



photo: Ilaria Geddes

Chapter 3

Lessons to be learned from the current Health Inequality Strategy, targets and indicators

3.1 Introduction

While recent policy approaches have struggled to reduce health inequalities, life expectancy has risen dramatically for all social groups in the last 10 years, a very significant achievement. So too is the fact that widening income and wealth inequalities, documented in Chapter 2, have not translated into commensurate widening inequalities in health and well-being. Nonetheless, this report advocates particular approaches, delivery systems and policies for tackling health inequalities and it is vital that lessons from recent policies and delivery organisations are learnt – and those lessons acted upon. These lessons are the subject of this chapter.

3.2 Current health inequalities policy

In 1998, Sir Donald Acheson, building on the Black Report and a considerable amount of research that had been carried out in the interim, published the *Independent Inquiry into Inequalities in Health*. That Inquiry emphasised the importance for health of social conditions through the life course.²³⁰ Acheson made 39 recommendations, three of which were concerned with health services. There were three priorities:

- To assess the impact on health inequality of all policies
- To give priority to women of child-bearing age, expectant mothers and young children
- To reduce the gap in living standards between the worst-off and the average.

Following the Acheson report, the Government developed a national health inequalities strategy, *Tackling Health Inequalities: A Programme for Action*, with twin aims: to deliver a national health inequalities target by 2010 (reducing inequalities in infant mortality and life expectancy at birth) and to support a long-term sustainable reduction in health inequalities.²³¹ See Chapter 2 for a description of the national health inequalities target and the two supporting objectives.

The Programme for Action had four themes:

- Supporting families, mothers and children
- Engaging communities and individuals
- Preventing illness and providing effective treatment and care
- Addressing the underlying social determinants of health.

Activities covered by the Programme for Action included:

- Improving employment opportunities and living conditions for disadvantaged groups
- Tackling poverty, particularly child poverty
- Reducing smoking prevalence and promoting access to a healthy diet in poorer communities
- Improving access to, and use of, health services among those who have traditionally been underserved.

The programme emphasised the importance of cross-government working at local, regional and national levels and partnership with other service providers and local communities.²³²

Alongside the two headline targets and to provide a broader context for assessing progress 12 national health inequalities indicators have been adopted. These cover mortality from specific diseases, access to health care, health behaviour, and the wider social determinants of health. The 12 headline indicators are:

- 1 Death rates from the ‘big killers’ – cancer and heart disease
- 2 Teenage conception rate
- 3 Road accident casualty rates in disadvantaged communities
- 4 Numbers of primary care professionals
- 5 Uptake of flu vaccinations
- 6 Smoking among manual occupation groups and among pregnant women
- 7 Educational attainment
- 8 Consumption of fruit and vegetables
- 9 Proportion of population living in non-decent housing
- 10 Physical education and school sport
- 11 Children in poverty
- 12 Homeless families living in temporary accommodation.

As indicated in Chapter 2, the social gradients originally identified in these indicators have persisted, despite improvements in average levels for many of them.

In this chapter we assess evidence about how the design and implementation of approaches to reducing health inequalities may have affected outcomes in three areas:

- 1 Policy design and approach
- 2 Targets and metrics
- 3 Delivery across the system.

3.3 Lessons learnt: policy designs and approach

3.3.1 The social determinants of health

In Chapters 1 and 2 we set out evidence demonstrating how health inequalities closely relate to other social inequalities, to the social determinants of health. Most effective actions to reduce health inequalities will come through action within the social determinants of health. However, attempts to reduce health inequalities have not systematically addressed the background causes of ill health and have relied increasingly on tackling more proximal causes (such as smoking), through behaviour change programmes.²³³

Part of the explanation for this emphasis lies with the comparative ease of identifying action to address behaviour, rather than the complexity of addressing social inequalities shaping such behaviours. This has led to the seemingly less challenging route of lifestyle interventions – this tendency has been described as ‘lifestyle drift’.²³⁴ The emphasis has been either on downstream actions that affect only a small proportion of individuals, or on approaches that have a socially neutral impact at best.²³⁵ Health inequalities are likely to persist between socioeconomic groups, even if lifestyle factors (such as smoking) are equalised, without addressing the fundamental causes of inequality.²³⁶

3.3.2 Investing in prevention of ill health

Within the NHS, there has been a longstanding, well documented focus on acute services, and on access and waiting times. The dominance of the acute sector at the expense of ill health prevention is evident in the pattern of spending. Less than 4 per cent of total NHS spending is targeted at prevention and this money is not required to be spent on reducing health inequalities (see Policy Objective F).²³⁷ Reducing health inequalities requires significant investment, but, even without considering the moral and social justice case, the financial costs of doing nothing about health inequalities are even more significant, as described in Chapter 2.

3.3.3 Cross-cutting action and all-policy focus on health equity

While the Department of Health has formal responsibility for reducing health inequalities, the causes of health inequalities extend far outside its remit. Reducing health inequalities is clearly a task for the whole of government, locally and nationally. However, too often action has been limited by organisational boundaries and silos. In Chapter 5 we propose mechanisms and systems for ensuring that action is taken across government.

3.3.4 Need to focus on the gradient in health inequalities

Where policies have been designed with a focus on health inequalities, they are often aimed at the lower end of the social gradient. Even if they are effective, these policies fail to tackle all the inequalities that exist for other socioeconomic groups. This report

argues that the whole gradient needs to be targeted, with proportionately more focus down the gradient. Both the universal aspects of policies and the increasing focus on those worse off are important. For example, social marketing campaigns are universal policies designed to improve health and change behaviours, but these are often poorly designed for reducing inequality.

Ill health preventions aimed at changing individual behaviours such as smoking, alcohol, diet and exercise are more quickly and commonly taken up by the middle classes and those who already have positive attitudes towards health.²³⁸ The most advantaged groups are often better resourced to take advantage of population-wide interventions. Indeed, without attention to distributional impact and the underlying causes of behaviours, interventions to improve health may increase inequalities.

3.3.5 Small-scale policies and short timescales

Social policy at the national level has witnessed a proliferation of highly targeted projects and new initiatives. This proliferation has been accompanied by undue emphasis on the need for new money for new initiatives, despite the widespread recognition, as evidenced by the inclusion of an inequality component in the NHS resource allocation formula, of the need to change the way mainstream resources are used and services delivered. Nationally set targets and performance management of delivery organisations have tended to focus on narrowly defined short-term objectives and targets, at the expense of broader and longer-term aims.

Many of those involved in delivery have argued that tackling health inequalities requires a commitment to longer time scales. Critical components in delivering reductions in health inequalities, such as community development and capacity building, partnership working, professional development, and local institution building, need ongoing investment and time to mature. By contrast, regular structural change, staffing shortages, and fragmented and short-term funding streams risk making improvements harder.

Long-term outcomes of interventions, including those for health, are complex to evaluate and measure. Isolating the impact of a particular mechanism or approach over time is particularly challenging. Given short political cycles and the culture of demonstrating quick impact, these challenges and longer time horizons can become prohibitive to taking action.²³⁹ It is therefore necessary to link long-term goals to shorter-term stepping stones, as the recommendations in Chapter 4 and associated metrics try to do (Chapter 5 and Annex 2).

Analysis of current delivery highlights these issues. In 1997, the appointment of a Public Health Minister and the implementation of Health Action Zones and Healthy Living Centres signalled a clear strategic direction towards partnership working focused on area- and community-based action. However, there followed a succession of policy and organisational changes that hampered the

partnership working that is essential to addressing the ‘wicked issues’ of health inequalities. Instead of allowing existing initiatives to mature, the pursuit of short-term objectives and targets, based on a ‘quick win’ ethos and a limited commitment to long-term funding, came to characterise many policies – and the scale of the challenge facing the agencies was simply not recognised.²⁴⁰

3.3.6 The hunt for quick wins

Reviews often look for new interventions, particular policies that may help turn the corner or make significant impact in improving service quality. However, a stream of new initiatives may not achieve as much as consistent and concerted action across a range of policy areas. A social determinants approach to health inequalities highlights how it is the intersection between different domains that is critical – health and work, health and housing and planning, health and early years education. Success is more likely to come from the cumulative impact from a range of complementary programmes than from any one individual programme and through more effective, coherent delivery systems and accountability mechanisms.

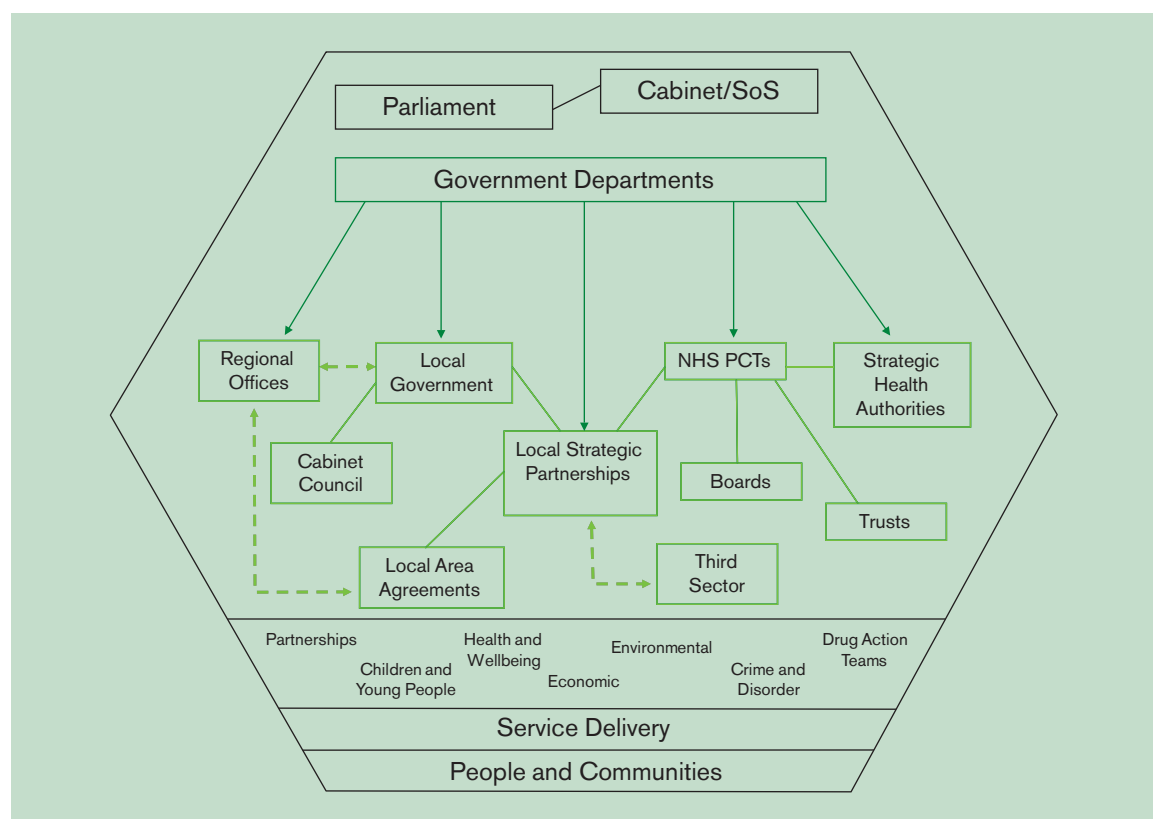
3.4 Lessons learnt from delivery systems

As discussed in the preceding section, achieving reductions in health inequalities requires coherent, concerted, long-term, cross-cutting policies, backed by sufficient investment. Achieving reductions in health inequalities also depends on correctly identifying and developing systems capable of delivering change at local and national level. To identify the lessons to be learned from the current delivery and monitoring framework, we considered the following questions:

- What were the barriers to delivery at national and local level?
- Did delivery systems and mechanisms facilitate accountability and performance improvement?
- Were the targets and metrics for measuring progress and galvanising action appropriate?

In framing our analysis of barriers to delivery we drew on the work of our task group and working committee, which were set up to explore and analyse barriers to delivery and potential remedies.²⁴¹ The Review’s work also drew on the work of the Health Inequalities National Support Team and widespread consultation with health inequalities beacon council representatives, local authority chief executives, Primary Care Trust chief executives, the third and private sectors and the public health work force. The analysis

Figure 3.1 The existing delivery system



Source: Whitehead et al.²⁴³

was also framed by the responses to the Review's consultation.²⁴² For ease of reference, the organisational relationships that characterise the existing delivery system are summarised in Figure 3.1.

3.4.1 Barriers to the national delivery system *Geographic area*

Initiatives tend to focus on specific geographic areas, particularly through the spearhead designation (described in Chapter 2). However, they do not necessarily target the people they are intended to target, as large geographic areas are mixed. In fact more deprived people live outside spearhead areas than within them. Further targeting of this kind, even if efficiently designated, fails to tackle inequalities along the whole gradient. Even given the policy of targeting the worst off, reductions in the gap within such broad target groups can often be achieved by focusing on the most numerous, but least deprived, individuals within a target group or area.²⁴⁴

Workforce capacity

There has been insufficient attention given to expanding workforce capacity to understand and act on the social determinants of health within both the non-specialist and specialist workforce.²⁴⁵ Where there are shortages of trained professionals required to deliver the basic functions of services necessary, this is of course a major impediment to successful interventions and public service delivery. There have been significant increases in the numbers entering some public sector professions – doctors, nurses, teachers – but other critical workforces, such as health visitors, are under pressure.

There are also concerns that as fiscal constraints bite, it is frontline workers, particularly those that lack political and popular support (for example, social workers and Jobcentre staff) whose jobs may be cut. At the same time, while there are concerns that substantial upskilling of the workforce is vital – for childcare workers, for instance – there may not be the resources to do this.

3.4.2 Barriers to local-level delivery systems

On a local level progress in delivering health inequalities has been inconsistent, partly as a result of some significant limitations in local delivery organisations, funding and difficulties with partnership working.

Local responsibility for health inequalities

There is a perception among some statutory agencies that responsibility for delivery lies with the local NHS. This is despite local government and other public sector partners, the police, fire service, third sector and private sector organisations, holding many of the levers that shape health inequalities.

The local authorities' role has been obscured by an artificial separation of health policy from other major policies central to the social determinants of health and sometimes they have been tentative in taking a lead in these circumstances. This displacement of responsibility can be compounded by there being limited evidence available to relevant local stakeholders of the key drivers of health inequalities.²⁴⁶

There are lessons to be learnt from the failure of some key stakeholders to give partnership working the priority it needs to be successful. These include significant variation in engaging the senior personnel necessary to deliver effective partnership and strategic change and a corresponding lack of commitment to drive forward and tackle the very challenging issue of health inequalities.²⁴⁷ Common objectives and agreed priorities can be seen as key components of a partnership but these are not easy to agree in a context of different roles and responsibilities, fragmentation of funding streams and financial pressures. There has been an overemphasis on targets by national government and pressure to demonstrate quick short-term wins to the detriment of the long-term strategic progress – hitting the target but missing the point.²⁴⁸

Efforts from partnerships in tackling health inequalities have sometimes showed an over-reliance on small-scale health improvement projects and programmes.²⁴⁹ In some instances, progress has been hampered by difficulties in achieving the information sharing needed to support joint action. This highlights a lack of understanding of the importance of using good quality evidence and the absence of agreed protocols for achieving systematic sharing.

All of these factors diminish the ability of delivery organisations to impact efficiently on the underlying causes of health inequalities. In Chapter 5 we outline mechanisms and systems to overcome these barriers. There are excellent examples of where such problems have been overcome, using approaches that could be adopted much more widely.

3.5 Appropriateness of the targets

England, Northern Ireland, Scotland and Wales have all set explicit health inequalities targets.²⁵⁰ While limitations in the scope, methods and approaches adopted for many of these targets is now widely documented, there is an equally strong body of opinion that it is important to have a health inequality target to focus attention on the issue.

The experience accumulated from the four countries about developing, setting and using health inequality targets has led to an acknowledgement that a successful target-led health inequalities strategy needs to be underpinned by clarity over the main determinants and dimensions of health inequality that are to be reduced, and the indicators used to measure progress.²⁵¹

3.6 Issues in the construction of the targets

3.6.1 Not all dimensions of equality and inequality are covered

The conceptualisation of health inequalities underpinning the current target does not capture the social gradient in health or the more complex patterning of health associated with other groups (for example, ethnic groups). Other inequalities intersect in

important and complex ways with socioeconomic position in shaping people's health status.

This includes the dimensions covered by current equality legislation and activities that underpin the general duty of public authorities to promote equality are not reflected in the inequality targets for health. However, significant health challenges have been identified related to specific groups based on age, ethnicity, sexuality, gender and disability. The Single Equality Bill places a duty on public bodies to promote equality (in relation to race/ethnicity, gender and disability), including the publication of information on progress on reducing inequalities in outcomes.

A single target cannot realistically incorporate the multiple dimensions of inequality.

3.6.2 Being clear about outcomes

Current targets are designed to provide a broad measure of longevity (life expectancy) and survival in the early years (infant mortality). Both are focused on the avoidance of mortality, but they do not reflect health status or other dimensions of well-being through the life course. The importance of other measures was illustrated in Figure 1.1 which shows gradients in both life expectancy and disability-free life expectancy according to level of neighbourhood income deprivation. As years of life are extended for most people, there is growing evidence of wider social gradients in health during the extra years. There should therefore be a focus, reflected in targets or indicators, on both adding years to life and life to years. The Review's proposals in this area are discussed in Chapter 5.

3.6.3 Use of national targets at local levels

It is increasingly recognised that the delivery of national inequality targets depends, to an important extent, on the effectiveness of local action.²⁵² There has, however, been a tendency to set health outcome targets at the national level and, in the absence of appropriate performance indicators, they are simply handed out to organisations at regional and local level and treated as if they were local performance targets. This has highlighted the importance of:

- Finding the correct balance between national and local relevance
- The need to integrate with key NHS and local authority processes, including performance management processes
- Data availability (national surveys may not provide adequate local data)
- Small numbers at local level, for instance as with the infant mortality target.

3.6.4 Use of local area information to monitor inequalities

In using area-based information to undertake monitoring, there is an implicit assumption that the information identifies inequalities between individuals. This is reflected in, and compounded by, targeting and monitoring large geographic areas or catchment populations. There are variations in health outcomes within spearhead areas and within

non-spearhead areas, and although spearheads were defined as areas with the highest levels of deprivation and poorest health, there are affluent people within spearhead areas and disadvantaged people within non-spearheads. By measuring changes only at local authority level, we cannot tell whether any improvements being made are confined only to the more affluent members of a generally deprived population.

The introduction of within-area inequalities targets attempted to address this problem. However, these targets were not only independent of the national targets but also continued to target areas containing households in widely varying socioeconomic circumstances.

To some extent, this can be viewed simply as a problem of granularity. The smaller the number of people in the area, the smaller the likely within-area variability. For example, sufficiently reliable small area data were not available when targets for spearhead local authorities were set nationally. Now that they are, as long as the numbers in the small areas are sufficient to enable analysis to be undertaken, both issues discussed above could be overcome. This is because:

- All or most local authorities would have had a stake in the target.
- Measures of inequality would have been more sensitive to change.
- The target could be scaled from national to regional to local level with ease.
- There would have been less incentive to focus on initiatives in specific areas (which may or may not hit the right individuals) and more incentive to focus initiatives on the right individuals across the district.

3.7 Monitoring progress in reducing health inequalities

Current targets cast inequalities as a health gap between the health of a defined disadvantaged group and the health of the population as a whole. This simple definition raises several issues.

3.7.1 Over-simplification

Target groups, defined on a cross-sectional basis, may change over time. Their composition may change substantially due to either high levels of churn in areas or systematic geographic or social mobility, for example, gentrification or decline of areas or structural shifts in the labour market.

3.7.2 Problems arising from targeting

While health inequalities are a population-wide phenomenon, the target defines health inequalities as a condition afflicting a sub-section of the national population. The life expectancy target relates only to spearhead areas, covering 28 per cent of the population. The infant mortality target relates to the 40 per cent of those infant deaths with a specified father's class who were in the routine and manual group; births registered solely by the mother or that cannot be classified are excluded from the calculation.

By targeting sub-groups, many deprived groups are excluded from priority action. There are disadvantaged areas that are not accorded spearhead status – around half of disadvantaged individuals and families live outside spearhead areas. Similarly, infant mortality rates for sole-registered and other unclassified births are markedly higher than in the targeted disadvantaged group.

3.7.3 Absolute and relative inequalities

Both the life expectancy and infant mortality targets are assessed in terms of a relative gap between the targeted group and the population as a whole. In contrast, in performance managing the life expectancy target at local level, the absolute difference in a proxy measure is being used (age-standardised mortality rates). There is a wider research debate on the advantages and disadvantages of relative and absolute differences and an emerging consensus that both are essential for public health purposes.²⁵³ However, when the relative and absolute gaps move in opposite directions or in the same direction but at different speeds, most people (public and health professionals alike) are confused by the apparently conflicting messages.

A further issue concerns the most appropriate measure for summarising inequality, for example, a rate difference or a slope index of inequality for an absolute gap; a rate ratio or relative index of inequality for a relative gap. Much confusion has arisen over the correct ways to measure the gaps. The following could provide a more robust approach to measuring gaps between areas. For example:

- For counts and event rates, use relative gaps
- For proportions or percentages, use odds ratios
- For indicators or indices of outcome that have a straight line relationship with the relevant social determinant, use absolute gaps.

Using only a relative and absolute index on its own tends to create perverse incentives for those tasked with implementation (see below). Therefore, both need to be used in measuring progress, using separate metrics for each.

3.7.4 Unintended consequences and perverse incentives

The heterogeneity of target groups is necessarily overlooked in setting a single target. As previously indicated, there are social, geographic, ethnic and other gradients within spearhead groups and within routine and manual classes. Reductions in the gap within such broad target groups can often be achieved by focusing on the most numerous, but least deprived, individuals within a target group or area.

A problem with setting targets that rely only on relative improvements in health among the poorest, is that inequalities can widen in terms of relative differences among social groups, depending on the rate of improvement among more affluent groups. This points to the need to monitor both the relative and absolute changes.

A further problem that may arise when assessing progress towards inequalities targets is systematic

variation in the completeness and quality of reporting and recording across social groups. For example, drawing attention to a particular adverse behaviour, with a specific target to reduce it, can lead to either under-reporting of the problem, due to individuals with these behaviours trying to hide their problem – for example, smoking in pregnancy, or an increase in reporting of a previously hidden problem, for example, domestic violence. Both exacerbate the problem of accurately monitoring progress.

3.7.5 The availability of monitoring information

The current targets, headline indicators and local indicators were necessarily shaped by the limitations of existing data systems and the need to monitor progress: they needed to be regularly updateable, robust enough to detect changes over time, compatible with broader policy objectives and so on. These limitations have not enabled a fully integrated and transparent approach to tracking progress.

Some of the issues encountered with the current national monitoring data are:

- Local availability: The task of addressing limitations in local systems can impose a significant burden, for example, developing new systems to measure, and process data on, the health of local populations.
- Timeliness: Where targets are based on health outcomes, there may be a considerable time delay. For example, mortality data that depend on death registrations and data processing tend to be at least nine months behind at the time of publication, and teenage pregnancies, which depend on birth registrations, can only be available over a year after the conceptions occurred. The use of three-year rolling averages can exacerbate this time delay. If rates are changing rapidly, such as for premature coronary heart disease mortality, this means that information lags behind what is needed.

3.8 Delivering across the whole system

In Chapter 5 we set out our proposals for a delivery system and performance improvement framework which, based on the evidence we have assessed and the consultations we have had, facilitate delivery of reductions in health inequalities. From recent policy experience there are several key messages to be drawn:

- Policies to tackle health inequalities must focus on the wider determinants of health.
- Policies, delivery systems and targets should tackle inequalities along the whole social gradient, rather than focus on specific segments of it.
- Policies need to be cross-cutting at national and local level and spread over the usual organisational boundaries at all levels.
- Policies need to have longer time horizons and sufficient funding for those time periods.
- Policies need scale and intensity. Small-scale isolated projects cannot make sufficient impact, however effective they may be at a small scale.
- Strategies to reduce health inequalities should

draw on the overlaps and synergies between different policy areas and not be developed in isolation.

- Strategies intervening in just one part of the social determinants will be insufficient to make the necessary difference to patterns of inequality. The scale of the challenge is significant.
- The experience so far suggests that the solutions to the above points are not straightforward for the disparate regions, cities, towns and villages across England.
- Geographic delineations of specific ‘priority areas’ have unintended consequences.
- Partnership working across a disparate and complex system involving separate organisations with differing responsibilities, perceptions and cultures is difficult to achieve, time consuming and often outside the experience of some of the key actors.
- Finally, while we separate national and local in this analysis of the issues, it is important that an integrated approach at national and local level is adopted if synergy is to be achieved to secure the maximum impact.

There are also some questions that underpin the discussion of whether the existing targets and indicators are appropriate:

- To what dimensions of inequality should the targets and indicators relate? Are there particular issues in incorporating all the dimensions covered by the Single Equality Bill, for example, age, gender, ethnicity, disability?
- Should targets be aspirational or do they need to be incorporated into a performance improvement framework? Is this affected by the timeframe for delivery – short, medium or long term?
- Are specific targets and indicators intended to be used at national or local level?
- For targets set nationally, what are the implications for local measurement?
- What is the balance between process, intermediate and final outcome measures?
- Should targets relate to the social determinants, the health care system or to health outcomes based on individuals, for example, their socio-economic classification; or group attributes, for example, area deprivation?
- How can targets be made to reflect progress across the gradient in a way that adequately captures proportionate universalism?²⁵⁴

In Chapter 5 we attempt to answer some of these questions through our proposed delivery systems, targets and metrics.