Delivery Systems and Mechanisms: Task Group 7
Summary and proposals

The full report of the task group can be found at
http://www.ucl.ac.uk/gheg/marmotreview/consultation/Delivery_systems_and_
mechanisms_report

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What is the task?

The task set for Task Group 7 was:

"*To assess new and under-exploited evidence on the most effective structures and organisations for jointly delivering reductions in health inequalities. In particular, this will include an assessment of the roles of health services, governance arrangements, national policy organisations, government departments, local government and the third sector in reducing inequalities, in both social determinants and health outcomes*"

Values are of central importance to this task. We therefore asked throughout our analyses: what *practical* steps can be taken at various levels to maintain shared public service values when striving to deliver reductions in health inequalities?

To tackle our remit, we took the WHO Commission on the Social Determinants of Health (Global Commission's) recommendations on delivery systems and mechanisms, and asked what these meant for the UK policy context. Six policy case studies were developed on issues selected for the insights they reveal about how systems in the UK operate to support or undermine equity objectives. Each case study combined a) synthesis of the evidence with b) policy analysis and c) interviews with a small number of key informants, to tell an illuminating story from which suggestions for future action could be generated. From the case studies we have tried to distil "principles for action" as well as indicating "what does <u>not</u> work" or "areas for disinvestment.

What is the relationship with health inequalities?

PART 1 of the main re-ort from task group 7, covers the relationship of delivery mechanisms and systems with health inequalities. We are asked to consider the role of health services, among other public systems. Conceptually, access to effective health services can be seen as a social determinant of population health and inadequate access a potential cause of inequalities in health status. With the NHS in the UK, however, inadequate access to health services is not considered to be a *major cause* of the observed social inequalities in health in the country. We consider, however, that the health system does have a pivotal role to play in the *solution* to the problem of inequalities in health in four main areas of activity:

- Putting its own house in order: maintaining an equitable NHS and addressing those inequalities in health *care* that are contributing to the observed inequalities in *health status*.
- Preventing or ameliorating the health damage caused by living and growing in disadvantaged circumstances (i.e. the health damage caused by wider social determinants of health).
- Acting as a champion and facilitator to influence other sectors to take action to reduce inequalities in health.
- Directly influencing other social determinants of health, such as local employment and economies, and acting as a good "corporate citizen".

What are the policy options for the UK?

PART 2 summarises the policy options under the following six key roles for the health system, which are then examined in greater depth in a series of case studies in **PARTS 3 to 8.**

Maintaining the universal health care system and addressing inequalities in service delivery:

The Global Report calls for the building of universal health care systems based on equity principles. What the UK is faced with (in common with other European health systems) is not the *building*, but the *maintaining* of the equitable system that the country already has, in the face of potential erosion of the fundamental principles on which it is built. At the same time, the system needs to improve the mechanisms for identifying and rectifying inequalities in delivery of the services and develop further the capability to take social determinants of health approach.

We illustrate the type of assessment that needs to be done with the case study in **PART 3** on the Quality and Outcomes Framework (QOF) introduced as part of the 2003 General Medical Services contract. The evaluation identified both positive and negative impacts on health inequalities and discovered that the

quality of care was already improving prior to the introduction of the QOF: highlighting the importance of looking at underlying trends. Crucially, this kind of assessment provides pointers on how the system could be improved in the future from an equity perspective.

Key proposal 1: equity assessments

Equity assessments should be carried out on system changes (planned or implemented) to assess not only whether they are meeting their stated aims, but also whether they are having detrimental effects on the values and equity objectives of the wider system as a whole. There should be provision built into the system for taking action on the findings of these assessments.

Sustaining a strong population health perspective within the health system

The Global Report recommends *"expand the health sector policy and programmes in health promotion, disease prevention and health care, to include a social determinant of health approach, with leadership from the Minister of Health"*.

Above all, this requires a system that takes a population health perspective, capable of going beyond the individual needs of registered patients or users of services. The UK system is already oriented towards prevention and health promotion to a greater extent than in many other countries, in that it includes these services within the comprehensive package covered by the NHS. Most importantly, it has had highly developed systems for taking a population health perspective on monitoring needs and delivering appropriate responses. This population health perspective contrasts with an approach limited to registered patients or users of services, where sections of the population can slip between two stools and only expressed needs for treatment services are addressed. The case study in **PART 4** of the main report on structural reorganisations illustrates the questions that need to be asked of the impacts of the various UK reorganisations on the vital public health function, and what mechanisms might be developed to address strengths and shortcomings.

Key Proposal 2: ability of system to take population health perspective

The UK's highly developed system for taking a population health perspective on assessing needs and delivering appropriate public preventive and health promotion services should be safeguarded and enhanced in planned system changes.

Championing local multi-sectoral work on social determinants

The health system has a major role in acting as a champion and facilitator to influence other sectors to take action to reduce inequalities in health. The case study in **PART 5** of the main report on local multi-sectoral working synthesises the evidence from attempts by different public sector agencies in the UK to work together over the past two decades on the social determinants of health. This evidence indicates a range of common facilitators and barriers to this kind of working and ways in which the conditions for effective partnership working can be enhanced in the future.

Key proposal 3: Local leadership on facilitating joint working
Local mechanisms need to be initiated to make multi-sectoral work on social determinants of health both easier and more effective. These include health and local authority leaders demonstrating the legitimacy and priority given to this kind of work by: agreement on common goals and targets between agencies focused on addressing inequalities in health and wellbeing; the setting up of joint appointments and joint operational units, the increasing use of joint funding mechanisms which are sustainable (moving away from reliance on short-term project funding); and the provision of long-term timescales for the processes of setting up and maintaining partnerships.

Key proposal 4: National and local synergy
Government departments need to support rather than undermine local joint working on the social determents of health and inequalities. This includes demonstrating that this kind of work is valued nationally through the targets and performance management mechanisms that are put in place; through the setting of adequate timeframes for setting up the joint work and evaluating impact.

Key proposal 5: Workforce development on determinants of health
Government departments and regional workforce development agencies need to expand capability to understand and act on the social determinants of health in the non-specialist, as well as the specialist, workforce. This requires both reaching out to include practitioners in sectors other than health, as well as expanding capacity in educational establishments to carry out this development work.

Having a direct influence on wider social determinants of health
Evidence is accumulating on the role of the health and social care sectors as major local employers and with purchasing power that can influence the local

economy in their own right. There is also a role of the NHS as a model employer and in helping people with illness back to work. The case study in **PART 6** presents examples of this kind of work in one region of the UK and leads to several principles for action.

Key proposal 6:
Local public agencies should be proactive in assessing how they can confront poverty, unemployment and disadvantage in their communities more directly. This includes using opportunities in health care settings to help patients get the social welfare benefits they are entitled to; contributing to rehabilitation of people with longterm sickness to help them get fit for work; and using their organisation's employment and purchasing power for the benefit of the local communities that they serve.

Co-ordinating efforts across the whole of government

The Global Report emphasises the need to ensure that health equity is embedded in all policies, systems and programmes across the whole of government:

What does this mean for the UK? We are not starting with a blank sheet. There is a long tradition of using targets, for example, which have emerged as key drivers of the public policy system in the UK. Targets have been used to try to achieve improved performance, indeed to measure performance, across a range of government departments and goals. From this UK experience to date, there are lessons to be learnt, both negative and positive, in the use of this kind of mechanism. The case study in **PART 7** of the main task group report on targets as a planning mechanism in public policy and service systems draws out these lessons. It traces the way in which the regime of targets in the UK has evolved over several decades and has produced unintended consequences along the way, including fragmentation or silo-based working. This goes against the coordinated efforts on equity across the whole of government that are needed. However, the case also identifies emergent action that is being undertaken that shows more promise in serving an equity purpose.

Key Proposal 7: *Developing common view*
Policy makers, professionals and service managers across the system need to escape from the blame culture which has emerged during the operation of previous target regimes. They need to harness the considerable scope for developing common ground, and particularly the scope for developing a common view about the key priorities and how they should be tackled. The new

generation of Public Service Agreements (PSA) and the creation of the Local Area Agreement (LAA) system provide promising vehicles for developing the desired common ground on values and outcomes.

Key proposal 8: shared targets on shared objectives
Targets which are based on shared objectives, and driven through relationships based on mutual respect and appreciation of the logics which drive different players, stand every chance of helping to influence the social determinants of health inequalities.

Considering the global equity impacts of UK initiatives

Increased resourcing of the UK health system may have far reaching impacts on health systems in other parts of the world. As part of the NHS 10-year Plan published in 2000, for example, the UK identified the need for 10,000 more doctors and 20,000 more nurses to improve access and quality of care. The policy of recruiting overseas health workers to fill these gaps has had serious repercussions in middle- and low-income countries and raised issues about ethical international recruitment. The case study in **PART 8** synthesises the evidence on the origin, progress and unintended side effects of UK policy on this front and discusses what would be needed to ameliorate these adverse effects.

Key Proposal 9: assessment of global impact
Policies which lead to increased health resourcing in England need to be assessed in terms of their impact on health and health equity in other countries.

Key proposal 10: sustainable workforce development
Expansion of the England's Health work force needs to be planned in a sustainable way so that it does not exacerbate the health workforce deficiencies in developing countries.

What principles for action and what <u>not </u>to do?

These are detailed in **PART 9** of the main report and include:

Principles for action:

1. **Completing the jigsaw**

Strategies that rely just on local interventions will be insufficient to make a lasting and profound difference to the patterns of inequality across the country. Action at all levels of government and active engagement with civil society and the business sector is required over a sustained period of time (probably a decade or longer).

2. **Recognise existing contributions**
   Much of the NHS and other welfare services make a remarkable contribution to reducing (health) inequality and addressing SDH. Without them, the situation would be far worse. Specific areas of note here are primary health care, universal benefits, and open access (free at the point of delivery)

3. **Resist regular re-organisation**
   Health reform should take full account of the wider effects/impacts including the anticipated consequences (positive and negative) upon health equity and the social determinants of health. Formal re-organisation and `natural evolution' of local organisational forms disrupt local partnership working and create planning blight over a period of 18-24 months.

4. **Secure local accountability**
   Accountability for action and inaction (to reduce health inequality and address SDH) should be more explicit and transparent at the local level, not just to national reporting mechanisms. Such accountability mechanisms would be enhanced by much closer working (and possibly, integration) between welfare agencies at the local level. Recent thinking on systems approaches point toward the benefits of this approach.

5. **Create a culture of equity**
   Reducing health inequality and addressing the SDH should not be seen as additional activities or objectives but integral to the conduct of a well-functioning health system (in the widest sense of the term). It should become as much as part of the culture of an organisation as quality improvement, for example.

6. **Equity starts at home**
   The NHS and local government should take greater recognition of their potential to influence patterns of inequality locally through their decision-making (such as employment practices, procurement strategies and internal management of organisations). Inevitably, the extent of reliance of locally-inspired, developed and implemented policies will create the potential for

wider variations between areas. This approach should be clearly justified as a response to local needs.

What does <u>not</u> work?

- The research evidence on what does <u>not</u> work has become more unequivocal, including:
    - Top-down implementation on its own
    - Strategies that rely solely on behaviour change
    - Strategies that ignore the role of context as a mediating factor

What should be stopped?

- Each department should examine how to reduce compliance requirements on local public service bodies, and the assumptions should be that systems extraneous to PSAs should be removed.

- Central government administrative resources should be re-configured to remove those posts predominantly involved in monitoring compliance with centrally set targets outside the PSA / LAA system.

- 'Tactical' tweaking of activities which leads to 'hitting the target but missing the point' should cease, despite the fact that missing the target may be reported as a failure by audit bodies or the media.