

Shaping healthy communities: a report on the second symposium on the role of local authorities in reducing health inequalities.

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SHAPING HEALTHY COMMUNITIES II

A report on the second symposium on the role of local authorities in reducing health inequalities

How effective Local Authorities are being in reducing health inequalities: strengths and future action

Symposium convened by Sheffield City Council 20th July 2009



Introduction

Sheffield City Council achieved Beacon Status for its work on reducing health inequalities in 2007. The Council is hosting a series of three symposiums to promote more effective dialogue and action in this important area of local authority (LA) business.

The first symposium - was held on 5th November 2008. This aimed to share an understanding of what works in tackling health inequalities and how, collectively, the region can develop significant and sustainable programmes of work in this area. A report of the symposium was compiled by staff of the Centre for Health and Social Care Research at Sheffield Hallam University; it is available from <http://www.sheffieldfirst.net/our-partnerships/health-and-wellbeing-partnership/healthy-communities>.

The second symposium - was held on 20th July 2009. Its focus was LA practice in tackling health inequality: what are they doing well and where could practice be improved. This document reports from the second symposium.

The third symposium - will be held on 27th November 2009. Its focus will be on the future for healthy public policy in local authorities.

Overview

The aim of the second symposium was to share good practice. In the same way, this report aims to be of use to those who are concerned with tackling health inequality at LA level. It is divided into four main sections.

- Background - key points from the first symposium plus details of the speakers at the second symposium;
- Making the case - having a shared commitment within the LA to tackling health inequality;
- What works - this section sets out what has worked well for LAs tackling health inequality; some specific examples of good practice;
- Summary - a short list summarising the key points followed by a list of further resources.

Background

Key points from the first symposium

- The international agenda on health inequality has been set by the World Health Organisation (WHO). In its 2008 Report it states that: "Achieving health equity within a generation is achievable, it is the right thing to do, and now is the right time to do it" (CSDH 2008). Nationally, this agenda is being taken forward by the Marmot Commission, which is due to report finally in February 2010 following a consultation period. A first phase report was published in June 2009.
- Health inequality is LA business. The causes of health inequality include factors such as housing, transport, social capital and the environment. Many of these are beyond the remit and resources of the National Health Service (NHS) but are almost always within the scope of Local Authority (LA) business. It follows that LAs have an important role to play in tackling health inequality.
- Locally, both Local Authorities and Health bodies are working on the agenda of reducing inequality. Sheffield has been a WHO "Healthy City" since the late 1980s; inequality is part of this agenda. Nationally, inequality has moved to the fore, as illustrated by the White Paper Choosing Health (Department of Health 2004).
- The WHO defines good health in broad terms, to include physical, mental and social wellbeing (see below). It follows that work on health inequality needs to address more than people's material conditions; for example, also crucial is the control people have over their own lives.
- We cannot rely on improvements in health and economic status for the privileged sections of society to ratchet up the status of the least privileged. Some societies have great wealth but very poor health and economic status for the least well off; and there are other wealthy societies with far less inequality. The UK is at the wrong end of the continuum here, suggesting that progress is possible (Mackenbach 2006).

Delegates at the first symposium also set out in broad terms the steps that LAs could take in tackling health inequality.

The second symposium

The second symposium focused on what is being done locally, what works and what could be done better. There were three speakers and around thirty delegates, who came from a variety of LA and NHS organisations in the South Yorkshire and Trent region. Councillor Gail Smith greeted the delegates and outlined the background and objectives of the symposium. The meeting was chaired by Kieron Williams, Interim Director of Health Improvement, Sheffield City Council.

The speakers at the symposium were

Mike Grady, Senior Research Fellow, University College London. Mike Grady is currently with the Marmot Review Team. His talk concerned the process, evidence and themes of the Marmot Review, Strategic Review of Health Inequalities in England post-2010.

David Quinney, Advice and Assistance Lead, Northern Region, Audit Commission. One of the key issues for the Commission in the forthcoming Comprehensive Area Assessments (CAA) is how public agencies, such as LAs and Primary Care Trusts (PCTs) are addressing health inequalities with their partners. David Quinney's talk focused on this aspect.

Tony Elson, Adviser on Local Government, Broomstile Consultants Ltd. He is an adviser to the Department of Health's Health Inequalities Unit and to the Improvement and Development Agency's (IDeA's) Healthy Community Team. In the latter role, he is involved with peer review of local authorities assessing current achievements and capacity to change in relation to the healthy communities programme. This work includes looking at how LAs tackle health inequalities and empower communities. Tony Elson drew on this work in his talk about what is effective.

What works for Local Authorities tackling health inequality?

1. Making the case

Tackling health inequality requires a shared commitment from different departments and individuals in the LA; for example those in the Highways department should think that health inequality is part of their business. This point was made in the first symposium. However, in this symposium the importance of the health inequality gradient was introduced.

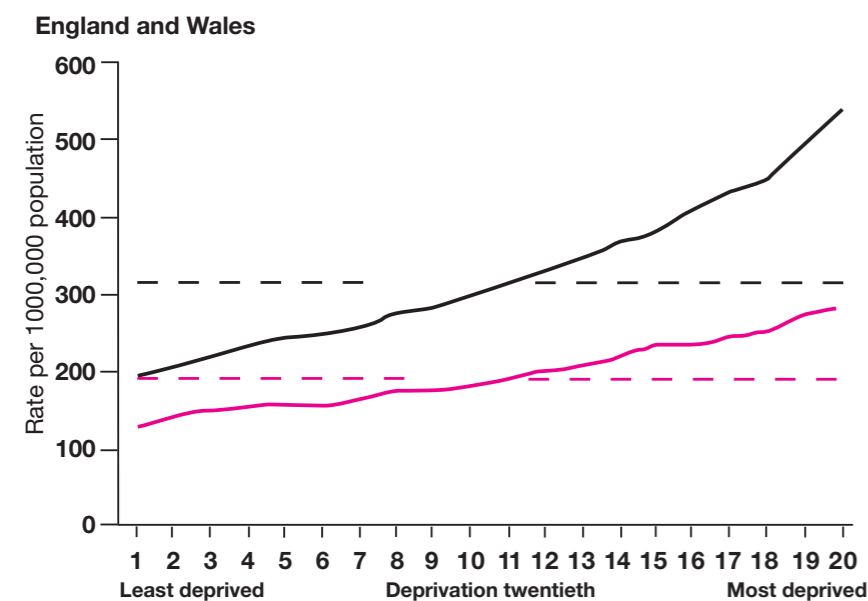
The health inequality gradient

Much health inequality is experienced as a gradient. In the lowest ten percent there are those who suffer the worst health; but in the next ten percent are those who suffer poor health when set against the average, and so on. A society with a high level of health

inequality will have steep gradients across many measures. Mike Grady's talk showed that this is the case for the UK in many areas, such as mortality and children's cognitive development.

It is tempting to think that tackling inequality involves targeting help for those at the bottom of the pile. However, if we do this, the slope itself remains. Tackling health inequality involves attempts to reduce or remove the slope. In theory this could be done by trying to reduce the health of those at the top of the slope; but this is clearly unacceptable.

Therefore, tackling health inequality involves helping all those beneath the top of the slope. Those at the bottom might need the most help, but we should not ignore those higher up the slope.



Deaths rates (age standardized) for all causes of death by deprivation twentieth, ages 15-64, 1999-2003, England and Wales: The dashed lines are average mortality rates for men (black line) and women (pink line) in England and Wales: Source (Baker, Griffiths and Romeri 2006)

Social Justice and Equity versus Charity?

The First Phase Report of the Marmot Review was published in June 2009. It addresses several of the questions that are set out in its original remit, the first of which is, "Are the principles and values of social

justice the right approach to addressing the social determinants of health inequality?" The first phase report acknowledges the importance of values and their importance in tackling relative inequality and of addressing the gradient of health inequality. A key difference here is between the values of charity and of equity (or social justice) (see Box 1).

BOX 1 Charity or Equity

Charity: We should help the neediest on a discretionary basis;

Equity/social justice: We should create a fairer distribution of social goods as a matter of duty.



(left) Source Needham, Geo C. "Street Arabs and Gutter Snipes" (1884)

(right) Statue of Iustitia by John Massey Rhind, Shelby County Courthouse, located in Memphis, Tennessee. Photo by Einar Einarsson Kvaran October 2006 (UTC) .

This raises a political issue. In discussion, Mike Grady was asked how the response to the Marmot Review would be affected by the difficult economic climate and by a possible change in Government in 2010. In the background is the memory of the burying of the Black Report in 1980 (Townsend and Davidson 1982). Mike Grady said the Commission was being careful to engage a wide range of people and organisations; it is consulting widely with the stakeholder organisations, politicians, civil servants other Government Departments, the third sector and Local Government. He said that the aim was to secure consensus in tackling health inequality across a range of stakeholders. Whilst he was talking about the national level, it clearly applies also at local level. Being aware of the equality/charity distinction is crucial; two parties might think they are agreeing on tackling health inequality but in reality one might be driven by charity and the other, equity. It is the equity and social justice agenda which is a key driver.

This is not necessarily easy. For some time the political environment has been one in which it is thought desirable for people to make large amounts of money provided that some of that trickles down to help the poorest. However, there are signs that the equity agenda is on the rise, particularly given concerns about social breakdown and so forth. The work of Wilkinson and colleagues, and affirmed by the Marmot Review shows how inequality itself is a problem, no matter how wealthy the society (Wilkinson 2005).

¹ See further information on Professor Green at http://www.shu.ac.uk/research/cresr/publication_downloads.html and Malcolm Whitfield at <http://www.shu.ac.uk/research/hsc/sp-malcolm-whitfield.html>.

There is at least one point that favours the equity motivation for Local Authorities. Help that is targeted only at the poorest few is often directed to particular electoral wards; this can look like favouring particular voters. The equity (or justice) agenda avoids this problem.

Justice is not enough

Many delegates felt, though, that equity itself would not be enough to make tackling health inequality a LA priority. Prospects for future public spending are bleak; there needs to be an economic case made for tackling health inequality. In relation to this, there was a consensus that LAs should make use of health economists. Precisely how they should do this was a matter for discussion: the suggestion that individual LAs should employ a health economist was thought unrealistic by some. However, collectively this could be possible. Health economists could also be employed on a consultancy basis on work conducted on a partnership basis by LAs, NHS, and third sector organisations. Several delegates referred to the work of Professors Geoffrey Green and Malcolm Whitfield¹, both of Sheffield Hallam University. An example of Malcolm Whitfield's work is given in box 2.

Box 2

A recent study in Sheffield explored the clinical and economic impact of investment in a public-health-based health-risk-reduction programme with particular emphasis on the potential return on investment in terms of acute episodes of ill health avoided, premature deaths avoided, acute hospital admissions avoided and revenue costs avoided. The study used a combination of evidence to construct a mathematical model which estimates the number of heart attacks, strokes, heart failure events and kidney failure events for a given population. The study concluded that reducing these population-level risk factors through changes in housing, transport, educational and environmental policies along with targeted public health programs could lead to a reduction in acute hospital admissions for heart attacks, strokes, kidney failure etc by around 2000 per year after 10 years. Around 200 premature deaths could be avoided each year after 10 years and up to £6.5million per year could be saved on acute hospital admission costs alone (Whitfield, 2006)

Electoral and Commissioning Cycles

There was a further point underlining the need for shared commitment to tackling health inequality. Delegates pointed out that LA work is subject to cycles. One of these is the electoral cycle; LAs are subject to changes in their political make-up every three years. Another is the commissioning cycle. Work commissioned by LAs is usually on a fairly short-term basis, of months rather than years. By contrast, tackling health inequality is an issue that requires long-term planning and commitment. It follows that if the issue is not a shared commitment across the council, work can be undermined by political and organisational change. This point relates also to the previous one concerning health economics: work for tackling health inequality needs to find sources of sustainable funding.

2 What works - good practice

Link to wider agendas - globally

If the health inequality agenda can be linked to other LA priorities then clearly this strengthens the case for it. A number of examples, from global to local, were given and discussed.

On the global front, climate change is an issue of immense importance. It is also one which has strong links to health inequality in a number of ways (UKPHA, 2008). Theoretically, the concept linking the two issues is sustainability: sustainability in terms of the environment, the economy, the community and health. Wilkinson's work shows the link between sustainable health and communities: health inequalities undermine communities. However, environmental issues also link to health inequalities in at least two ways.

- Climate change is likely to affect the health of the worst off most: it is they who will suffer disproportionately from floods, disease, food shortage and so forth. As such, tackling climate change indirectly tackles health inequality, as does preparing for the affects of climate change.
- Some measures aimed at tackling health inequality have a side-benefit of helping the environment. An example would be measures aimed at tackling fuel poverty through conservation. Another example would be using local suppliers for school dinners.

Link to wider agendas - locally

There are links between health inequality and many other local issues with which agencies might be concerned. The police are concerned with road traffic accidents, binge drinking and domestic violence: these are all issues which contribute substantially to ill-health and to health inequality. The fire and rescue service is concerned with house fires which also contribute to ill-health and death and which affect the

poorest disproportionately. Furthermore, many house fires are related to smoking at home, itself a contributor to illness and to inequality. It makes sense, therefore, for health, LA and third sector agencies to work together in tackling these issues; to share expertise and resources. An example of such a scheme is given in Box 3. As well as this, the Fire Service in South Yorkshire has been involved in fire safety work with vulnerable older adults.

Box 3

Smoke-Free Homes: Smoking at home contributes greatly to the ill health of all who live at the home, including the children. Some of the risks arise from second-hand smoke, others from the risk of house fire. In 2002, a Smoke-Free Homes campaign commenced in West Yorkshire. Similar campaigns have been set up in Rotherham, Manchester and elsewhere. The basic idea of the campaign is to get people to sign up to not allowing smoking in their home or car. In Rotherham's case, this involves liaison between PCTs, the Fire Service, LAs and third sector all of whom recruit for the project. Alongside this, PCTs offer linked services to clients, such as stop-smoking clinics; whilst the Fire Service offer to visit clients' homes to do a fire safety check.

Innovation

Sheffield was given Beacon status in 2007 for its approach to tackling health inequality. It was among a number of Local Authorities and local services to do so. What these had in common was some form of innovation. For example, Liverpool Fire and Rescue Service was involved in several campaigns that were linked to public health, including an advocate scheme and a healthy home scheme. Some details of these schemes are in a report for the Beacon Scheme (Beacon Scheme, no date). In Sheffield, the Local Authority and NHS Sheffield have worked together on a number of schemes aimed at improving public health and reducing health inequality. These include:

- South Asian Taxi Driver service: this began as a screening programme which sought to target people who are at high risk of heart disease but who are unlikely to use other screening services; the scheme has since developed and NHS Sheffield is now running a training programme for South Asian male taxi drivers to become health champions.
- Enhanced Public Health Programmes (EPHPs) which provide resources and help in fifteen areas in which health is poorest. The programmes include projects aimed at increasing use of preventive health services, promoting healthy lifestyles and, importantly, tackling issues such as poor quality housing.

- Social marketing was mentioned by some delegates. This is the use of marketing techniques to achieve a social good. It seems of particular relevance in relation to behavioural change objectives such as stopping smoking rather than, say, improving the quality of housing. Marketing involves careful attention to demographics; social marketing could be used to affect behavioural change in different groups (such as ethnic or class) in the LA area. There has been a social marketing campaign in Doncaster that aimed to encourage people with persistent coughs to visit their GPs and ask for a chest x-ray. Initial indications are that this campaign has been successful. Social marketing can also inform new job roles such as health trainers or smoke-free homes coordinators.

Leadership

As well as a clear vision based on equity, tackling health inequality requires good leadership. One example of this is that some chief executives of primary care trusts (PCTs) have tackling health inequality as one of their personal objectives. LAs could act similarly. However, David Quinney and Tony Elson pointed out that it is not simply that tackling health inequality should be identified as a responsibility at senior level; at the operational level, the leadership and responsibility of others needs to be clearly stated to staff that have the power and capacity to deliver.

Using what is already there

There are many resources already available to LAs wanting to tackle health inequality. The following were mentioned:

Joint Strategic Needs Assessment (JSNA) is a collection of all the information available on the needs of the local population and analysis identifying issue and priorities. It has great potential as a tool for those developing a strategy for tackling health inequality. In Nottingham, the LA have developed a Shared Intelligence Network that helps in the delivery of the JSNA and other policies (see Box 4)

Voluntary, community and private organisations: these include local health groups, trade unions, businesses, churches and so on. They have the potential to help greatly with, for example, targeting particular parts of the community. This is important given that tackling health inequality involves looking a wide spectrum of people and groups, not just those at the lowest end.

Box 4

Nottingham City Council has developed a web-based intelligence network, the Shared Intelligence Network, hosted at www.nomadplus.org.uk. It is available to policy makers and analysts based in the public sector in Nottingham. Partners can share their strategies and underlying intelligence. The cooperation of partners ensures commissioning of services is derived from shared intelligence. The SIN has aided the development and delivery of many of Nottingham's key strategies and plans, including our Sustainable Community Strategy, the Joint Strategic Needs Assessment (JSNA) and the Children's Trust Needs Assessment. The sharing of local data through this network also allows partners to understand better the inequalities across the city. Simple mapping tools allow partners to see variations in indicators, such as educational attainment, life expectancy, crime rates and unemployment (across the LAA spectrum). The use of this local data informs operational plans and aids research and policy development around service provision.

[Example provide by Liz Jones, LAA Programme Manager, Nottingham City Council

3) Evaluation

Consistent targets

Given that LAs are subject to a wide range of internal and external scrutiny, it is important that they are evaluated consistently and unambiguously. For example, a target might be set that asks the LA to ensure that its health inequality programmes help the neediest in its area. This has an ambiguity that can be described in terms of the equity/charity discussion mentioned earlier. To be consistent with a charity agenda, such a target would require this be true of each programme; to be consistent with an equity agenda, it need only be true of the programmes overall.

Outcomes not outputs

David Quinney drew a distinction between outputs and outcomes. Roughly, outputs are means to an end and outcomes are the ends themselves. In relation to health inequality, numbers attending diabetic clinics would be an output, reducing the disparity in the level of diabetes between ethnic groups would be an outcome. Wherever possible, LAs should focus on outcomes in their targeting of actions and evaluation. Some outcomes might take too long to occur to evaluate in the short term; if large numbers stopped smoking today, some benefits might not show for many years. In such cases, there are usually fairly reliable markers that can be used to show progress towards the outcome. For example, reducing the level of smoking in a community is a reliable marker for reducing lung cancer deaths in the future.



Summary

Many LAs are already doing much to tackle health inequality; their experience and knowledge is invaluable.

Tackling health inequality requires a long-term commitment from LAs. It follows that the agenda must be widely accepted. That agenda implies a commitment to reducing the health inequality gradient, not just helping the worst off: this is a commitment to equity rather than charity.

LAs also need to show that money spent on tackling health inequality is repaid, that it is cost effective. Health economists will be helpful in making this case.

The health inequality agenda can be usefully linked to: 1) Other LA agendas such as global warming, crime reduction and preventing house fires; 2) The work of other public sector agencies, particularly the NHS; and 3) The work of the third sector.

There is great scope for innovation: some examples are given above but links to the third sector will probably lead to the greatest inspiration and source of innovative projects. Social marketing may also be a useful tool in reaching different groups.

The evaluation of programmes requires consistency of targets. Further, LAs should be concerned with more than mortality and the absence of disease; good health has many other elements that should be captured in evaluation.

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Beyond mortality

Life expectancy and death rates are both commonly used markers of health inequality. Clearly, they will remain very important. However, they may not show all the significant elements of the problem. For example, people may have a poor quality of life but live a fairly long time in that state; resilience is a virtue but it should not be allowed to hide inequity. Furthermore, mental illness will not necessarily be shown on death-related statistics. As such, it is important also to collect data on the impact of chronic illness on people's lives, for example, on employment. Furthermore, it is worth recalling that the WHO defines health very broadly:

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.²

In thinking about health inequality we should think beyond absence of disease and towards other relevant markers of quality of life, such as educational achievement. Delegates emphasised the need for qualitative as well as quantitative research. This could be used to provide narratives of a) What health inequality really means for people at the wrong end of it and b) How health inequality programmes have affected people's lives. Mike Grady pointed out that health inequality was not simply a function of income inequality (although in large part it is). He referred to the work of Artazcoz (Artazcoz et al. 2005) which shows that having insecure contracts of employment has a deleterious affect on mental health.

Boast drawer

Tony Elson said that all LAs should have a boast drawer in which is held details of their achievements in tackling health inequality; and these should be of outcomes not outputs. Below this boast drawer, LAs might also consider an aspiration drawer.

² Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

Further resources and weblinks

Equality and Human Rights at Department of Health

www.dh.gov.uk/en/managingyourorganisation/equalityandhumanrights

Kings Fund

Report of a seminar held by the King's Fund with the London Health Observatory: Equitable Commissioning **Equality and Human Rights at Department of Health**

www.dh.gov.uk/en/managingyourorganisation/equalityandhumanrights

Kings Fund

Report of a seminar held by the King's Fund with the London Health Observatory: Equitable Commissioning for a Diverse Society: are we using the right intelligence?

The seminar was held in June 2007 to discuss the challenge of equitable commissioning for ethnically diverse populations and explore what data and intelligence is needed by commissioners in order to commission well. The focus of the day was on ethnicity data in the NHS in England, although it was recognised that similar, if not greater, challenges lie ahead in relation to data collection and use relating to disability and sexual orientation.
<http://www.kingsfund.org.uk/go.rm?id=20582>

NHS Constitution

http://www.dh.gov.uk/en/Healthcare/NHSConstitution/DH_093184

MIGHEALTHNET

Part of an EU Project that aims to give professionals, policy makers including health authorities, researchers, educators and representatives of migrant and minority groups easy access to a dynamically evolving body of knowledge and a virtual network of expertise.
http://mighealth.net/uk/index.php/Main_Page

Mosaic: equality procurement for the NHS

The Mosaic project team work with key stakeholders in the NHS supply-chain to promote equality in and through procurement. Funded by the Department of Health, it works with staff, suppliers and interested parties to align efficiency and equality goals. It also looks at facilitating greater links between the procurement and commissioning processes and the need to look at the wider equalities agenda in relation to effective healthcare.
<http://www.mosaic.nhs.uk/>

Pacesetters Programme

Pacesetters is a partnership between local communities who experience health inequalities, the NHS and the Department of Health (DH). The Equality and Human Rights Group (EHRG) of DH is working with six strategic health authorities (SHAs) on the programme including Yorkshire and the Humber.
<http://www.dh.gov.uk/en/Managingyourorganisation/Equalityandhumanrights/Pacesettersprogramme/index.htm>

Making the difference: The Pacesetters beginner's guide to service improvement for equality and diversity in the NHS (2008) is available here:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PolicyAndGuidance/DH_086039

Strategic Review of Health Inequalities in England Post 2010 (Marmot Review)

The Review follows the publication of the global Commission on Social Determinants of Health, also chaired by Sir Michael Marmot and published by the WHO. The CSDH advocated that national governments develop and implement strategies and policies suited to their particular national context aimed at improving health equity. The English review is a response to that recommendation and to the Government's commitment to reducing health inequalities in England. The aim of the Review is to propose an evidence based strategy for reducing health inequalities from 2010.
<http://www.ucl.ac.uk/gheg/marmotreview>

Symposium Programme

Welcome

Councillor Gail Smith

Strategic review of health inequalities in England post 2010

Michael Grady

Messages from the Audit Commission's work on health inequalities

David Quinney

Messages from the Improvement and Development Agency (IDeA) local authority peer reviews

Tony Elson

Discussion

Panel and delegates

Summary

Kieron Williams



SHARPENS YOUR THINKING



2008-2009
Reducing Health
Inequalities