Inequalities in health: approaches by health authorities in an English health region

Peter McCarron and Brendan Yates

Abstract

Background In 1995 the Department of Health published Variations in health: what can the Department of Health do? This recommended that health authorities should have a comprehensive plan for identifying and tackling variations in health. We investigated how health authorities in the South and West Region were taking forward this work.

Methods Semi-structured interviews and reviews of documentation were conducted in all health authorities in the South and West Region of England.

Results All health authorities viewed tackling inequalities in health as important; however, explicit strategies did not exist and Health of the Nation targets were a vehicle for determining priorities of inequalities. Explicit corporate commitment was often weak. Analyses were being conducted to determine the magnitude of local health inequalities and to assist in designing appropriate interventions. The importance of alliance working was highlighted; much work was being done although success was variable.

Conclusions Efforts are being made throughout the South and West region to tackle inequalities in health. Although strategic vision at the corporate level was often lacking, there was evidence of commitment to tackling the inequalities agenda forward within public health directorates. Strengthening of primary care and alliance working roles is essential. Recent national strategy documents, forthcoming legislation, and a review of health inequalities recognize the health effects of inequalities and require health authorities to collaborate with local partners to tackle these, and will offer opportunities to improve corporate commitment and alliance working. Uptake and success of these opportunities will have a major influence on progress in tackling health inequalities.

Keywords: health inequalities, health authorities, alliance working, government strategy

Introduction

Since the 1980s much research has accumulated on the strong, positive associations between inequalities and ill health,¹–³ including research demonstrating that the health gap between the affluent and deprived is widening.⁴,⁵ The previous health strategy for England, The health of the nation,⁶ noted that effective strategies for health improvement need to be sensitive to variations in health, and guidance was issued to health authorities (HAs) on reducing such variations.⁷ Nevertheless, there was no target on inequalities in the health strategy and little information on effective interventions.⁸ However, the growing body of evidence on the relationship between socioeconomic inequalities and ill health has re-energized the drive to tackle inequalities.⁹ Accumulating evidence also resulted in the establishment of a Chief Medical Officer working group to advise the Department of Health (DH) and the National Health Service (NHS) on what it should be doing to tackle variations in health. The findings of this group were published in 1995 in Variations in health: what can the Department of Health do?¹⁰

Cumulative differential exposure to health-damaging or health-promoting environments was cited as the main explanation for the observed variations in health and life expectancy, with social mobility, health behaviours, health services use, and genetic and biological factors also contributing. In light of these variations, section 7.14 of Variations in health recommended that:

1. HAs and general practitioner (GP) purchasers should have a plan for identifying and tackling variations in health, and for evaluating interventions;
2. the plan should include provision for working in alliance with other relevant bodies;
3. HAs, GP purchasers and Trusts should take steps to monitor access to services to safeguard equitable access;
4. the DH should hold the NHS to account for implementing these recommendations.

Accordingly, the South and West Regional Office (SWRO) of the NHS Executive (NHSE), covering the counties of Cornwall, Devon, Dorset, Gloucestershire, Hampshire, Somerset, Wiltshire, the former county of Avon and the Isle of Wight,

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undertook to assess progress made by HAs in tackling variations in health. Specific objectives of this exercise were:

1. to determine action by HAs to identify and quantify local variations in health;
2. to determine whether HAs have tools in place to monitor and evaluate progress in tackling variations in health;
3. to report areas of good practice, innovation and success, and also failures and barriers to progress.

The election of the Labour government in May 1997 and the early commitment made to tackle inequalities in health boosted further the importance of undertaking this review as a way of assessing baseline activity, which could be subsequently reviewed in the light of future national policy. This paper presents the findings of meetings with the Directors of Public Health (DsPH) and colleagues from the 12 HAs in the South and West (S&W) Region.

Methods

The topic was first broached with the HA Chief Executives from the S&W Region, who gave support for a series of meetings between representatives of the SWRO and the HAs. The 12 DsPH, who were also keen that this exercise took place, were asked to invite individuals who they felt should attend, including members of their own and other HA departments, and representatives from other relevant agencies. The template for performance managing the Health of the Nation targets was adapted for this task and the meetings took the form of semi-structured interviews. Areas covered at each meeting included: (1) awareness and priority of inequalities in health; (2) strategies for reducing health inequalities; (3) ownership of the agenda and corporate commitment; (4) measuring inequalities; (5) alliance working: the role of primary care; (6) alliance working: other agencies; (7) access to care; (8) influencing contracts; (9) research; (10) evaluation of initiatives; (11) problems encountered by HAs; (12) examples of local activities. Each of the 12 areas was explored in detail; initially, the answers given by the attendees were written down, and they were then discussed in detail. Where opinions were offered we tried to substantiate these by requesting supporting evidence, e.g. DPH annual reports, local policy documents, minutes of meetings, reports of specific projects, collaborative initiatives, scientific papers and jointly signed reports. The views of those present at each of the meetings supported as above were analysed to give a unified view of what was happening in each locality. The key issues and common concerns across the 12 HAs were then synthesized to present an overall regional picture.

Results

Table 1 shows the numbers attending the meetings from each discipline. As well as DsPH and public health physicians, there were also health promotion and health information professionals. However, other HA executives, local authority (LA) representatives and primary care colleagues were seldom present. The findings therefore largely represent the views of the HA departments of public health.

An overall regional synthesis of key issues and concerns is presented to reflect the 12 areas discussed at each meeting as detailed in the Methods section.

Awareness and priority of inequalities in health

The issue of inequalities in health was felt to be extremely important within departments of public health of HAs. There was universal awareness of the impact of inequalities on health, and the priority of this work was very high as evidenced by the extensive analyses, and completed and continuing projects in many HAs.

Strategies for reducing health inequalities

No HA had a specific strategy for tackling inequalities. Nevertheless, inequalities were frequently addressed in other strategic documents such as local Health of the Nation service plans, and joint working documents such as anti-poverty strategies. The issue was also addressed in DPH annual reports, local policy documents, minutes of meetings, reports of specific projects, collaborative initiatives, scientific papers and educational material. The weaving of an inequality in health thread through the various local health service activities was felt to be an effective way of maintaining an awareness of health inequalities.

Ownership of the agenda and corporate commitment

Despite the claimed importance that HAs assigned to health inequalities, a major barrier in addressing the problem was lack of HA corporate commitment, reflected in an absence of wider ownership at the executive and non-executive director level of the HA. This resulted in lack of explicit priority given to tackling inequalities, with work being undertaken under the umbrella of the Health of the Nation targets. The opportunities

<table>
<thead>
<tr>
<th>Job description</th>
<th>Number of HAs fielding these individuals</th>
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<tr>
<td>Directors of Public Health</td>
<td>12</td>
</tr>
<tr>
<td>Public health medicine consultants (including dental public health)</td>
<td>11</td>
</tr>
<tr>
<td>Public health medicine trainees</td>
<td>1</td>
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<tr>
<td>Health Authority managers</td>
<td>1</td>
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<tr>
<td>Health promotion</td>
<td>2</td>
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<tr>
<td>Information managers or researchers</td>
<td>9</td>
</tr>
<tr>
<td>Local authority representatives</td>
<td>1</td>
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<tr>
<td>Other Health Authority Executive Officers</td>
<td>1</td>
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to debate inequalities at board level were seldom taken up. All DsPH welcomed the recent raised profile of tackling health inequalities as a means of furthering corporate commitment and engaging a wider ownership of the agenda.

Measuring inequalities
Often the first step in identifying inequalities was to analyse routinely available data. Each HA had conducted, or was planning, analyses of the association between factors such as age, sex, social class and area-based measures of deprivation, and health. Supplementary data were often collected through health and lifestyle surveys and locality profiles to give a fuller picture of inequalities in health. By combining the information gathered, a locality dataset could be constructed, which then formed the basis for local needs assessment.

Although socioeconomic inequality was the most common and important variable assessed, much work had been undertaken to understand and address other factors contributing to health inequalities. Examples include the following.

Age
For the elderly, transport is a potential source of inequity; expensive and unreliable public transport may mean having to rely on the car to obtain access to both health care and other resources recognized as important for health such as shops, libraries and recreational facilities. Also, as the elderly are more likely to be unable to drive, they are exposed to the worst health effects of this inequity, especially in rural areas.

Gender
The issue of poor access to coronary artery bypass grafting for females had been examined in several HAs. Similar concerns had more recently arisen around the prescribing of statins.

Urban–rural differences
Rural poverty is often hidden, and consequently unaddressed, and yet it exists at levels comparable with poverty in urban areas. In HAs with proportionately large rural populations the standard deprivation measures were not always appropriate for identifying rural poverty, partly as a result of the small populations in rural areas.

Minority groups
Although the South and West does not have a large ethnic population, certain groups, such as people living in the Forest of Dean and travelling communities, may often have reduced access to health services. Sometimes this is a choice on the part of the individuals concerned but it can nevertheless have detrimental effects on health.

Prisons
Local prisons were recognized as being areas of extensive health inequalities. Problems highlighted included the lack of comprehensive services for prison inmates especially in the area of mental health. However, health promotion within prisons has often been good, with well-established initiatives in the areas of HIV and AIDS, sexual health and drug misuse. Currently, HAs do not have statutory responsibility for the provision of prison services and there was concern that should they be given this duty there would be major resource implications.

Alliance working: the role of primary care
This topic was explicitly addressed by a minority of HAs. There was acknowledgement of the need to work closely with GPs and to improve their understanding of, and role in, tackling health inequalities. However, it was generally felt that few GPs viewed health inequalities as a priority area. For inner city GPs, lack of access to services was a more pressing concern than tackling inequalities per se. Concerns about the difficulties of inducing GPs to work in deprived areas were expressed; salaried GPs were considered an important means of improving the level of equity in care in deprived localities. Ways of strengthening the role of GPs were sought, particularly efforts to encourage GP practices to develop the role of addressing locally determined needs. The difficulties of allocating resources at a primary care level on the basis of need were felt to be enormous and it was recognized that GPs should be aware of, and involved in, this task.

Alliance working: other agencies
Working with other agencies was viewed as crucial, both to overcome the limitations of what HAs alone could achieve and to improve awareness in these agencies of their role in reducing inequalities in health. Strong, well-functioning multi-agency links were also a means of avoiding duplication of work. Most often alliance work was with the LA, particularly the departments of housing, social services, education and transport, but also the police and probation services. Reported success of these contacts varied from excellent, with evidence of commitment and ability to influence health and combat inequalities, to poor, with frustration with different agendas, difficulty in communication and therefore little positive action. Overall it was felt that there was a need for a better integration across agencies. Further development of the roles for the police and voluntary organizations was viewed as important. Although not yet well developed there were signs that links were being made with private business, and a small number of projects, aimed specifically at reducing health inequalities, financed by the private sector, were being undertaken.

Anti-poverty strategies
All HAs believed that a central plank in tackling inequalities in health through alliance working is the development of anti-poverty strategies. HA representatives stated that it was essential for LAs to understand the health consequences of poverty and their role in alleviating them. Where LAs had an anti-poverty strategy and were keen to work with the HA, this was seen to be advantageous in tackling inequalities.
Access to care
As well as the poorer access for females to coronary surgery, and possibly statins, there were also other concerns about equity of access to care. One HA found a recent rise in the number of admissions to cardiothoracic specialties for the population registered with GP fundholders (GPFHs) at the expense of those not registered with fundholding practices. A review of the provision of cardiothoracic services was being carried out by the HA to determine the appropriate level of activity for each population group. However, another HA found no evidence that hospital admission rates for conditions that might be more common in deprived populations (cardiorespiratory disease, diabetes, asthma, severe mental illness and selected paediatric conditions) were systematically lower for relatively deprived practices compared with more affluent practices. In many HAs there were continuing studies of potential inequity in access to health services.

Influencing contracts
All HAs reported limited success here, and stated that it was rarely possible to influence the inclusion of health inequality findings into the secondary care contracts.

Research
In addition to service commitments much empirical research was also taking place throughout the region, illustrating that HAs have a valuable contribution to make. Some HAs are well positioned to collaborate with the large academic centres but even where this was not the case grants had been sought and awarded. Several HAs, however, reported that increasing distance from an academic centre reduced the likelihood of receiving funding.

Evaluation of initiatives
There was recognition of the need for valid and measurable performance indicators, at all levels of care. One HA has put together outline proposals for future action in the area of inequalities. These proposals are comprehensive and cover the areas of planning, resource allocation and activity analyses, management arrangements, rural deprivation, access to services, health promotion and community development. Emphasis is laid on work by the HA and GP practices, with both being required to prepare plans that identify ways of tackling inequalities. However, on the wider role of evaluating local initiatives there was a paucity of well-evaluated work that clearly identified health benefits or disbenefits to local populations.

Problems encountered by HAs
The most often cited major obstacle to success was the then current organizational ideology wherein inequalities were not explicitly seen as part of the health framework. There was also concern over the uncertainty that exists about continuing information flows with, for example, the development of unitary authorities, and in general it was felt that trying to develop and sustain partnership working through repeated LA and HA reorganization was difficult. There was concern over funding and recognition that to tackle ingrained socioeconomic deprivation there was a need for a large level of sustained interest and resources. Currently, local partners were unable to meet this investment and relied on small pots of short-term funding.

Examples of local activities
Examples of the range of projects being undertaken throughout the region are shown in Table 2. Here we wished to highlight the diversity and breadth of work being carried out locally and the extent of alliance working. The following factors were considered in selecting activities: relevance to tackling local need; evidence of effective alliance working; inclusion of evaluation component; innovation of approach.

Discussion
Although the South and West is a generally affluent region each HA contains areas where the effects of socio-economic differentials are obvious and often stark. The priority for tackling these inequalities in health was high throughout the region and despite the lack of both previous national and sometimes HA corporate commitment, and the absence of local inequalities plans or strategies, excellent work had been and was being conducted.

Local determinants of health were described through extensive analyses and research. These had led to the design and implementation of a wide range of local work to tackle inequalities, taken forward on a multi-agency basis. However, there was poor engagement of primary care and little evaluation of these activities.

Access to health services was being monitored in a limited way across the region to examine whether access to care is equitable and appropriate. Unfortunately, despite the substantial research that has been carried out, there has been little influence on the contracting process, with failure to put research findings into service specifications.

Strengths of the study included (1) the use of a semi-structured questionnaire, validation by supporting documentation, and having the same two interviewers for all visits; this ensured consistency of approach and cross-checking of the information presented; (2) the importance of engaging the HA in the process through the Chief Executives and DsPH, which ensured joint ownership of the process.

The major limitations were two-fold. First, the findings included here largely represent the viewpoint of HA departments of public health. There was poor attendance by other HA staff, primary care members and non-NHS partners. This could potentially bias the information presented. Second, it was
Recently, there have been encouraging national developments, which bode well for such progress. These include the appointment of a Minister for Public Health and the commissioning of the Independent Inquiry into Inequalities in Health. Further evidence of the renewed commitment to tackling health inequalities is found in recent national policy and strategy documents including:

- the Government White Paper *The new NHS*, which requires HAs to develop Health Improvement Programmes (HIMPs)

### Table 2 Examples of local action

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<tr>
<th>Setting</th>
<th>Example of local action</th>
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<tr>
<td>The community</td>
<td>• In Cornwall and the Isles of Scilly a project to support improvement of damp housing, to combat childhood respiratory conditions, has been carried out, resulting in a significant improvement in the respiratory symptoms of the children with asthma and a significant reduction in the loss of days from school because of asthma</td>
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<td>• Wiltshire HA was involved in a national study to devise ways of measuring the often hidden but prevalent problem of poverty in rural England; one aim was to establish the extent to which key Census indicators relate to the distribution of income support claims at ED level, thus identifying pockets of poverty, and to construct an index of low income and then test it in a number of rural districts</td>
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<td>• Healthy Rushmoor is a 5 year strategy in conjunction with an LA to improve health in a borough of North and Mid Hampshire; a multidisciplinary framework for action at all levels of health and health care is used to improve the health and quality of life of local citizens</td>
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<td>Primary care</td>
<td>• In the Isle of Wight HA GP practice indicator data are being used to address the area of quality and performance in primary care by allowing comparison of the indicators of individual practices or practitioners with the average performance, to encourage questions about appropriateness of the service provided</td>
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<td>• Knowle Health Park, implemented by Avon HA, includes both primary care facilities and also services that respond to the community’s needs; a key objective is to move the emphasis of health services from cure to prevention, and to help people be active for their own health; objectives are to be met through partnership working with LA, hospitals charities and the local community</td>
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<td>Secondary care</td>
<td>• In Southampton and SW Hampshire a study found a recent rise in the number of admissions to cardiothoracic specialists for the population registered with GP fundholders (GPFHs) at the expense of those not registered with GPFHs; a review of the provision of cardiothoracic services was being carried out by the HA to ascertain the appropriate level of activity for each population group</td>
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<td>Alliance work</td>
<td>• Dorset HA has developed charters for health to address a broad range of areas that combine to produce inequalities in health</td>
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<td>• In Gloucester HA the safer driving with age (SAGE) project involves a test of eyesight, review (by a pharmacist and GP) of drugs and their effect on ability to drive, knowledge of roads, vehicles and Highway code, and practical driving ability; the project aims to increase safety on the roads and to ensure that any problems for this age group can be tackled in a positive manner so that older people can continue to drive</td>
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<td>• Research has been carried out in S&amp;W Devon HA to determine how best to incorporate community development (the process by which people are involved in collectively defining and taking action to grow and change according to their own needs) into a local health strategy; issues highlighted included the need to balance the positive aspects of enabling communities to identify and take action on issues to improve health with potential negative aspects such as manipulation of the agenda and the problem of raising unrealistic expectations</td>
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<td>• In Somerset a pilot project setting up low-cost child safety equipment has been launched; the aim of the project is to prevent morbidity and mortality in children, through a multidisciplinary approach to accident prevention; the project is directed at individuals with a high likelihood of having an accident given their risk factors</td>
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<td>Reports</td>
<td>• Portsmouth HA compiles a community health atlas, which brings together work on several aspects of health, and disseminates it to potential users to give a fuller understanding of the local population health and health care needs as well as being useful in the role of advocacy of the inequalities agenda</td>
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<td>• In 1996–1997 the N&amp;E Devon HA annual report took the form of a poster with the focus on variations in health; the poster, which showed a map of the HA, highlighted factors that affected health: geography, social class, gender, age and employment, and the action needed to combat any deleterious effects of these variations was used, as it was felt the annual report would then be more accessible and widely read</td>
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with local partners to identify local inequalities, set targets for reducing these and put in place programmes of action;
- the NHS Health Act, which allows pooling of budgets across local partners;
- the recent White Paper, Saving lives: Our Healthier Nation,15 which emphasizes the wider determinants of health and the need to tackle inequalities in health through local, regional and national partnerships;
- the Social Exclusion Unit reports.16–18

In addition, the National Priorities Guidance 1990/00–2000/01 set a shared objective for the NHS and Social Services to tackle local inequalities in health.19 These wide policies have also been supported by a raft of area-based initiatives to support local activity including Health Action Zones, Sure Start and Healthy Living Centres.

The recent Independent Inquiry into Inequalities in Health summarized the evidence of inequalities in health and identified priority for future policy development and cost-effective and affordable interventions to reduce health inequalities.13 Despite some criticism of the document,20 the main recommendation that ‘all policies likely to have a direct or indirect effect on health should be evaluated in terms of their impact on health inequalities, and should be formulated in such a way that by favouring the less well off they will, wherever possible, reduce such inequalities’ provides a framework by which government and other national, regional and local organizations could review current and future policies.

Progress in the area of health inequalities will ultimately be shown by absolute reductions in avoidable morbidity and mortality among those in the most deprived groups. Factors such as the commitment of HA staff to the inequalities agenda, the setting of priorities, awareness raising, detailed and informative analyses, implementation of interventions and alliance working are clearly important in achieving this goal. It is to be hoped that recent national initiatives for tackling socioeconomic differentials in health will allow and encourage HAs and new local partners to fully embrace their role and act to remove inequalities. Nevertheless, as highlighted by Acheson, a more strategic approach is required and will be an important marker of HAs seriously tackling this issue.

References
12 Dorset Health Authority. Deprivation and health in Dorset. Ferndown: Dorset Health Authority, 1996.

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