



Policy briefing – July 2010

# Tackling Health Inequalities

## SUMMARY

In 1997 when Labour came to power, one of their key objectives was to Commission an inquiry into health inequalities. This was known as the Acheson Inquiry and it paved the way for understanding the wider determinants of health, and provided a context on which future policies could be based.

The Marmot Review published in 2010, built on the Acheson Inquiry but also concluded that health equality was a matter of social justice, stating *'that the conditions in which people are born, grow up, live and work are responsible for health inequalities'*.

Statistics for Kensington and Chelsea in 2008 found that the health inequality gap had widened between the four most deprived wards (St Charles, Golborne, Notting Barns and Colville), all in the north, and the rest of the borough.

This was because the pre-mortality rate (death under 75 years of age) for the whole of the borough had improved much quicker than the London and national averages, particularly in areas such as Queen's Gate and Brompton.

Inclusion Health, published by the Government in 2010, states that there must be strong leadership and a strong workforce to drive up standards in meeting the health needs of the socially excluded.

The voluntary and community sector in Kensington and Chelsea also has a strong role to play in tackling health inequality. Through a collaborative approach, providing support to tackle the wider determinants of health, the sector seeks to bring about lasting change for the communities living in the borough.

## Introduction

When looking at the Department of Health targets on the progress on health inequalities, the Centre for Parliamentary Studies report that since 1999 there has been some improvements in terms of lower rates of infant mortality and longer life expectancy for all groups and areas. However, the Centre also states that the gap between the disadvantaged groups and areas and the rest of the population has remained. Evidence shows that standards have improved in health for people in disadvantaged groups but narrowing the gap between these groups and the rest of the population has proved to be more difficult.

The challenge of tackling health inequality is not an issue that should be looked at in isolation. The context of health inequality needs to take into account a much broader approach considering the relevance of social justice alongside the health needs of the individual.

The Centre for Parliamentary Studies reports that programmes such as Sure Start, the Child Poverty Strategy and Neighbourhood Renewal were all based on the wider social determinants of health that impact on poverty and health inequality. It was found that tackling housing and overcrowding and reducing child poverty all had a direct impact on achieving success in reducing infant mortality.

However, the Centre states that one of the issues with particular programmes that aim to improve health is that it is the advantaged groups rather than the disadvantaged that tend to benefit the most. This is because advantaged groups are likely to have greater awareness and knowledge of how to use the system.

## How to tackle health inequality

The Centre for Parliamentary Studies reports that around the country there have been good examples of projects and programmes that have made a difference, but have also been unable to have a wide spread impact. Reasons for this have been that projects delivered at a local level often lack secure funding and organisation capacity. The centre suggests that a sustained long-term approach is required rather than one based on short-term and time limited projects and initiatives.

Suggested ways in which projects and programmes can achieve long-term sustainability are:

### 1. Local Partnerships

Well co-ordinated partnerships between the local authority, the local NHS and the voluntary and community sector can foster a shared vision and shared aims to make local projects work.

### 2. Local Strategic Partnerships (LSPs)

LSPs are the vehicle by which all local statutory and voluntary and community sector partners agree local priorities that reflect local need. There should be a joint approach through the LSP to tackling inequality embedded within local strategies.

### 3. Mainstreaming

Embedding action on health inequalities into the planning and performance regime of local statutory bodies should be necessary in establishing the issue as part of everyday business.

## **The Acheson Report**

The Acheson Report into health inequality was published in 1998; the report – ‘*Independent Inquiry into Inequalities in Health*’ was commissioned to review the latest information on inequalities in health and to identify priority areas for future policy development at that time. The report was a key influence on future public health policy and led the way for the Marmot Inquiry into health inequalities.

The Acheson inquiry adopted a socio-economic approach to health inequalities and made 39 recommendations. It found that between 1995 and 1997 and 2005 to 2007 there were improvements in health. For example, life expectancy had increased and infant mortality decreased. However, the health gap between those at the top and bottom of the social scale had widened.

The four main areas identified for development in the Acheson report were:

1. Wider social determinants such as poverty, employment and education
2. The life course (families, mothers and children)
3. Other dimensions on inequality such as ethnicity and gender
4. The role of the NHS

## **The Marmot Review**

In November 2008, Sir Michael Marmot chaired an independent review into health inequality. In the introduction to the Marmot Report, Kensington and Chelsea is highlighted, stating that in one ward a man can expect to live to 88 whilst just a few miles away in Tottenham Green, a man can expect to live to just 71. This reference to Kensington and Chelsea belies the fact that health inequality exists within the borough itself.

The Commission on Social Determinants of Health (CSDH) set up by the World Health Organisation, concluded that social inequalities in health arise because of a person’s position within society. Social standing in relation to money, resources and power all play a large part in determining that person’s health.

However, Marmot’s review is clear that health inequality is ‘*preventable by reasonable means and putting it right is a matter of social justice*’. The review also makes it clear that inequality in income in Britain is not the only reason for inequalities in health. There are other important factors linked to life chances that also affect health.

Marmot highlights in the review that clear evidence now shows that:

1. The conditions, in which people are born, grow up, live and work is responsible for health inequalities.
2. Early childhood experience impacts on health and disadvantage throughout life

3. The cumulative effects of disadvantage through life reveals a relationship between disease and ill health.
4. The more stress people suffer and the less control they have over their own lives reveals a relationship with negative health outcomes.
5. Mental well-being has a profound role in shaping physical health and contributing to life chances as well as being important to individuals and as a societal measure.

Factors such as decent housing, having enough money to eat and live healthy lives, living in a safe neighbourhood, support from family and friends and family history all play a part in determining health outcomes. Marmot states that these factors are also influenced by social position such as education, occupation, gender, ethnicity and race. These are in turn influenced by *'the social political and cultural context of the current time in which we live'*.

Marmot's review produced a framework for action which sets out ways to reduce health inequalities and improve health and wellbeing for all. To achieve this there are two overarching policy goals:

1. Create an enabling society that maximises individual and community potential
2. Ensure social justice, health and sustainability is at the heart of all policy making.

Beneath the two policy goals are six policy objectives relating to the main social determinants of health which are:

1. **Give every child the best start in life**

Marmot calls on the Government to increase the proportion of overall expenditure allocated to early years. The expenditure should focus proportionately across the child's early years from pregnancy through to primary school including early education and childcare.

2. **Enable all children, young people and adults to maximise their capabilities and have control over their lives**

Marmot states that in order for children and young people to maximise their potential there needs to be closer links between schools, the family and the local community. More work should be done to develop the skills of teaching and non teaching staff to work across home school boundaries. Training and skills development should be provided for once the child reaches the age of 16 and should be based within local communities.

3. **Create fair employment and good work for all**

Ensure that labour market programmes not only increase employment opportunities for the long-term unemployed but also that people are given quality jobs avoiding low paid, insecure and health damaging work.

4. **Ensure a healthy standard of living for all**

Marmot recommends that the current benefit system be overhauled to strengthen incentives for people to work. He suggests the redistribution of income and reduction of poverty through delivering a net tax cut to people who are not incentivised to work. Through increasing people's levels of income, Marmot states that people will then have enough money to increase their ability to adopt a healthier lifestyle.

#### **5. Create and develop healthy and sustainable places and communities**

Building healthier and more sustainable communities will strengthen people's resilience against poor physical and mental ill health. Marmot suggests investing in communities in a different way that builds social capital e.g. investing in new parks rather than new roads.

#### **6. Strengthen the role and impact of ill health prevention**

Marmot recommends that prevention in the wider context of the social determinants of ill health requires more than the responsibility of the NHS. It will require involvement of a range of stakeholders. Evidence shows that partnership working between primary care, local authorities and third sector organisations can bring important benefits to tackling ill health.

Underpinning these actions is the need for equality and effectiveness to be embedded in all policies and that there should be further development of evidenced based practice.

A question of how much the recommendations contained within the Marmot review can be afforded given the current economic climate still remains. However Marmot states that the case for action is a moral one and that the benefits of tackling health inequality will be of economic as well as social value.

## **HEALTH INEQUALITY IN KENSINGTON AND CHELSEA**

A report produced by NHS Kensington and Chelsea in 2007 - *'Is the Health Inequalities "Gap" in Kensington and Chelsea changing?'* looked at whether health inequality was getting better or worse locally. Using premature mortality (death under 75 years of age) as a measure of health inequality the report found that the premature mortality rates in the four most northerly deprived wards (St Charles, Golbourne, Notting Barns and Colville) had improved over the last 5 years, similar to the regional and national rate.

But when looking at the health inequality gap between the four most northerly wards and the rest of the borough, the gap had widened, due to the fact that the pre-mortality rates in the rest of the borough had improved much quicker than the London and national averages. This was particularly the case when comparing against Queen's Gate and Brompton wards and the South Kensington area. Therefore, evidence showed that whilst there had been improvements in the health of people in different parts of the borough compared to London and England, as the report states *'the life expectancy gap between the least and most healthy wards is still in excess of ten years'*.

The health profile of Kensington and Chelsea for 2009 again reveals that the general health of the population in the borough is better than the England average. Both male

and female life expectancy is the highest in England. The profile also states that whilst rates of infant mortality and death from smoking are better than average, levels of drug misuse and road injuries and deaths are worse than the average. People in the most deprived parts of the borough still continue to have lower life expectancy than those in the least deprived.

The Health Summary for Kensington and Chelsea for 2009 reveals the health of people in the borough compared to the rest of England. The chart below highlights where statistics are higher than the rest of England.

Indicator	Local Value	England Average
Deprivation	21.8	19.9
Obese Children	12.4	9.6
Children's tooth decay (age 5)	2.2	1.5
Drug Misuse	20.5	9.8
New cases of tuberculosis	27.9	15.0
Excess winter deaths	18.8	17.0
Road injuries and deaths	65.8	54.3

People in the north of the borough are also more likely to be at risk of readmission to hospital despite the fact that the residents here are on average are younger than in the far south.

### Health Inequality by Ethnicity

RBKC's 'A Picture of Our Community' published in 2005 reveals that in self-reported health by ethnicity, people from black and minority ethnic groups suffer poorer health than those from white groups, this is also typical of regional and national figures.

According to the Index of Multiple Deprivation of 2007 based on the 2005 RBKC population figures, 21.8% (38,394) of residents in the borough live in the most deprived areas compared to 0.9% (1,629) that live in the least deprived areas. Health deprivation and disability is contained mainly in the north of the borough, with pockets contained in the centre and to the south of the borough. The highest concentration of ethnic minorities is also in the north of the borough.

Free school meals are used as an indicator of deprivation, people who suffer from deprivation tend to have poorer health. Comparing health inequality using free school meals as an indicator shows that the black children are most likely to receive free school meals at 48.8%. This compares to White (28.6%), Mixed (34.4%), Asian (28.2%), Chinese/other (45.7%)

### What are some of the solutions to tackling health inequality in Kensington and Chelsea?

NHS Kensington and Chelsea and the Council have developed a joint strategy 'Choosing Good Health - together' which identifies seven priorities for action up to 2012, these are:

- Alcohol and Drugs
- Mental Health and Well-Being

- Nutrition
- Physical Activity
- Sexual Health
- Smoking
- Wider determinants of health

The Strategy states its commitment to working with local people to meet local needs and delivering on each of these priorities.

### **What needs to be considered locally in tackling health inequality?**

'*High Quality Care for All: NHS Next Stage Review*' published in 2008 identified the challenges which face the health services, ranging from the complex needs of clients, to lack of awareness amongst practitioners (particularly to deal with the most excluded in society) to Leadership with no national voice for the socially excluded.

'*Inclusion Health: Improving the way we meet the primary health care needs of the socially excluded*' published in 2010 provides a framework for driving improvements in health outcomes for socially excluded groups.

The objectives of Inclusion Health are:

1. **Focus** - to increase the understanding and visibility of the health needs and outcomes of socially excluded groups and to establish clear accountability at local and national level
2. **Voice** - to provide a strong voice and advocacy for the most disadvantaged ensuring strategic planning and commissioning processes adequately address their needs
3. **Personalisation** - to promote flexible and tailored responses to complex needs
4. **Quality and innovation** - to drive improvements, promote innovation and build evidence of what works
5. **Recovery** - to ensure services support clients to continually improve by raising health aspirations, improving continuity of care and building capacity and capabilities for individuals to take control of their own lives
6. **Professional development** - to recognise the achievement of professionals and researchers, to build connections between professionals across disciplines and exploit the synergies between clinical and social models of care.

To achieve these aims, Inclusion Health will be setting out a framework for action. Six building blocks and actions will lay the foundation for an inclusion health approach.

1. **Leadership – strong clear national and local leadership**  
Strong leadership is particularly required at a community health level in deprived areas where there are significant concentrations of socially excluded clients.
2. **Workforce – a strong, stable and capable workforce to drive change**

Nationally and locally there are opportunities to build the inclusion health agenda into workforce development. To improve the link between investments in education and new ways of working there will be a review on training and education lead by the Department of Health.

### **3. From needs to outcomes**

To achieve a step change in the way the primary care needs of the socially excluded are met work should include identifying why access to services may have been poor for specific groups. Also stronger joint commissioning between health, the third sector and local authorities' should take place to stimulate innovation and increase impact.

### **4. Responsive and flexible services**

Innovative models of joined up cost effective and equitable care.

### **5. Health promotion and prevention**

Improve health aspirations, prevention and early intervention

### **6. Assurance and accountability**

Making the best use of available resources and levers to focus on the most excluded and track progress.

The government will support delivery of the Inclusion health agenda by establishing a national inclusion health board.

## **The role of the voluntary and community sector**

The local voluntary and community sector in Kensington and Chelsea is increasingly relevant to the fight against health inequalities, particularly in the context of the current economic climate.

Many voluntary and community organisations focus on preventative work and work closely with local communities to promote health and well-being.

If the council and the local NHS want to tackle entrenched behavioural issues that cause health related problems, tackle the wider determinants of health and promote wellbeing then working with the local sector will be key.

## **Health consortium**

Voluntary and community organisations in Kensington and Chelsea have already built networks that will enable professionals to work together. These include the Voluntary Organisations Forum and its sub-groups, the BME Health Forum, the Sexual Health Providers Forum, and others. Many local organisations have also undertaken contractual partnerships for delivery of services, and therefore the sector is developing a wealth of experience of collaboration.

The work to develop a local voluntary sector health consortium lead by the Social Council in Kensington and Chelsea has the potential to make a significant contribution to the effectiveness of the borough's Health and Well-Being Centres in promoting well-being and reducing ill-health.

This work is on-going with a strong sense of direction and purpose, the Consortium aims eventually to be a vehicle for voluntary sector health service delivery as well as an acting

as an advocate for local people, supporting them to articulate their views on services and to influence developments.

## **Recommendations**

- 1.** Local voluntary and community groups should be financially supported to come together in partnerships that will provide the sector with greater opportunities to compete in the market place. Consortia and partnership building takes time and resources, but a well-managed process to support this area of work can pay huge dividends in the long term, not only for the voluntary sector but for statutory sector too.
- 2.** Continue to fund BME organisations that support their communities but ensure that funded organisations are building bridges between their community and mainstream services. BME organisations play an important role in understanding the wider determinants of health and need to be supported to help address those issues.

## References

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