning foundations  
♦ Tackling health inequalities will be built into performance management systems.  
♦ Recognition that public health needs to be strengthened at all levels, including creating local public health networks, co-locating regional directors of public health in government offices for the regions and implementing the CMO’s report.  
♦ Continued efforts to develop an evidence base and analytical tools for tackling health inequalities, for example, health impact assessment and equity audits. |
| | Cross-cutting action  
Treasury spending review across Whitehall on action to tackle health inequalities.  
Rationalisation of local partnerships and of ABIs.  
New local ABI funding requires LAs and LSPs to address health inequalities (NDC and neighbourhood renewal areas). Some local PSAs include reducing health inequalities as one of their targets. |  

Department of Geography, QM UL
THE ROLE OF THE NHS IN TACKLING HEALTH INEQUALITIES IN THE FUTURE

The findings from across this project have implications for the new policy framework that the Government has introduced to address health inequalities. While the roles and the responsibilities of each agency and, in some cases the agencies themselves, have changed, generally, the same key mechanisms are operating at each broad level of implementation. This section considers how these mechanisms can be developed to improve local efforts to tackle health inequalities.

The national level

At the national level there are three broad mechanisms that can be strengthened to better enable local players to tackle health inequalities in the future:

- clarify the national priority given to reducing health inequalities;
- link funding more explicitly to addressing health inequalities;
- develop a national framework for addressing health inequalities.

The priority given to health inequalities

At this vital crossroads in the history of the NHS, it is unfortunate that the Government appears to be continuing to send out mixed messages about the status of health inequalities as a priority. The overwhelming message from the survey and case study respondents was that health inequalities were a second order priority. This is echoed in other studies (Abbott et al. 2001; Exworthy et al., 2002) and by other commentators (Appleby and Coote, 2002). Respondents to this study argued that the Government needs to make health inequalities a core priority, of equal status to waiting lists and other ‘critical targets’, if it wants local agencies to make serious efforts to reduce them. Moreover, it would be easier for local agencies to focus on such ‘critical targets’ or ‘must dos’ if there were fewer targets overall. If reducing health inequalities continues to be a second order priority, local efforts to address them will remain on the sideline in all but a few committed places.

Implication: ‘Reducing health inequalities’ needs to be made a ‘must do’ to rank alongside other ‘critical targets’.

A second issue that needs clarification at the national level relates to the kind of health inequalities it is appropriate for local agencies to prioritise. It is clear from this study that local players define health inequalities in a wide range of ways. As a result, strategies to address health inequalities are taken to mean all things to all people. A clearer focus would help to sharpen strategic thinking and to clarify goals. The national health inequalities targets are precisely defined in terms of reducing socioeconomic inequalities and inequalities between disadvantaged areas and the rest of the country (DH, 2001d). However, this focus has not yet fed through into local plans. Moreover, places with reasonable levels of overall health but pockets of deprivation have found it hard to use these targets to galvanise local action. Abbott and colleagues (2001) reported similar concerns among primary care organisations. The recent emphasis by the Government in their response to the Select Committee, that it ‘expect[s] all NHS organisations to tackle the inequalities between more and less deprived areas and communities within their boundaries’ (Cm 5242, 2001, p.6) is therefore welcome. This clearer thinking about health inequalities goals needs to be
adopted at the local level. This is not to say that other forms of inequalities are not important, but that if effective strategies are to be developed they need to begin with clearer goals.

**Implication:** The Government needs to be clearer about what kinds of health inequalities it wishes to prioritise. Local agencies then need to adopt much more clearly defined goals themselves so that effective strategic plans can be developed to address local health inequalities.

Funding for health inequalities

Efforts to improve the resource allocation formulae to better reflect health inequalities are welcome. In addition, the experience of ABIs, HAZs and the health inequalities adjustment monies, shows that there is merit in explicitly ringfencing money for this purpose, providing local agencies are held to account for how the funds are spent. A similar recommendation is made in the review of Health of the Nation (Fulop et al. 1998). A study of the health improvement role of primary care organisations found that the availability of development monies had a significant effect of PCTs engaging in activities to promote health (Abbott et al., 2001). Ringfencing should ensure that specific funds are allocated for prevention, health improvement and addressing equity of access to care - issues that often fail to get adequate funding in the face of stronger health care imperatives. Dedicated resources also allow local agencies scope for more innovative development and learning activities that can then be built into the mainstream. However, there is a danger that the mainstream may abdicate responsibility for tackling health inequalities if it is separately funded and this must be guarded against (see below).

**Implication:** Consider ringfencing part of the general resource allocation for the NHS for activities to address health inequalities, but hold local agencies to account for how these funds are spent.

A framework for tackling health inequalities

The priorities identified in the Tackling health inequalities: consultation on a plan for delivery (DH, 2001c) will be welcomed by local players. However, many respondents felt that a ‘framework for thinking about health inequalities’ within the broad range of mainstream agendas was needed. There is a tension between making reducing health inequalities a distinct separate agenda, to ensure that something is done, and making it the responsibility of all mainstream activities where potentially more could be achieved, but it may become lost among other priorities. If tackling health inequalities is everybody’s responsibility, there is a danger that nobody will do anything. The Government needs to strike a balance between the two. As well as ringfencing resources, therefore, the Government needs to develop an inequalities framework. This framework would need to incorporate the following principles.

- Ensure that chief executives in all relevant agencies - PCTs, strategic health authorities, local authorities and NHS Trusts - champion reducing health inequalities and promoting equity of access to health care and that they are held accountable for their progress.
- Develop an equity dimension to more of the core targets for improving health and access to health care, for example, in the NSFs. In particular,
issues of equity of access as well as reduced waiting times, need to become more central to service development in the NHS.

♦ Allow local agencies the flexibility to tackle local issues that are significant causes of local inequalities, as well as requiring them to address national priorities.

♦ Build a health inequalities perspective into the thinking of all relevant managers and professionals. In the long term this can be done through making issues around equity and public health integral to core managerial, medical and other professional training. In the short term, it needs to be made part of ongoing professional development activities, leadership training and learning sets, etc.

♦ Develop a health inequalities checklist to be considered as part of all NSF, HIMP, community plan and other strategy implementation. Obviously both health inequalities impact assessment and equity audits, which the Government are already developing, play a part in this. However, they need to be seen as integral to mainstream activities rather than an add-on. More importantly, the Government must ensure that this is a meaningful rather than a paper exercise.

♦ Ensure that any health inequalities framework more explicitly recognises the long-term nature of the problem and develops clear links between local action, intermediate milestones and long-term outcome goals.

Implication: Develop a framework to ensure that the impact of all mainstream activities on equity of access to care and health inequalities is considered.

The local level

At the local level there are three broad arenas within which action to tackle health inequalities needs to be promoted and supported:

♦ the local NHS;
♦ local partnerships;
♦ the voluntary and community sectors.

The local NHS

Crucial to taking a strategic approach to addressing health inequalities at the local level is the new role of PCTs and their integration into LSPs. There was widespread concern among many respondents to the survey, and in the case study areas, about whether PCTs had the interest, or capacity, to address these issues. This concern has been echoed elsewhere (Marks and Hunter, 1998). While some PCTs very clearly had tackling inequalities in health at the heart of their activities, others had barely considered it. This appeared to be a function of the particular interest of key people in positions of power within the organisation and their stage of development. Other studies have found that have increased their engagement in the health improvement agenda as they develop (Gillam et al. 2001), but that the role of senior support in doing this is crucial (Abbott et al., 2001). Given that PCTs will now have the leadership role in relation to tackling inequalities locally, it can no longer be left to the actions of particular individuals to ensure that it gets on their agenda. Reducing health inequalities needs to be made a clearer priority for PCTs than it appears to be in
Shifting the Balance of Power within the NHS (DH, 2001a). PCTs need to be supported to develop the capacity, skills and partnerships to engage in this agenda as quickly as possible. Four domains of work are important for this:

- working in partnership to ensure that reducing health inequalities is an integral part of LSP and LA plans and strategies;
- working in partnership with communities and the voluntary sector to promote community capacity;
- improving prevention and promoting healthy lifestyles especially for people living in disadvantaged circumstances;
- promoting equity of access to health and social care services.

The chief executives and boards of PCTs need to be held to account to ensure that progress is made in each of these arenas. To support PCTs in this endeavour they need both a multidisciplinary team, and board, that have broad perspectives on health and are skilled in partnership working. In this respect it is not clear that social services are necessarily the best LA representatives on the board, nor that public health consultants will have all the requisite skills. Local boards will need to be imaginative in their appointments to ensure that appropriate perspectives are represented. Staff and members of PCTs will almost certainly require public health and partnership training and ongoing support. At the same time PCTs will need general support in their organisational development and help in managing the huge agenda that they need to address in their early days. A similar set of policy implications were made in a study of the health improvement role of PCG/Ts (Abbott et al., 2001). As discussed above, being given clear guidance about priorities and a framework for building health inequalities into all policy considerations will ensure health inequalities do not fall from this busy agenda.

**Implication:** The PCT chief executive and board need to be held to account for progress in reducing health inequalities in each of the four domains identified above.

**Implication:** PCTs need a multidisciplinary board that has a broad health perspective and an understanding of partnership working.

Local partnerships

Future health improvement and modernisation plans need to make tackling health inequalities a much more focused part of local health improvement than it has been to date, if the health of the worst off is to begin to improve at a faster rate than that of the general population. Crucial to this will be working in partnership to tackle the root causes of ill health, which requires close collaboration and integration between the health improvement and modernisation plans and the community plans. All LSPs and PCTs need to be held jointly accountable for the health inequalities dimension of local community plans. It is vital to ensure that local regeneration, social inclusion and economic development initiatives take account of their health impact. Among other things, this means ensuring that the wide range of agencies and staff within them have a greater understanding of the impact of their roles and responsibilities on health. Networks, learning sets, work shadowing, secondments, workshops and other forms of professional training could all aid this understanding.
In addition, all public agencies need to ensure that they use their role as employers, developers and purchasers to promote local economic development in ways that are health promoting.

Implication: LSPs and PCTs should be required to demonstrate how the health improvement and modernisation plans and the community plans are integrated, and that they are working effectively together to address the root causes of ill health, to improve equity of access to services and to reduce health inequalities.

Implication: All public agencies need to demonstrate that they are using their role as an employer, developer and purchaser to promote local economic development in health-enhancing ways.

Other commentators are better placed than we are to identify factors to promote effective partnership working locally (e.g. Funnell et al. 1995; Nuffield Institute for Health, 1997). However, a number of the messages that came from this study are that effective partnership working to reduce health inequalities requires:

- leadership from senior management across the partner agencies that champions health inequalities;
- clear shared goals, shared priorities and agreed terms of reference;
- joint or shared resources;
- time to allow partnerships to develop;
- teambuilding activities in partnerships, especially at the most senior levels where they appear to be poorest at present;
- more general development activities to promote the awareness of the need for partnership working and for community development among all staff;
- support for staff to engage in partnerships by providing time within their job descriptions;
- a reduction in the number of partnership initiatives locally;
- joint and/or consistent accountability.

Implication: Continued support and development is needed to promote effective partnership working locally.

The voluntary and community sectors
A clear message from the case studies was that tackling health inequalities required a much stronger investment in community development and capacity building, and that often the voluntary sector was well placed to do this. The requirement to include a community development project in the CHD NSF and the establishment of the community empowerment fund in neighbourhood renewal areas are therefore welcome. However, this support needs to go beyond these specific initiatives. LSPs, LAs and PCTs all need to place a higher priority on community development and on supporting local voluntary sector agencies. Two issues were seen to be important here. First, providing core funding for key local voluntary sector umbrella organisations to provide support to local voluntary groups on the ground. Secondly, making accessing external income more straightforward and less bureaucratic. In particular, this would be easier if funding application processes and performance
management systems were standardised between different agencies, and if voluntary
groups were able to apply for core funding as well as funding for innovative projects.

**Implication:** Local public agencies need to make stronger efforts to understand
community development approaches and to adopt them locally. Closer working
relationships with, and support for, the voluntary sector will assist with this.

**The intermediate level: the role of strategic health authorities**

Strategic health authorities will be responsible for providing overall direction to
health policy in their area, and performance managing PCTs and NHS Trusts. It is
essential that tackling inequalities in health be seen as a core part of both these roles.
Strategic health authorities need to support PCTs to become public health agencies,
and to provide more general organisational development support as they grow into
their new roles. They need to ensure that PCTs give sufficient priority to all relevant
domains of addressing health inequalities. In doing this they need to help PCTs
achieve the right balance between addressing national priorities and meeting local
needs. However, they must also ensure equity between PCTs in their area, and that
consistent standards are established. In addition, they need to hold both PCTs and
NHS Trusts to account for their role in local economic development.

**Implication:** Strategic health authorities need to provide an overview of tackling
inequalities in health in their area that balances national priorities with local
flexibility.

**Implication:** Strategic health authorities need to support PCTs to become public
health agencies and to build equity considerations into their service development
plans.

**All levels: Underpinning foundations**

In order for the NHS to develop an effective strategy to reduce health inequalities,
structures and strategies need to be underpinned at all levels of the NHS by a strong
public health function, clear performance management and a commitment to develop
and to utilise the evidence base.

**Public health**

Public health needs to become a much more central part of the NHS agenda than is
suggested by its location in Appendix 2 of Shifting the Balance of Power within the
NHS. Unless the managed public health networks are carefully developed and
supported, there is a real danger of the public health function becoming fragmented by
dividing it between PCTs and strategic health authorities. Moreover, the need for a
broader perspective within public health, and for public health to become part of core
education for a wide range of health professionals has been argued for some time
(Blackburn, 1993; Doyle and Thomas, 1996; Schofield, 1996; Daykin and Naidoo,
1997; Benzeval and Donald, 1998). Alongside supporting the public health function
in its new locations, there is a need to implement the CMO’s recommendations to
strengthen and broaden public health. While it is recognised that Saving Lives (Cm
4386, 1999) and the Government’s response to the Select Committee (Cm 5242,
2001) do make a commitment to many of these developments; a more assertive
approach is required. Action is required at all levels and by all agencies. Central
Government needs to demonstrate their commitment and leadership in this areas, to
give it priority and a clear sense of purpose. The directors of public health in
government offices for the regions and strategic health authorities need to provide
clear guidance and support, and local players, PCTs, LAs, medical and nursing
schools, management training schemes, etc, need to develop good practice on the
ground. In particular, action is required:

♦ to ensure that directors of public health have the necessary skills and the
  relevant leadership roles in agencies and partnerships at all levels (local,
  intermediate, regional and national) to act as champions for tackling health
  inequalities;
♦ to improve public health awareness and skills across a wide range of
  public sector managers and professionals;
♦ to develop the public health role of community nurses and other
  practitioners;
♦ to enhance the role and value of non-medical public health staff and health
  promotion professionals, by providing better career paths.

Implication: Real effort needs to be put into creating local public health
networks to ensure that staff members are not isolated in their new roles, and
that responsibilities are shared effectively across PCTs.

Implication: More concerted effort is needed to strengthen, value and support
public health perspectives and the public health function.

Implication: A broader understanding of public health and multidisciplinary
ways of working needs to be built into the training and development for all
managers and professionals to contribute to tackling health inequalities.

Performance management

Respondents to the survey and those interviewed in case study areas were clear that if
local agencies were to make health inequalities a more central part of their activities,
then tackling health inequalities must become a significant part of the performance
management system. Chief executives of PCTs and acute trusts need to be held to
account for their progress in tackling health inequalities in the same way that they are
for reducing waiting lists or ensuring a financial balance. Similarly, government
offices for the regions need to support and to hold LSPs and LAs to account for their
contribution to this endeavour. This needs to be done in an innovative way to take
account of the long timespan and complex interaction of policies that are required to
address health inequalities. A similar recommendation was made in the review of
Health of the Nation (Hunter et al, 1998; Fulop et al., 1998). At the same time, there
was a strong feeling among respondents that performance management needs to be
made more consistent across relevant agencies; so that they are jointly accountable for
delivering goals that require joint action.

Implication: Reducing health inequalities needs to be made a central part of
performance management systems and ensure consistent targets for partner
agencies.
Developing the evidence base

Many of the people interviewed for this study felt that not enough was known about how to reduce health inequalities: what local projects and strategies would work best, in what circumstances, for which groups of the population? The Government is committed to an evidence-based policy approach, and has established a number of national initiatives to strengthen this. These initiatives should be encouraged and supported, and ways of disseminating and sharing the good practice that already exist need to be enhanced. However, more support is also needed to encourage local evaluation and learning. Project managers rarely feel able to devote resources or time to evaluation with the ever-present pressure to meet short timescales within tight budgets. Moreover, a greater understanding is needed about how to translate lessons from specific projects into improving ways of working in mainstream agencies. Local agencies need support to be able to experiment and the time to ensure that they can evaluate effectively and feed the learning back into the mainstream.

Implication: Continue to put effort nationally into developing an evidence base of ‘what works’ to reduce health inequalities and into promoting effective ways of sharing good practice within and between local areas.

Implication: Support and enable local agencies to put resources into innovation and evaluation.
APPENDICES

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# APPENDIX 1: POLICY CHRONOLOGY

<table>
<thead>
<tr>
<th>Time period</th>
<th>Significant policy announcements in relation to reducing health inequalities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>DH Variations in Health report published on how the NHS and the Department of Health can reduce variations in health, together with a systematic review of available interventions.</td>
</tr>
<tr>
<td>1996</td>
<td>Planning and Priorities guidance for 1997/8 included reference to ‘improving health of the population as a whole and reducing variations in health status by targeting resources where needs are greatest’; and acknowledges ‘variations in health between different areas, social groups, ethnic groups and men and women’. HA’s were required to ‘pay particular attention to these variations’ in planning and resource allocation, and in collaboration with others.</td>
</tr>
<tr>
<td>1997</td>
<td><strong>ELECTION: NEW LABOUR GOVERNMENT</strong></td>
</tr>
<tr>
<td>May</td>
<td><strong>Tony Blair acknowledged the link between poverty &amp; health and announced the establishment of an Independent Inquiry into Inequalities in Health, chaired by Sir Donald Acheson.</strong></td>
</tr>
<tr>
<td>June</td>
<td><strong>Frank Dobson announced the HAZ initiative ‘to act as ‘trailblazers in leading the way to tackle inequalities in health’.</strong></td>
</tr>
<tr>
<td>July</td>
<td><strong>Tessa Jowell announced the launch of Our Healthier Nation with ‘tackling inequalities in health at its heart’.</strong></td>
</tr>
<tr>
<td>September</td>
<td><strong>Priorities &amp; Planning Guidance 1998/99 published with an ‘overall aim to develop a coherent strategy for public health ... a key part of this will be tackling inequalities in health’.</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Alan Milburn announced a review of NHS resource allocation formulae to better focus resources on tackling inequalities in health.</strong></td>
</tr>
<tr>
<td>December</td>
<td><strong>The New NHS: modern, dependable (Cm3807, 1997) White Paper published: which stated that the Government wanted to create ‘an NHS that does not just treat people when they are ill but works with others to improve health and reduce health inequalities’ and that ‘lead responsibility for improving overall health and reducing health inequalities will be at the heart of the new HA role’.</strong></td>
</tr>
<tr>
<td>1998</td>
<td><strong>February</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Our Healthier Nation Green Paper (Cm 3852, 1998) published - one of its two goals was ‘to improve the health of the worst off in society and to narrow the health gap’.</strong></td>
</tr>
<tr>
<td></td>
<td><strong>DETR Guidance Sustainable local communities for 21st century: why</strong></td>
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</table>
and how to prepare an effective local agenda 21 strategy published. Healthy Life expectancy is one of 15 headline indicators in the Government’s strategy.

HSC 1998/021 Better health, better health care published, set out guidance to local agencies on implementing The New NHS and Our Healthier Nation – tackling inequalities in health was first objective listed in the report, which emphasised the need for partnership working and the development of HImPs.

CMO’s interim report on strengthening public health function is published, which set out a range of initiatives to broaden and develop public health in England.

<table>
<thead>
<tr>
<th>Month</th>
<th>Event</th>
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<tbody>
<tr>
<td>April</td>
<td>Eleven first wave HAZs launched, Frank Dobson said they ‘will begin to make real progress on tackling inequalities’.</td>
</tr>
<tr>
<td>July</td>
<td>Modernising local government: in touch with people (Cm 4014, 1998) published – it set out major reforms to the way local authorities will be run, including changing committee system to cabinet-style political management, and establishing best value reviews. It also introduced a ‘duty of well being’ and said that LA’s powers to work in partnership to promote social inclusion would be strengthened. It set out requirement for LA’s to produce local community plans.</td>
</tr>
<tr>
<td>September</td>
<td>HSC (98)158 National priorities guidance 1999/00 – 2001/02 published with ‘cutting health inequalities’ key area.</td>
</tr>
<tr>
<td>October</td>
<td>Draft guidance for HImPs (HSC 1998/167) and the NHS Executive HImP Resource Development Pack published.</td>
</tr>
<tr>
<td></td>
<td>Tessa Jowell announced £1m innovation fund to develop the capacity and role of health visitors as part of the broader public health strategy.</td>
</tr>
<tr>
<td></td>
<td>Modernising Social Services (Cm 4169, 1998) published, included the establishment of national objectives and standards, a fair access to care initiative to standardise criteria for qualifying for support, and a range of initiatives to improve outcome for children in care.</td>
</tr>
<tr>
<td></td>
<td>Independent Inquiry into Inequalities in Health published. It set out 39 recommendations across a wide range of social economic and NHS policies to reduce health inequalities.</td>
</tr>
<tr>
<td>December</td>
<td>HAZs receive an additional £30m for tackling inequalities in health in 1999/00.</td>
</tr>
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</table>
### 1999

<table>
<thead>
<tr>
<th>Month</th>
<th>Event</th>
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</thead>
<tbody>
<tr>
<td>January</td>
<td>Healthy Living Centre initiative launched by the New Opportunities Fund, with priority given to bids from areas of disadvantage and, in particular, HAZs.</td>
</tr>
<tr>
<td>April</td>
<td>First wave HIMPs published. Second Wave HAZs launched in 15 areas where Frank Dobson said ‘special action will be taken to improve the health of local people, reduce health inequalities ... Health Action Zones are a key part of the Government’s drive to target areas with particularly high levels of ill health...and so improve the health of the worst off at a faster rate than the general population. This is the first time a British Government has set itself such a task. (Dobson, DH 98/329).</td>
</tr>
<tr>
<td>June</td>
<td>SEU Report on teenage pregnancy published two goals to halve the rate of conceptions under 18 by 2010 and to reduce poverty and social exclusion as a result of being teenage parent through education and employment initiatives. A cross-Government unit was established and all local areas had to identify a co-ordinator to link activities to reduce teenage pregnancy into the HIMP.</td>
</tr>
<tr>
<td>July</td>
<td>Saving Live: Our Healthier Nation (Cm 4386) the public health White Paper and Reducing inequalities in health: an action report published. Saving Lives confirmed the broad inequalities goal ‘to improve the health of the worst off’ and the four targets to reduce average rates of CHD, cancer, suicides and accidents. It introduced a range of initiatives to develop public health in England. Reducing inequalities in health described the range of policies introduced to tackle health inequalities since Labour took office. HSC 1999/152 guidance on local implementation of Saving Lives included a requirement to set local inequalities targets and to incorporate plans to tackle inequalities into HIMPs.</td>
</tr>
<tr>
<td>August</td>
<td>Leadership for health: the health authority role published, which included reducing health inequalities as key strategic role for HA’s. HSC 1999/192 sets out the HA’s' strategic role ‘to ensure service improvements... are coherently planned and delivered’ and ‘to provide strategic leadership for improving health and tackling health inequalities’ by supporting the development and effective performance management of PCG/Ts.</td>
</tr>
<tr>
<td>September</td>
<td>Mental Health National Service Framework published, included standards to promote mental well being, improve services and prevent suicides.</td>
</tr>
<tr>
<td>November</td>
<td>HAZs received an additional £60m for tackling inequalities in health in 2000/01.</td>
</tr>
<tr>
<td>December</td>
<td>National Priorities Guidance 2000- 2003 (HSC 1999/242) published,</td>
</tr>
</tbody>
</table>
‘reducing health inequalities’ goal now subsumed into the ‘improving health’ priority.

Planning for health & health care: incorporating guidance on HimPs, SaFFs JIPs and PCIPs (HSC 1999/244) published. Improving health and tackling health inequalities is one of five priority areas. There is a requirement to set local health inequalities targets as part of the HimP process.

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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<tbody>
<tr>
<td>2000</td>
<td>SureStart Plus initiative announced. 20 pilot areas (within HAZs) to reduce social exclusion and poverty as a result of teenage pregnancy through personal support and advice programme. Health Act Partnership guidance (HSC2000/10) published.</td>
</tr>
<tr>
<td>April</td>
<td>The vital connection: an equalities framework for the NHS (HSC 2000/14) focused on the NHS being an equal opportunities employer, providing services which meet the needs of different groups and using its role as an employer to benefit local people.</td>
</tr>
<tr>
<td>June</td>
<td>Change in HAZ funding announced, generally perceived as a “cut”.</td>
</tr>
<tr>
<td>July</td>
<td>The NHS Plan (Cm 4818-I) published with ‘Reducing health inequalities’ as one of ten PSA target areas for the DH. It also made a commitment to produce national health inequalities targets. In addition, local action to tackle health inequalities and improve access to health care to be made part of NHS Performance Assessment Framework by 2001. A range of specific measures were included, such as an additional 200 PMS sites and further incentives to improve primary care, a national translation and interpreting service, nicotine replacement therapy on prescription and a national school fruit scheme. It emphasised the role of NHS in neighbourhood renewal and local strategic partnerships. It said that in the medium term of HAZs would merge into LSPs.</td>
</tr>
<tr>
<td>August</td>
<td>DETR published Draft guidance on developing community strategies.</td>
</tr>
<tr>
<td>September</td>
<td>NHS Cancer Plan published, which included a range of standards to improve treatment, extend screening and improve palliative care. The prevention targets focused on smoking with the first-ever smoking inequality target ‘to reduce smoking rates among manual groups from 32% in 1998 to 26% by 2010 in order to narrow the health gap’.</td>
</tr>
<tr>
<td>October</td>
<td>DETR published Local Strategic Partnerships consultation document. Inequalities and public health taskforce established to oversee the implementation of this aspect of The NHS Plan.</td>
</tr>
<tr>
<td>Month</td>
<td>Event Description</td>
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</tbody>
</table>
| November   | Health inequalities adjustment to HA revenue allocations for 2001/02 announced (HSC 2000/034), accompanying letter set out eight priority areas one of which is ‘reducing the health gap’.  

National Service Framework for CHD published, which set out a range of standards to improve treatment and prevention of CHD, including reducing CHD risk factors and inequalities in risk factors. There was a requirement for HAs to establish mechanisms for health impact assessment and to produce an equity profile and audit by April 2001. |
| December   | DETR published guidance on Preparing community strategies which stated that ‘where deprivation, social exclusion, a poor quality environment and health inequalities are significant factors. ... The community plan will need to address how these are to be tackled’.  

NHS Plan Implementation Programme published, which repeated commitment to develop national health inequalities targets. |
| 2001       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| January    | SEU published New Commitment to Neighbourhood Renewal: National Strategy Action Plan, which set overall target ‘to narrow gap between most deprived neighbourhoods and the rest of country’. Neighbourhood renewal monies invested in 88 most deprived LAs. In relation to health and health care outcomes it reiterates The NHS Plan national health inequalities target commitment and activities.  

NHS Plan Performance Improvement Agenda published - Health inequalities and health improvement were not listed as part of the ‘must dos’ in the Performance Traffic Light system. While fair access, health improvement are part of performance assessment measures, there is no ‘reducing gap’ focus to these. |
| February   | National health inequalities targets published (DH, 2001d).  

To reduce the health gap between children in different social classes. Starting with children under one year, by 2010 to reduce by at least 10 per cent the gap in mortality between manual groups and the population as a whole.  

To reduce the difference in life expectancy between areas with the lowest life expectancy and the national average. Starting with health authorities, by 2010 we will reduce by at least 10 per cent the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole. |
| March      | NHS Plan technical supplement on target setting for health improvement published.  

House of Commons Select Committee Second Report on Public Health published. It identified a range of concerns about the relative importance of public health, and the need for effective strategies to support health inequalities targets. |
The final report of the CMO’s project to strengthen the public health function (Donaldson, 2001) published -It argued that there was a need to achieve: wider understanding of health & wellbeing, better co-ordination with public health; effective joined up working; sustainable community development and public involvement and an increase in the capacity and capability of public health function.

National Service Framework for Older People published, which set out a range of standards to promote healthy life expectancy, to improve services and to reduce age discrimination.

DETR published Local Strategic Partnerships: Government guidance. In relation to health the report cited The NHS Plan health inequalities target to improve life expectancy for the bottom 20 HA s and the target to reduce inequalities between wards in teenage pregnancy rates.

DETR Guidance to LAs on their Power to promote or improve economic social and environmental wellbeing published ‘should consider how power can promote... delivering... community strategy, which could include... reducing health inequalities ... and to contribute to share priorities within other plans such as Health Improvement Programme’.

| April | Alan Milburn announced the Shifting Balance of Power agenda. This set out the abolition of current HAs and the creation of 25-30 strategic health authorities by 2004; most of the existing functions of HAs devolved to PCTs, and ‘specifically that ‘more of the planning ... to tackle health inequality will also take place at this local level’ (the only mention of inequalities). |
| June | Election: NEW LABOUR’S SECOND TERM

Alan Milburn announced the priorities for new term – he made no reference to promoting health or reducing inequalities.

HM Treasury announced seven initial cross-cutting spending reviews that will make up the 2002 Spending Review, one of which examines health inequalities

Local Modernisation Review guidance published. LMRs required for all DH PSA targets (including health inequalities). HAs had to assess local capacity to deliver on each target and then to develop action plans for ‘high risk’ targets. Flagged HImPs becoming health improvement and modernisation plans. |
<p>| July | Shifting Balance of Power within the NHS: Securing Delivery published. PCTs made responsible for improving the health of their communities and working in partnership with LSPs to do so. Strategic health authorities to support and performance manage them to this end. Public health staff to be based in both PCTs and the new strategic HAs. Regional DPHs based in government offices for the regions. Tackling health inequalities was not mentioned until Appendix 1 (p.41). Public |</p>
<table>
<thead>
<tr>
<th>Date</th>
<th>Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>August</td>
<td>From vision to reality published, which set out the progress made since the publication of the Acheson Report on tackling inequalities in health. It stated that PCTs are central to delivery of health inequalities targets locally, and that they need to work as part of LSPs to do so. Tackling health inequalities: Consultation on a plan for delivery published. It explained the national targets and set out six priority areas, describing what was currently being done in each of them and asking what else needed to be done. It also asked about local processes that need to be developed to support PCTs and local partnerships to tackle health inequalities. It also discussed a range of relevant indicators that should be considered as part of this process.</td>
</tr>
<tr>
<td>September</td>
<td>Involving patients and the public in healthcare published which set out proposals for greater user and public involvement in NHS decision-making.</td>
</tr>
<tr>
<td>November</td>
<td>Alan Milburn announces £3million community budgets to be controlled by community practitioners to spend on improving health in disadvantaged areas. The consultation process for Tackling health inequalities: Consultation on a plan for delivery ended on 9 November 2002.</td>
</tr>
</tbody>
</table>

Government’s response to select committee for health’s report on public health (Cm 5242, 2001) published, which ‘reaffirmed its commitment to tackle disadvantage in all its forms’ and outlined the new public health structures and responsibilities as described in Shifting Balance of Power within the NHS.
## APPENDIX 2: GRANT CHRONOLOGY

<table>
<thead>
<tr>
<th>Time period</th>
<th>Grant activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan-May 1999</td>
<td>Project put on hold to await publication of Saving Lives and first local HimPs</td>
</tr>
<tr>
<td>June-Oct 1999</td>
<td>Review of First round HimPs</td>
</tr>
<tr>
<td>Nov 1999-July 2000</td>
<td>Project delayed by principal investigator’s move between institutions and the appointment of RA staff</td>
</tr>
<tr>
<td>Oct-Dec 2000</td>
<td>Survey of all DPHs conducted and analysed.</td>
</tr>
<tr>
<td>Jan-Feb 2001</td>
<td>Designed case study methodology and approached areas to take part. Telephone survey of NHS Executive regional offices conducted.</td>
</tr>
<tr>
<td>Mar-May 2001</td>
<td>Fieldwork in case study sites</td>
</tr>
<tr>
<td>June-Oct 2001</td>
<td>Analysis and writing up draft report for DH</td>
</tr>
<tr>
<td>Nov 2001</td>
<td>Draft report submitted to DH R&amp;D Division and to the consultation process on a plan for delivery for health inequalities.</td>
</tr>
<tr>
<td>Nov 2001-Mar 2002</td>
<td>Awaiting comments from DH</td>
</tr>
<tr>
<td>Apr-June 2002</td>
<td>Report revised in light of referees’ comments and a final report submitted to DH.</td>
</tr>
</tbody>
</table>
APPENDIX 3: THE HIMP ANALYSIS

The original proposal for this project contained plans to review both the last year of purchasing plans (for 1998/99) and the first year of HImPs. The aim of these reviews was to identify the broad approaches adopted by health authorities to addressing health inequalities, in order to provide a general orientation to the way in which health inequalities were defined, identified and tackled. The 1998/99 purchasing plans were produced in autumn 1997, and did not really take on board the full extent of the policy shift of the new Labour Government in terms of the attention given to tackling health inequalities. Given this, although the review was undertaken, it is not included in this report. The analysis of the HImPs has been used to underpin the study, to design the questionnaire of HAs and of regional offices, and to shape the case studies.

Both of these reviews were carried out using the NHS Health database (Health Data, 1999). This included the full text of a range of purchasing plans, public health reports, HImPs and other strategy documents of all health authorities in the UK. In the database, the text of the reports is divided into subject categories, such as cancer, local population, children services, minority ethnic groups, health promotion, etc. The database also allows free word search. With the purchasing plans it was relatively straightforward to use a combination of free word searches and section selections to identify the relevant parts of the documents that discussed health inequalities. This was not the case with HImPs. For the HImP review, it was necessary to study the complete document to understand the way in which health inequalities were incorporated into the overall strategy. It was not easy to do this through the database, and so hard copies of reports were obtained.

HImP Analysis

The general approach to analysing all of the qualitative data collected for this project was based on the Framework approach developed by Social and Community Policy Research (Ritchie and Spencer, 1994). The Framework method involves the systematic sifting, charting and sorting of material according to key issues and themes, and is particularly useful when projects are conducted by more than one interviewer. The Framework is developed in five stages:

♦ familiarisation with the data (e.g. interview transcripts, extracts from documents) by immersion in the data to develop lists of key ideas and recurrent themes;
♦ identifying thematic framework from the original research questions, emergent issues from the respondents and the analytical issues identified during the familiarisation phase;
♦ indexing the text (e.g. interview/text) in relation to the thematic framework;
♦ charting the text by considering the range of attitudes and experiences under each theme (e.g. by different types of respondent or area);
♦ mapping and interpretation of the data to develop patterns and connections and seek explanations for these internally within the data.

More specifically for the analysis of the HImPs, fifteen documents were studied in order to become familiar with the structure and the content. From this familiarisation, and employing the general framework of the community health improvement process,
a set of questions was identified which were posed systematically for each HImP reviewed. These are set out below. However, the HImPs were extremely diverse in their content and structure. As a result it was very difficult to extract information systematically in relation to these issues. Instead, therefore, the broad themes in each of these areas were identified and used to structure the survey of HAs and to underpin the study more generally. This meant that individual HAs did not receive a summary of the authors’ understanding their particular strategy to address health inequalities with the survey, as originally planned. The mapping of local strategies to tackle health inequalities is therefore entirely based on the survey responses, with the HImP analysis providing additional detail and illustrations where deemed helpful.

The questions explored in order to describe the community health improvement process in each area were:

♦ Does the vision statement/general strategic aims mention reducing health inequalities?
♦ At this level how is the aim interpreted, for example, inequalities between whom – within area or between an area and an external reference point, between different areas or social groups etc? Is there a clear focus in their action – for example, determinants of health; lifestyle or access to health care issues?
♦ Are there any specific sub-aims or outcome targets related to reducing health inequalities?
♦ In the assessment of ‘need’ what sort of discussion of health inequalities is there? For example, is there a model of the determinants of health? Is there a description of the socio-economic profile of the area and its implications for health? Is there evidence about inequalities in health and access to health care? What are viewed as the key health inequality problems in the area?
♦ How does the strategy to reduce health inequalities fit within the overall HImP? For example, is there a specific strategy/section on health inequalities or have health inequalities informed the choice of priorities? Is there an inequalities component to each priority or is there a commitment to develop an inequalities strategy over the next year?
♦ How have the priorities for tackling health inequalities been chosen? What is the rationale for the particular policies that are being developed/implemented?
♦ To what extent does the HImP follow national policy guidance on reducing health inequalities - be it the national priorities guidance, Acheson Report or something else?
♦ Within the strategy to reduce health inequalities, what is the balance of action between working with others to tackle the determinants of health; employing community development techniques; focusing on healthy lifestyles and improving access to health care?
♦ Are there any statements about what the expected consequences of the policies may be, how it is envisaged that the strategy will reduce health inequalities, or the time horizons involved?
♦ To what extent is there a commitment to develop the capacity to reduce health inequalities in the future, either by undertaking analyses or developing partnership initiatives? For example, discussion of strategy development,
Health inequalities: a priority at a crossroads

cross-agency working groups, joint bids for funding, policy reviews, need assessments, equity audits, HIAs, etc.?

♦ Outside of the defined strategy to tackle health inequalities (if there is one), is there an equity focus in any other priority areas?

♦ To what extent does there appear to be a policy to allocate resources to areas of high need across the whole HImP or in specific sections?

♦ Is there any specific mention of the role of PCGs in tackling health inequalities?

♦ What mechanisms are described for working with other agencies to tackle health inequalities?

♦ Is the HA involved in other partnership initiatives which it views as contributing to reducing health inequalities, for example, action zones, SRB, New Deal, SureStart? Are these co-ordinated in any way? What is the health input?

♦ Where appropriate, what is the relationship between the HAZ strategy and the HImP with respect to tackling health inequalities?

♦ To what extent have local communities been involved in the development of the strategy to tackle health inequalities?
APPENDIX 4: THE HA SURVEY DESIGN

A postal survey of all health authorities was conducted with three aims. First, to provide a systematic picture of local strategies to tackle health inequalities, building on the findings from the analysis of HImPs described in Appendix 3. Secondly, to acquire information on the perceptions of key actors about the role of HAs in this pursuit, and their progress to date. Thirdly, the survey attempted to begin to explore the inhibiting and facilitating factors in HAs’ efforts to address health inequalities, in order to help to shape the case study analysis.

The survey was designed on the basis of the analysis of 1st wave HImPs. The original intention had been to confirm and to expand findings from the HImP analysis. However, as discussed earlier, given the considerable variability of HImPs in general, and in particular in the way they described their approach to tackling health inequalities, it was not possible to extract material in a systematic way from them as originally planned.

Instead, therefore, drawing on the conceptual framework of the community health improvement process and the HImP analysis, a number of general dimensions to strategies to tackle health inequalities were identified and these were used to structure the questionnaire. These included:

♦ the local history of the problem and efforts to tackle it;
♦ the definition of health inequalities;
♦ the specification of goals;
♦ the priority given to health inequalities, and the factors behind this;
♦ the overall strategic approach;
♦ illustrative activities;
♦ progress to date and expectations for the future, and the key factors that were seen to influence both of these.

The draft questionnaire was circulated to key policy leads within the Department of Health for comment, and was also piloted in a small number of HAs. Minor changes were made to the questionnaire on the basis of the returned comments and the pilot responses.

The final version of the questionnaire is available from the authors. It contains 28 main questions, plus a final box asking for any other comments. However, many of the questions were sub-divided so that, in total, respondents were asked to complete 39 closed items and 16 open questions, including lists of varying lengths. Respondents were also given the opportunity to provide supplementary information for 11 questions and explain any of the potential 7 ‘other’ category they had included. Respondents were also requested to provide any relevant supporting documentation, which a number of them did.

The survey was initially sent out in November 2000 to all DPHs of English HAs with a letter explaining the study and a return envelope. At this point in time there were 99

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1 It should be noted that the survey has also been conducted in Wales and Scotland. It is intended to undertake a comparison of the different local approaches to address health inequalities in the near future.
Health inequalities: a priority at a crossroads

As. A rigorous follow up process was adopted as described in Box A4.1. Forty-four replies were received by the first deadline. Non-responders were followed up initially by telephone and subsequently by letter to try to encourage them to return the questionnaire. In our final letter to non-responders it was suggested that they reply only to the closed part of the questionnaire. This resulted in a differential response rate per question. The majority of responses were received by the end of 2000, and the last questionnaire was returned in March 2001.

Overall, a response rate of 77 per cent was achieved. Box A4.2 shows that this was relatively evenly spread across the NHS regions, although the response rate from South West Region was only 50 per cent. There was a reasonably balanced response rate by HAZ and non-HAZ health authorities and by HAs across the ONS socioeconomic classification, where no ‘family’ had a response rate of less than 70 per cent.

Although the questionnaire was originally sent to the DPH, many passed it on to other colleagues to complete. Nevertheless, as shown in Box A4.2 nearly 60 per cent of respondents were DPHs, with a further 22 per cent other members of staff working in public health departments. In addition, a range of other people completed the questionnaire including HImP co-ordinators, directors of planning, HAZ co-ordinators and health strategy managers. Most of these respondents therefore will have been appropriately placed within the HA to be able to provide a good overview of current local strategies, priority and activities in relation to tackling health inequalities.

Finally as noted above, not all of the returned questionnaires were completed in full. Over 60 per cent of respondents completed all of the closed items, 40 per cent completed all of the open questions but only about 5 per cent answered all of the supplementary questions. However, most closed questions were completed by nearly all of the respondents. The actual number of responses is reported in full in the accompanying tables. Overall, this suggests that, given the high response rate, answers to the closed questions are likely to be representative of the views of public health directors across the country. Answers to the open and supplementary questions were less comprehensive and hence perhaps less representative. This needs to be borne in mind when reading the analysis.

All data from the closed questions were input into SPSS by a researcher and checked independently. Open questions were coded thematically. A number of questionnaires were examined to become familiar with the responses, and relevant categories were created and used to code the questions. A second researcher also checked this process.

Quite simple analyses of the survey were then conducted in SPSS. As well as straightforward frequencies on all questions, cross-tabulations were also produced with a range of variables that grouped HAs by factors that might be expected to affect their approach to addressing health inequalities. These included variables external to the survey such as: region, the ONS classification of areas; whether or not the HA was part of a health action zone; the type of LAs its boundaries overlapped with; and, the index of multiple deprivation (as discussed in Appendix 5). A number of variables from within the survey were also used to create groups of HAs that might be expected to take different approaches to addressing health inequalities. These included: the length of time the respondent reported the HA had worked in partnership in this arena; the priority that was given to addressing health inequalities; and, the extent to which the respondent felt health inequalities were perceived to be a problem locally.
### Box A4.1: The survey timetable

<table>
<thead>
<tr>
<th>Activity</th>
<th>Week beginning</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Provisional questionnaire sent to DH and pilot HAs</td>
<td>12.10.00</td>
</tr>
<tr>
<td>2. Revised questionnaire sent to all English DPHs</td>
<td>10.11.00</td>
</tr>
<tr>
<td>First completed questionnaire received</td>
<td>14.11.00</td>
</tr>
<tr>
<td>3. The personal assistants of all DPHs were telephoned to check that the DPH had received the questionnaire and, if they had passed it on, to whom (27 questionnaires were sent out again either to the first respondent or to a ‘substitute’ respondent)</td>
<td>20.11.00</td>
</tr>
<tr>
<td>4. First deadline for response</td>
<td>08.12.00</td>
</tr>
<tr>
<td><strong>44 replies received from English HAs</strong></td>
<td></td>
</tr>
<tr>
<td>5. Remaining DPH non-responders were sent a follow-up letter</td>
<td>12.12.00</td>
</tr>
<tr>
<td><strong>22 further replies were received</strong></td>
<td></td>
</tr>
<tr>
<td>6. All ‘substitute’ non-responders were sent a follow-up letter</td>
<td>15.01.01</td>
</tr>
<tr>
<td><strong>10 further replies were received</strong></td>
<td></td>
</tr>
<tr>
<td>7. Last reply received</td>
<td>12.03.01</td>
</tr>
<tr>
<td><strong>Total of 76 replies received from the 99 English HAs</strong></td>
<td></td>
</tr>
</tbody>
</table>
### Table A4.1: Response rate by NHS region

<table>
<thead>
<tr>
<th>NHS region</th>
<th>Number of HAs in November 2000</th>
<th>Number of HAs that responded</th>
<th>Response rate (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern</td>
<td>8</td>
<td>7</td>
<td>88</td>
</tr>
<tr>
<td>London</td>
<td>16</td>
<td>14</td>
<td>88</td>
</tr>
<tr>
<td>North West</td>
<td>16</td>
<td>11</td>
<td>69</td>
</tr>
<tr>
<td>Northern &amp; Yorkshire</td>
<td>13</td>
<td>9</td>
<td>69</td>
</tr>
<tr>
<td>South East</td>
<td>14</td>
<td>12</td>
<td>86</td>
</tr>
<tr>
<td>South West</td>
<td>8</td>
<td>4</td>
<td>50</td>
</tr>
<tr>
<td>Trent</td>
<td>11</td>
<td>9</td>
<td>82</td>
</tr>
<tr>
<td>West Midlands</td>
<td>13</td>
<td>10</td>
<td>77</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>99</strong></td>
<td><strong>76</strong></td>
<td><strong>77</strong></td>
</tr>
</tbody>
</table>

### Table A4.2: Profile of respondents

<table>
<thead>
<tr>
<th>Respondents’ Occupation</th>
<th>Per cent of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directors of Public Health</td>
<td>59</td>
</tr>
<tr>
<td>Public Health Consultants or Specialists</td>
<td>22</td>
</tr>
<tr>
<td>Health Promotion Staff</td>
<td>7</td>
</tr>
<tr>
<td>Health Strategy Development /HImp/HAZ/ Planning</td>
<td>12</td>
</tr>
<tr>
<td>N=76</td>
<td>100</td>
</tr>
</tbody>
</table>
APPENDIX 5: THE HEALTH DOMAIN OF THE INDEX OF MULTIPLE DEPRIVATION

In 2000 the DETR published a new ward level Index of Multiple Deprivation (IMD 2000) based on six domain indices. One of these was a health domain. This has been used in this project to undertake analyses of the overall level of health and the extent of health inequalities within each health authority.

The health domain of the IMD 2000 attempts to identify people ‘whose quality of life is impaired either by poor health or disability’. It is made up of five key indicators.

1. Comparative mortality ratios for men and women under 65 (district level figures for 1997 and 1998 applied to constituent wards).
2. People receiving attendance allowance or disability living allowance in 1998 as a proportion of all people.
3. Proportion of people of working age (16-59) receiving incapacity benefit or severe disablement allowance for 1998 and 1999 respectively.
5. Proportion of births of low birth weight (< 2,500 grams) for 1993-97.

These indicators are combined on the basis of weights derived from a factor analysis, then standardised and transformed to an exponential distribution (see DETR, 2000 for a more detailed description of health domain index).

To analyse HA level indicators, all wards were allocated to their HAs by the boundaries that were in place on 31st December 1999. From this dataset two variables have been constructed for each HA. First, the average ward-level health score for each HA has been created to gain some understanding of the overall level of ill health. (Note: this is based on the crude ward score and is not weighted by the size of the ward population). Secondly, a measure of health inequalities has been created, based on the coefficient of variation (standard deviation/mean) for the ward level health score within every HA. The higher the coefficient of variation the greater the variation in health within the HA.

For the purpose of the analysis of the survey these two measures have been used to create four crude groupings of health authorities as shown in Box A5.1.
**Box A5.1: Health and health inequalities in HAs (IMD health domain)**

<table>
<thead>
<tr>
<th>Label</th>
<th>Values of health index &amp; coefficient of variation</th>
<th>No of HAs</th>
<th>Illustrative authorities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group 1</strong></td>
<td>Good health, low inequalities</td>
<td>Avera...</td>
<td>12</td>
</tr>
<tr>
<td><strong>Group 2</strong></td>
<td>Reasonable health, high inequalities</td>
<td>Avera...</td>
<td>36</td>
</tr>
<tr>
<td><strong>Group 3</strong></td>
<td>Poor health, high inequalities</td>
<td>Avera...</td>
<td>14</td>
</tr>
<tr>
<td><strong>Group 4</strong></td>
<td>Universally poor health</td>
<td>Avera...</td>
<td>37</td>
</tr>
</tbody>
</table>

Table A5.1 shows the proportion of wards in the bottom half of the health distribution for the whole of England in each of the four categories. Not surprisingly the proportion of wards with health disadvantage rises as one moves from group 1 to group 4. However, it is important to note that 12 per cent of wards in group 1 and 39 per cent of wards in group 2 are in the most disadvantaged half of wards in England in terms of their health. This is an important consideration, as often Government incentives to reduce health inequalities are targeted at HAs in groups 3 and 4. While these clearly do have the most significant problems, not requiring other HAs to make the same efforts to address health inequalities, may health in a significant number of disadvantaged wards is not addressed.

**Table A5.1 Distribution of wards in the bottom half of the health distribution (IMD health domain)**

<table>
<thead>
<tr>
<th>Percentage of wards in each group in the bottom half of the health distribution for whole of England</th>
<th>Group1: Good health, low inequalities</th>
<th>Group2: Reasonable health, high inequalities</th>
<th>Group 3: Poor health, high inequalities</th>
<th>Group 4: Universally poor health</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>12</td>
<td>39</td>
<td>68</td>
<td>91</td>
</tr>
</tbody>
</table>
The distribution of HAs according to the health dimension was compared to that based on the overall IMD, which is more commonly employed as a measure of disadvantage. The health domain and the overall IMD are highly correlated. However, categorisation of the IMD according to the above criteria produced slightly different groupings of HAs than those based on the health, particular among those with health better than the median. Nevertheless, repeating the analyses of the survey conducted using a categorisation based on the health domain with one based on the overall IMD, produced a very similar patterns of results.
APPENDIX 6: THE CASE STUDY DESIGN

The aim of the case study component of the project was twofold. First, to identify the inhibiting and enhancing factors in getting health inequalities on the local agenda and in tackling them effectively. Secondly, to assess what opportunities could be created in the future for health authorities to reduce health inequalities. Given the significant structural changes that had taken place in the local health economy since the commencement of the research, this aim was expanded to cover the range of local agencies that were relevant to addressing health inequalities.

Selection process

It was proposed to work with six areas for the study. Case study sites were chosen a priori on the basis of two broad criteria:

♦ the extent of health problems and health inequalities within the HA, based on the analysis of the health domain of the DETR’s ward based Index of Multiple Deprivation (IMD) 2000 (see Appendix 5);
♦ the extent to which reducing health inequalities appeared to be a local priority, based on the responses to the survey.

In addition, an attempt was made to ensure a mix of HA areas where PCGs had already developed into PCTs and others where this process had still to take place. The selection also required a reasonable spread of sites between regions. Finally, given the national evaluation of HAZs, it was agreed with the DH that this study would not include any HAs that were part of HAZs. HAs that were already engaged in other local or regional evaluation in relation to health inequalities were also avoided.

Criteria 1: the extent of health inequalities in the area

It is clear from DH policy documents that it is concerned with two broad kinds of inequalities at the HA level: inequalities between HAs and the national average, and inequalities between more and less deprived areas within their boundaries. In order to assess these two dimensions, the IMD, as described in Appendix 5, was used to calculate two scores for each HA:

♦ the overall level of ill health in the HA;
♦ the extent of variation in health between wards in each HA.

Health authorities were then divided into the four groups described in Appendix 5. Box A5.1 below shows the number of total HAs, survey respondents and non-HAZ HAs in each group. The DH asked that this study should focus on disadvantaged areas, so no HAs were selected from group 1 (those HAs with lower than average levels of both ill health and inequalities). In order to have a reasonable selection of HAs from each of the other groups, it was decided to select three HAs from the 25 available in group 2 (where HAs had the highest levels of internal health inequalities), one from the six HAs available in the group 3, and two from the 11 available in group 4. The selections from each group were made on the basis of second main criteria detailed below.
Box A6.1: Case selection by levels of health and health inequalities (IMD health domain)

<table>
<thead>
<tr>
<th>HA s grouped by the IMD health domain</th>
<th>Number of HA s (end of 2000)</th>
<th>Number of HA s that responded to the survey</th>
<th>Number of non-HAZ HA s that responded to the survey</th>
<th>Number of HA s approached to be case studies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group 1</strong> Good health, low inequalities</td>
<td>12</td>
<td>9</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td><strong>Group 2</strong> Reasonable health, high inequalities</td>
<td>36</td>
<td>29</td>
<td>25</td>
<td>3</td>
</tr>
<tr>
<td><strong>Group 3</strong> Poor health, high inequalities</td>
<td>14</td>
<td>11</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td><strong>Group 4</strong> Universally poor health</td>
<td>37</td>
<td>27</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>99</td>
<td>76</td>
<td>51</td>
<td>6</td>
</tr>
</tbody>
</table>

Criteria 2: the approach adopted to tackling inequalities in health

Information about the approach HA s have adopted to tackling health inequalities was taken from their replies to the survey. Using this data source as a selection criteria meant that those health authorities that had not replied to the survey by the end of January 2001 were excluded. It was recognised that this may introduce a bias into the sample. For example, if all of those HA s that had not replied were not concerned with health inequalities, the sample may not be representative. However, a number of HA s that are generally perceived as having begun to develop an effective strategy to tackle health inequalities (for example, Croydon and East Norfolk) were among the non-responders. It was therefore felt that this implied that non-response to the survey was not systematically related to the investment, or lack thereof, in health inequalities.

From the survey, four questions were identified from which to judge whether or not HA s were attempting to prioritise tackling health inequalities:

- whether or not they had developed an explicit strategy for health inequalities;
- what priority the respondent felt health inequalities were given within the HA;
- what ‘effort’ was being put into ‘root cause’ activities to reduce health inequalities;
- the extent to which equity considerations were being built into plans for general developing NHS services.

In order to explore the reasons why some health authorities were investing more in tackling health inequalities than others, four HA s were selected that were making significant efforts in relation to these criteria, and two which were not.
Resulting sample
Based on these criteria, the sample included one HA from each region except the West Midlands and Northern and Yorkshire. In terms of the ONS families, the selection included:

- two urban fringe areas;
- one rural area;
- one coastal & service area;
- one education or outer London area;
- one mining, manufacturing & industry area.

In February 2001, the respondent to the survey was approached in each potential area to ask if they would be willing to work with us as a case study. One of the selected areas chose not to participate in the study. Unfortunately, by the time this negative response had been received, there was insufficient time to find a replacement HA.

Case study design
In each case study area, a review was undertaken of their HImPs, public health reports and any other policy document that was particularly relevant to their strategy to address health inequalities. Advice was sought from the initial contact about who the key people in that particular place were to interview to gain a range of perspectives, both positive and negative, about local approaches to address health inequalities. However, an attempt was also made to ensure that contact was made with key individuals in the relevant local organisations, including:

- the health authority, in general, and in public health, in particular;
- PCG/Ts;
- acute trusts, and where appropriate community trusts, especially health promotion;
- local district and, where appropriate, county councils;
- local voluntary groups and community groups;
- some specific large regeneration partnerships;
- key local projects aimed at reducing health inequalities.

In all, 64 interviews were conducted across the five case study areas. A specific breakdown of the people who participated in the interviews can be found in Table A6.1. Two researchers conducted the case study interviews. Each case study area had only one researcher conduct the interviews in that place.

A basic interview schedule is shown below. The aim of the interview was to develop an understanding of both the local community health improvement process and the way in which the national mechanisms to put health inequalities on the agenda (outlines in Part 1) had interacted with the local context to achieve their aim. The schedule was adapted as appropriate to suit to the role of each particular individual respondent. All interviewees were assured of confidentiality. All interviews were taped with permission and transcribed. Using the Framework approach, the researchers involved in the case studies identified common themes from the transcripts and then coded all interviews in QSR Nud*ist for analysis.
### TABLE A6.1: CASE STUDY INTERVIEWS – PROFILE OF RESPONDENTS

<table>
<thead>
<tr>
<th></th>
<th>Place A</th>
<th>Place B</th>
<th>Place C</th>
<th>Place D</th>
<th>Place E</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>HA (outside public health)</td>
<td>4*</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>Public health within HA</td>
<td>5</td>
<td>4</td>
<td>6</td>
<td>1</td>
<td>2</td>
<td>18</td>
</tr>
<tr>
<td>PCG/T</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Acute Trust</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Community Trust (health promotion)</td>
<td>1</td>
<td>0</td>
<td>n/a</td>
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*2 joint HA/LA posts
Case study interview schedule

The schedule below was used to guide the interview discussion and adapted to reflect the position and organisation of each respondent.

1. Please briefly describe your responsibilities/role with regard to tackling health inequalities. Please explain the role of your organisation within local partnerships in this respect.

2. How is responsibility for policies related to tackling health inequalities organised within your organisation?

3. How committed do you feel your organisation is to taking action to reduce health inequalities 1) by improving public health 2) by promoting equity of access to health care?

4. What are the key problems that need to be addressed to reduce health inequalities in your area?

5. What factors do you feel have influenced this level of commitment/priority?

6. We have a reasonable idea of what is being done locally from the HImpS etc., what we are interested in finding out is what lies behind this approach. How and why have you chosen to address health inequalities in the way set out in the local HImp?

7. What do you see as the key achievements to date locally in tackling inequalities in health?

8. What factors have affected local progress with respect to developing an approach to tackle health inequalities and achieving objectives that have been set?

9. How are you monitoring your progress with regard to your health inequalities activities?

10. Are you undertaking an evaluation or other kinds of learning with regard to your activities to tackle health inequalities?

11. Have you set targets with regard to health inequalities? How did you choose them? Do you plan to set targets in the future following the announcement of the national targets and guidance for local targets?

12. How do you think the local strategy to tackling inequalities in health should be developed in the future? What role do you see for your organisation in this? What role do you see the HA playing in this?

13. In an ideal world what would you view as being the key components of an effective strategy to tackling inequalities in health?

14. What advice would you give the government about three things it should do differently to enable local partnerships to tackle inequalities in health more effectively?

15. Are there any other comments you would like to make?
APPENDIX 7: THE TELEPHONE SURVEY SCHEDULE FOR NHS EXECUTIVE REGIONAL OFFICES

Part 1: regional office's role in supporting health authorities to reduce health inequalities

1. Can you please outline what your role is with the regional offices in relation to the development of HAs’ strategies for tackling inequalities in health?

2. What type of support does your regional office provide to HAs?
   ♦ To what extent do you provide guidance to all HAs?
   ♦ To what extent do you work with individual HAs?

3. To what extent are equity considerations, in relation to health inequalities, built into performance management?

4. Are there any other processes through which you monitor HAs’ progress in tackling inequalities in health?

5. To what extent does your R&D strategy address health inequalities issues?

6. How do you believe that your role in supporting HAs will change due to restructuring in HAs? (Performance management, monitoring role, work with PCG/Ts etc)?

7. Do you know how your regional public health observatory supports LAs, HAs and PCG/Ts in their health inequalities strategy development?

8. In relation to regional regeneration issues, have you developed links with the government offices for the regions?

9. What aspects of the support your regional office has provide HAs with, in relation to their efforts to reduce health inequalities, do you feel have been most and least effective and why?

10. What are the next steps for the regional office in relation to their strategy to tackle inequalities in health?

11. What do you see as the future obstacles for regional offices in relation to their strategies to tackle inequalities in health?

Part 2: HAs’ strategies to reduce health inequalities in your region:

12. More generally, what factors do you think have helped or hindered HAs so far to make progress in their efforts to reduce health inequalities?

13. What do you see as the key issues facing the HAs in the future?

14. What do you believe would help HAs to make progress in reducing health inequalities over the next couple of years?
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