



Tackling Health Inequalities

Consultation on a plan for delivery

Contents

Foreword by the Minister for Public Health	3
Executive Summary	5
1. Introduction	7
Health inequalities in England	7
2. National health inequalities targets	13
The national health inequalities targets	13
Other targets which impact on health inequalities	14
What is already being done across Government	16
3. Developing a plan for delivering action on health inequalities	19
Priority 1: Providing a sure foundation through a healthy pregnancy and early childhood	19
Priority 2: Improving opportunity for children and young people	20
Priority 3: Improving NHS primary care services	22
Priority 4: Tackling the major killers: coronary heart disease and cancer	23
Priority 5: Strengthening disadvantaged communities	24
Priority 6: Tackling the wider determinants of health inequalities through Government policy	26
4. Delivering the priorities	29
Systems and processes to support delivery of the priority actions	29
The role of the NHS	29
5. Indicators to support action on health inequalities	33
The indicators	33
The framework	34
6. We want your feedback	39
Regional workshops	40
Responses	40
List of Figures	
Figure 1 Health Inequalities in infant mortality (by social class and for sole registrations)	9
Figure 2 Inequalities in life expectancy at birth (by Local Authority area) – male	10
Figure 3 Inequalities in life expectancy at birth (by Local Authority area) – female	11
Figure 4 Inequalities in life expectancy at birth (example by ward)	12
Figure 5 Possible high level health inequalities indicator set	35
Figure 6 Illustrative example of a topic-specific selection of indicators	37
Figure 7 Review of public health information sources	37

Foreword by the Minister for Public Health



What greater inequity can there be than to die younger and to suffer more illness throughout your life as a result of where you live, what job you do and how much your parents earned? Yet at the turn of the 21st century, opportunity for a healthy life is still linked to social circumstances and childhood poverty. Although this country has seen increased prosperity and reductions in mortality over the last 50 years, the gap in health between those at the top and bottom of the social scale has widened between the mid-1970s and mid-1990s.

Tackling health inequalities has been a high priority for the Government since it took office, a key strand of its modernisation programme designed to develop responsive, effective public services. One of the first things we did was to commission Sir Donald Acheson's *Independent Inquiry into Inequalities in Health*, published in 1998, which found that inequalities in health status ranged across geographical areas, social class, gender and ethnicity. Mortality and life expectancy follow a social gradient and the Inquiry found that many social class differences had widened over the previous 20 years. Since then, a great deal has been achieved. *The NHS Plan* has given prominence and priority to tackling health inequalities through the actions of the NHS. **Two new national targets to reduce health inequalities** in infant mortality and life expectancy have been set. Right across central and local government, key building blocks to tackle these inequalities have been put in place.

We now need to build on these foundations, and the excellent work they have stimulated to make a step change in the reach and impact of action to reduce health inequalities. This consultation highlights examples of that good practice and seeks views on our proposals to make further improvements.

The Government has announced a cross-cutting spending review on health inequalities which will provide a major opportunity for the whole Government to focus on health inequalities and establish priorities for action that will deliver the national targets. The views expressed in response to this consultation will inform that process.

In preparing this document, I have worked with Ministers right across Government, and we will continue working together to make change on this fundamental issue of equality.

A handwritten signature in black ink, appearing to read 'Yvette Cooper', written in a cursive style.

Yvette Cooper MP
Parliamentary Under Secretary of State for Public Health

Executive Summary

What is the purpose of this document?

In February 2001 the Government announced national health inequalities targets. The purpose of this document is to consult on the action needed to achieve these challenging targets.

The *Independent Inquiry into Inequalities in Health* chaired by Sir Donald Acheson analysed the determinants of health inequalities and made recommendations for action. *Saving Lives: Our Healthier Nation* presented a whole Government approach to tackling health inequalities, and *The NHS Plan* set out a range of measures and commitments for the NHS. This consultation focuses on delivery of both the NHS and wider Government commitment to reduce health inequalities.

Who is it for?

Anyone with a responsibility for or interest in tackling health inequalities.

This includes people in the NHS, social services, local government, schools, the emergency services, community and voluntary sector organisations, academics, employers, trade unions, central and local government policy makers and regional agencies who all have a role to play in reducing health inequalities.

What does the document do?

- Explains **what the new national targets are**, and their fit with existing Government priorities
- Seeks views on the **top priorities for action**
- Seeks views on how we can **build on existing good practice** to extend the reach and impact of work to tackle health inequalities
- Proposes that existing and emerging **planning structures and systems** are used to support local action
- Seeks views on the indicators we should use to monitor progress, leading to the development of a **cross-Government basket of indicators**
- Provides links to **supporting information**

What action is needed and by when?

You are invited to give your views on the key issues raised in the document by **Friday 9th November**. Please send your responses by e-mail to Healthinequalities@doh.gsi.gov.uk or by post to the Health Inequalities Consultation Team, Department of Health, Room 534 Wellington House, 133-155 Waterloo Road, London SE1 8UG.

Consultation workshops will be held in each region and you are welcome to join these workshops to give your views in person (subject to availability) – see <http://www.doh.gov.uk/healthinequalities> for details of time and place of the workshops or contact Jeff French at the Health Development Agency, telephone 020 7413 1926.

What will happen next?

We will publish an implementation report following the consultation, and will regularly publish the cross-Government basket of indicators as data become available.

1. Introduction

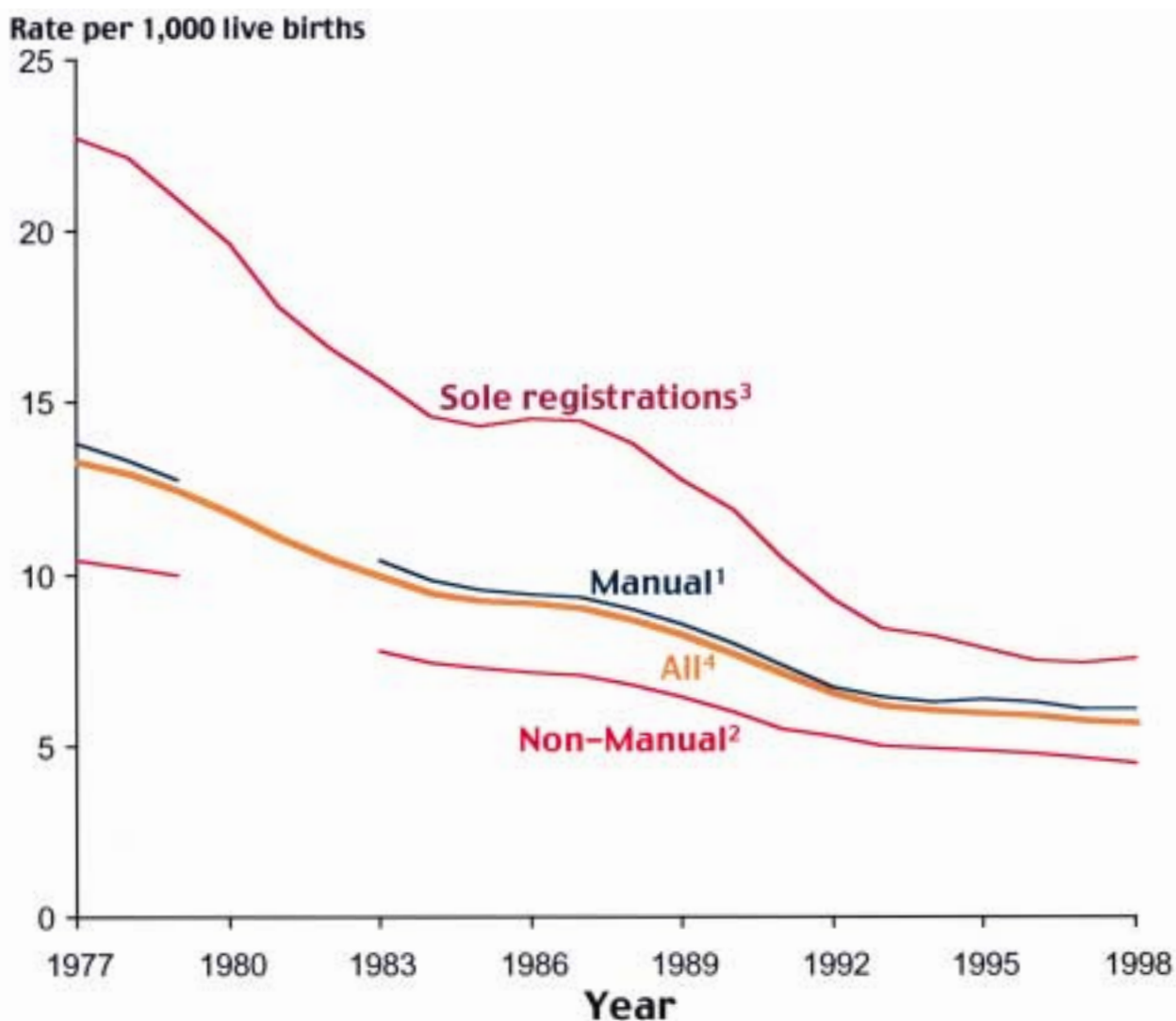
Health inequalities in England

- 1.1 Some differences in health status are unavoidable, the consequence of genetic and biological differences in individuals. Many are avoidable, and often unjust. Such inequalities in health are a consequence of significant differences in opportunity, in access to services, and in material resources, as well as differences in personal lifestyle choices.
- 1.2 The best analysis of the nature and determinants of health inequalities in England in recent years remains the *Independent Inquiry into Inequalities in Health* chaired by Sir Donald Acheson. It was commissioned and published by the Government in 1998. The Acheson Inquiry identified the compound effects on health of poor living and working conditions that are a product of income, education, employment and housing. These in turn are modified by more subtle influences associated with social networks and location. Ethnicity and gender present further dimensions to these root causes of inequalities. Both gender and ethnicity shape individual experiences and opportunities across life.
- 1.3 To summarise these findings, people who experience one or more of: material disadvantage, lower educational attainment and/or insecure employment are likely to experience worse health than the rest of the population. In addition there is evidence to suggest that living in materially deprived neighbourhoods contributes to worse health for individuals.
- 1.4 These differences are apparent from the beginning of life. Children born and brought up in families with low levels of educational attainment, material disadvantage or in lower socio-economic groups are likely to experience worse health in later life. Although this country has seen increased prosperity and reductions in mortality, the gap in health between those at the top and bottom of the social scale has widened, particularly between the mid-1970s and the mid-1990s. This is significantly avoidable and fundamentally unfair.
- 1.5 **Figure 1** shows infant mortality in England by social class, and separately for sole registrations (ie births outside marriage registered by the mother alone). It shows that progress has been achieved in all social groups in reducing infant mortality. It also shows differences between manual and non-manual social groups, and indicates that this gap has widened since the early 1990s. Births to single mothers have the highest rate of infant mortality, but this rate has shown the steeper decline.
- 1.6 Geographical variations are also wide. Male residents of Manchester can expect to live over seven years less than those of Barnet, female residents can expect to live six years less than those of Kensington, Chelsea and Westminster.
- 1.7 **Figures 2 and 3** shows the wide variation in life expectancy in different parts of the country for males and females by local authority area.

- 1.8 **Figure 4** demonstrates that we should not focus our attention only on the most deprived areas. There are pockets of deprivation in every part of the country. Even a prosperous health authority area such as Kensington, Chelsea and Westminster, which has one of the highest life expectancies in the country, has areas of significant deprivation. This is closely associated with reduced life expectancy.
- 1.9 The *Independent Inquiry into Inequalities in Health* report (<http://www.official-documents.co.uk/document/doh/ih/contents.htm>) made 39 recommendations. These scientifically-based recommendations provided clear directions on what to do to tackle health inequalities. The Department of Health published an interim response to the Acheson report *Reducing Health Inequalities: an action report*, in July 1999 which indicated the steps already taken across Government to improve health and reduce health inequalities.
- 1.10 The *Saving Lives: Our Healthier Nation* White Paper (<http://www.doh.gov.uk/ohn.htm>) was published simultaneously with *Reducing Health Inequalities: an action report*. The White Paper set out a programme to save lives, promote healthier living and reduce inequalities in health. It rejected the view that nothing can be done to improve the health of the worst off and called for co-operation across Government to tackle health inequalities.
- 1.11 *The NHS Plan* (<http://www.doh.gov.uk/nhsplan/>) emphasised the importance of health inequalities in a context of considerable extra investment for a modernised NHS. It recognised that improving health is a key priority for all Government departments and emphasised the part the NHS has to play in prevention. It also stressed the need to work in partnership with other departments and agencies to tackle the underlying causes of ill-health and in doing so to reduce health inequalities. National strategies such as *A New Commitment to Neighbourhood Renewal* reflect this commitment. A nationwide programme of delivery is already implementing the recommendations of *Saving Lives: Our Healthier Nation* and *The NHS Plan*.
- 1.12 This document, *Tackling Health Inequalities: Consultation on a plan for delivery* builds on the existing range of actions across Government and through the NHS to deliver the health inequalities targets that were a commitment from *The NHS Plan*.

Figure 1

Health inequalities in infant mortality (by social class and for sole registrations)



¹ Manual = Social classes IIIM, IV and V

² Non-Manual = Social classes I, II and IIIN

³ Sole registrations = Births registered outside marriage by mother only

⁴ All = includes all social classes, sole registrations and other registrations

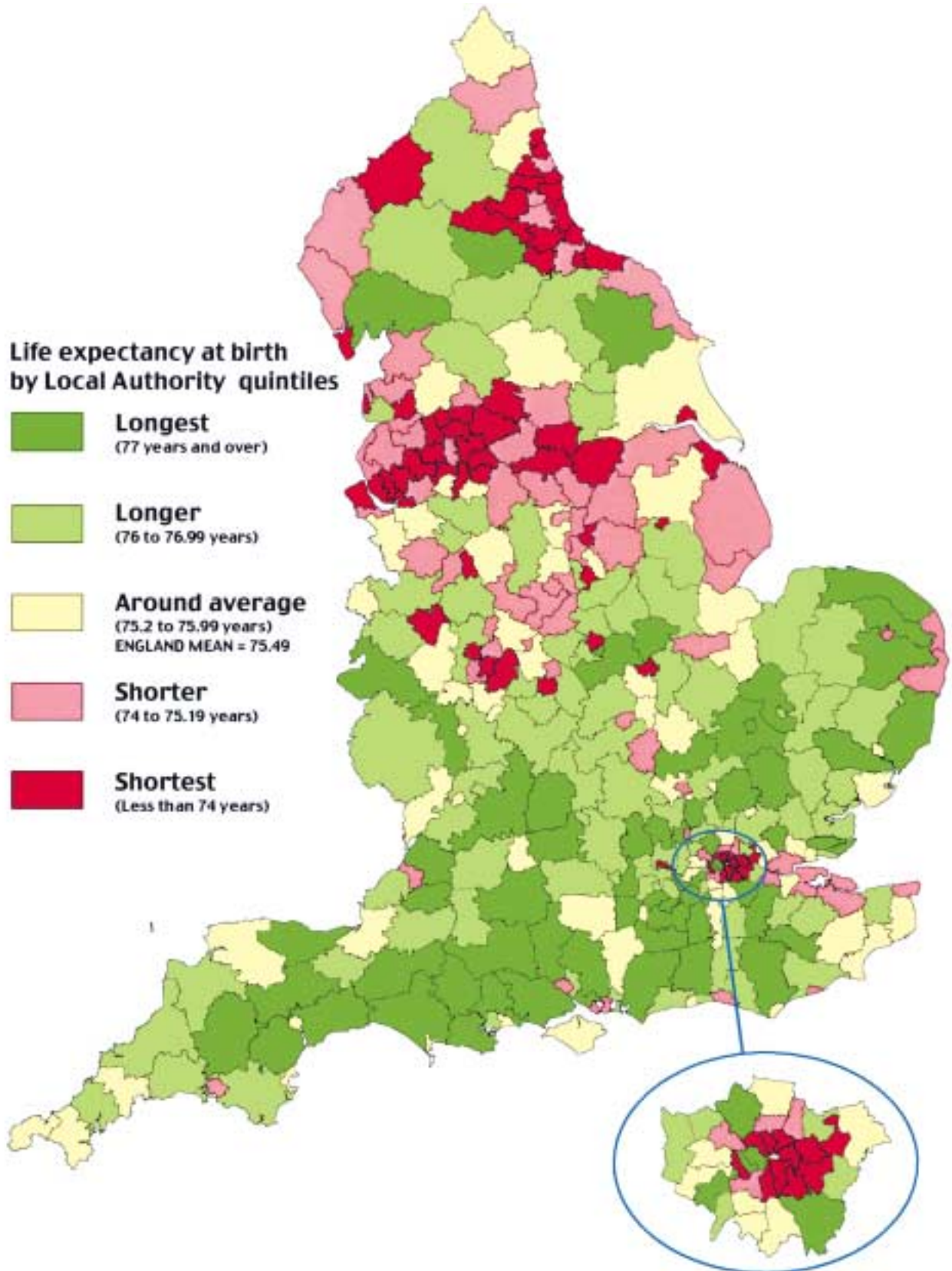
3 year rolling average plotted against middle year

Data for social class for 1981 are not available because of industrial action by registrars in that year

Source: Department of Health Statistics Division analysis of data from the Office for National Statistics (ONS)

Figure 2

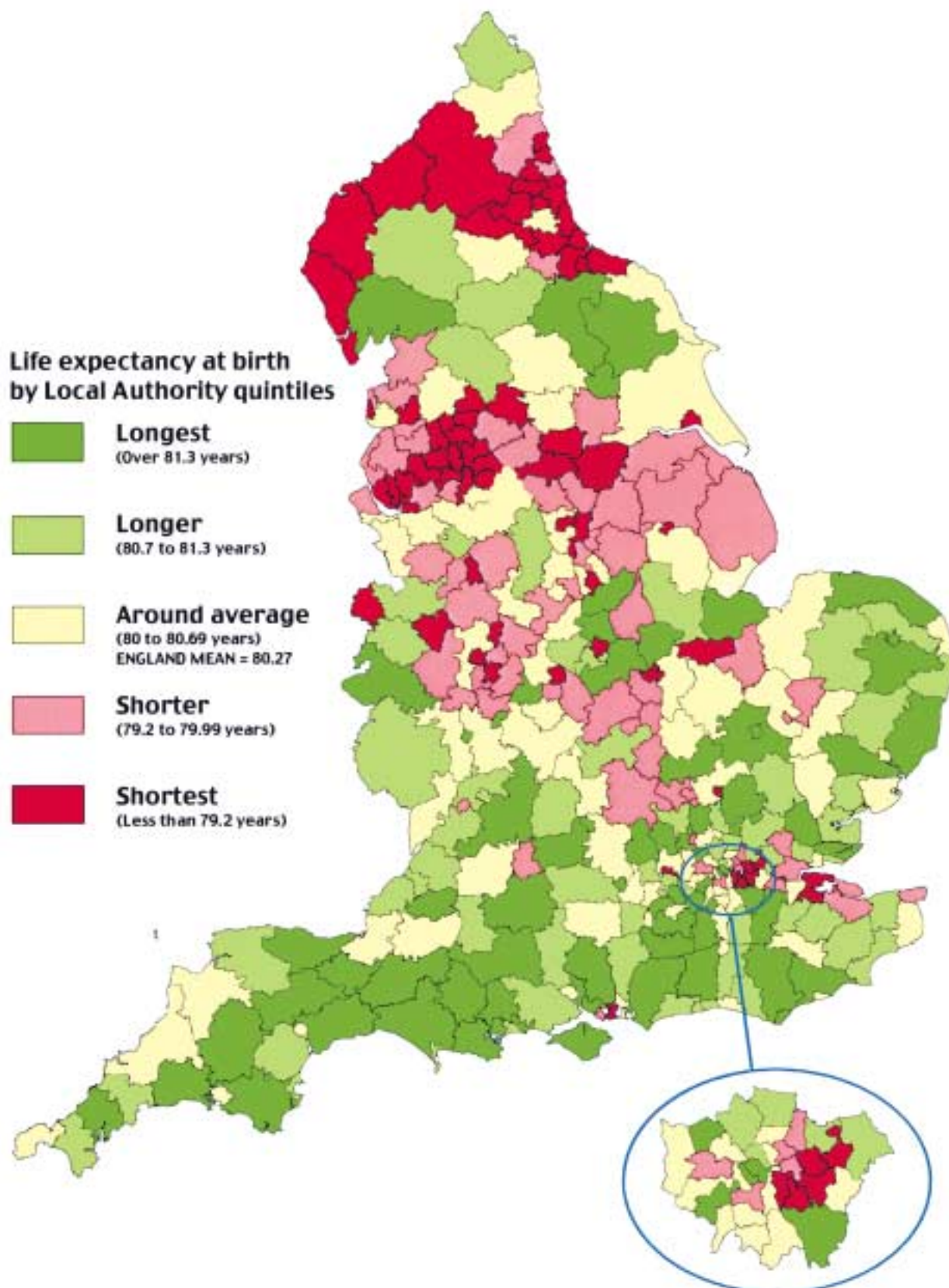
Inequalities in life expectancy at birth (by Local Authority area) – male, 1997–99



Source: ONS

Figure 3

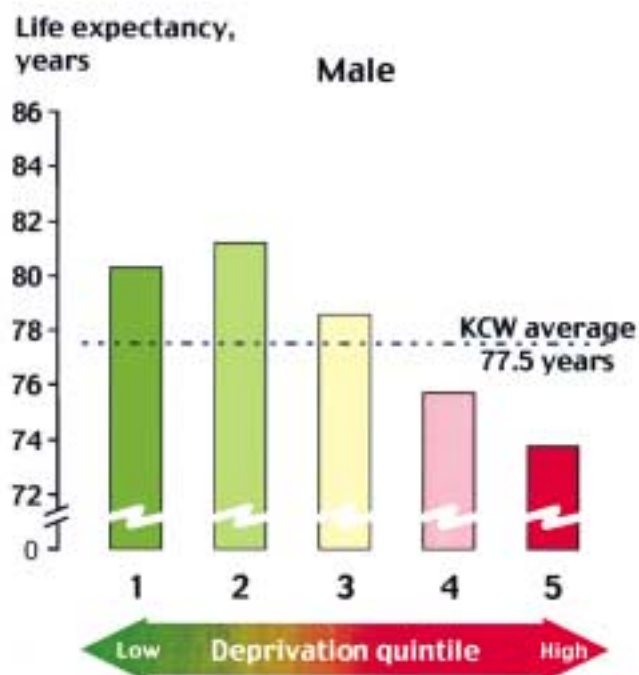
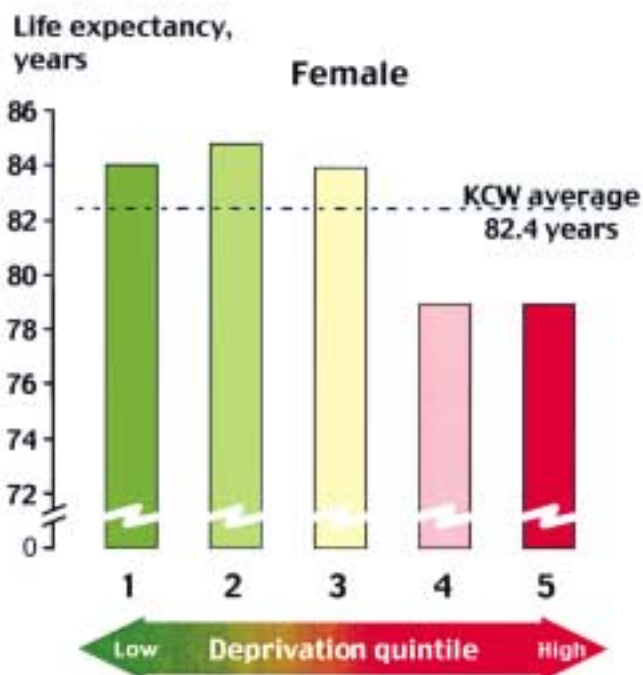
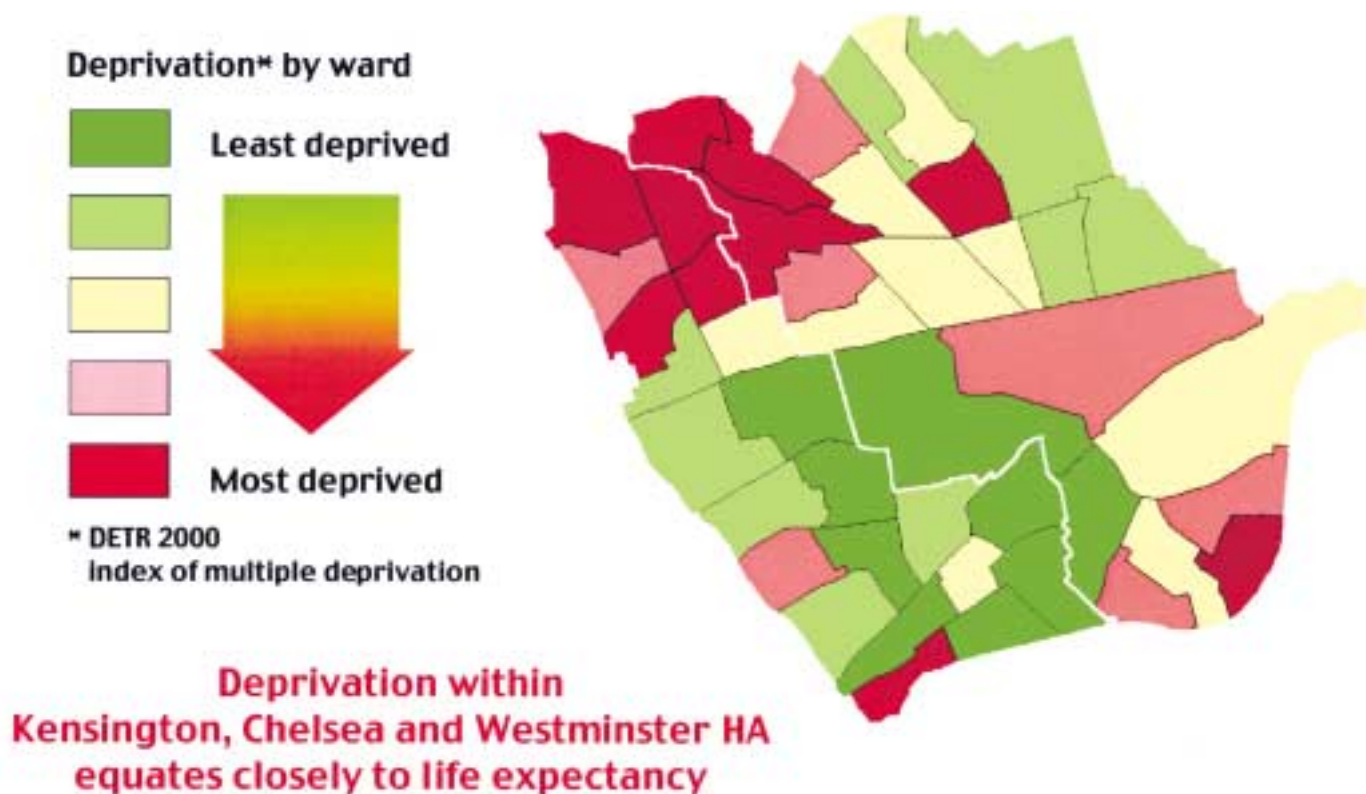
Inequalities in life expectancy at birth (by Local Authority area) – female, 1997–99



Source: ONS

Figure 4

Inequalities in life expectancy at birth (example by ward)



Source: London Public Health Observatory analysis of ONS and GLA data

2. National health inequalities targets

This section describes the national health inequalities targets, and outlines the actions already taken by the Government to address the determinants of health inequalities.

The national health inequalities targets

- 2.1 The Government gave a commitment in *The NHS Plan* to establish national health inequalities targets which would narrow the gap in childhood and throughout life between socio-economic groups and between the most deprived areas and the rest of the country. These national targets reinforce the local targets set out in the *Saving Lives: Our Healthier Nation* White Paper. These new targets were announced in February 2001, and are:

Starting with children under one year, by 2010 to reduce by at least 10 per cent the gap in mortality between manual groups and the population as a whole

Starting with health authorities, by 2010 to reduce by at least 10 per cent the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole

How were the targets arrived at and what are they for?

- 2.2 Both targets aim to narrow the gap between those suffering inequality and the population as a whole, a gap that is generally widening. Achievement of the targets is not only about saving lives overall, but is about ensuring that a higher proportion of the gains are made by those in poorer circumstances.
- 2.3 They are “headline” targets, chosen as high level measures of progress. Life expectancy and infant mortality are widely understood measures of health, both in England and abroad and, between them, the targets address health inequalities arising from social class and area. The wording of the targets – *starting with* and *at least* – signals the need for a step change in reducing health inequalities, and the intention to make progress more widely and on other indicators as soon as we can. In 2001, a new National Statistics socio-economic classification (NS-SEC) was introduced. As data become available using this new classification, it will be necessary to reset the infant mortality target based on the new groupings. In the light of the reorganisation of health authorities, the monitoring of health authority areas or smaller areas will also be reassessed and the life expectancy target amended accordingly.
- 2.4 Improvements in **life expectancy** will be achieved through a very wide range of actions. The *Saving Lives: Our Healthier Nation* White Paper emphasised the need for action to tackle “the big killers” – cancer and heart disease – where death rates remain unacceptably high overall and reflect a social class gradient, as well as action directed at the determinants of health highlighted in the Acheson Inquiry. Reducing smoking among manual social groups will be the key to achieving this target. The life expectancy target gives us a high level measure to see if action on a range of policies is having the desired overall effect.

- 2.5 The purpose of the **infant mortality** target is to galvanise action to improve the health of mothers and their children – starting with improving the health and survival of babies, and in particular, those from the more disadvantaged groups in our community. This reflects the view in *The NHS Plan* that health in early life is the foundation of health throughout life and is important because:
- infant mortality is a key indicator of maternal and child health, and action taken will, in time, reduce inequality gaps in the health of mothers and children of other ages
 - the things we need to do to stop these babies dying will help us to raise the standards of care for all babies
- 2.6 The infant mortality target has been built around “manual” groups – based on the father’s occupational social class – and encompasses the majority of births (and infant deaths) in disadvantaged groups. Information on infant mortality by father’s social class is not however available for one important group – “sole registrations”, i.e. births outside marriage registered by the mother only. Sole registrations are therefore not included in the target statement because of this anomaly in the data. Lone parents are, however, one of the key groups that will continue to be a focus for our efforts. It is our intention to monitor **all** social groups to ensure that trends are improving and the gaps in mortality are narrowing. Analysis of infant mortality trends amongst lone mothers will thus be an important and integral part of the process of monitoring and reporting progress towards this health inequality target. The infant mortality target is specified using the former social class groupings, as data are currently available only in this form.
- 2.7 International comparisons indicate that there is substantial scope for improvement in both life expectancy and infant mortality, another reason for their choice as targets. Current trends show a widening of both these inequalities. The targets have been set not only to stop any further widening but, beyond this, to achieve a narrowing. Turning around a long-term social trend such as health inequality, with complex roots and causes, is very challenging. The commitment made by the Government in setting the targets goes considerably further than most comparable countries.
- 2.8 Technical information on the data underpinning the national targets is available at <http://www.doh.gov.uk/healthinequalities>

Other targets which impact on health inequalities

- 2.9 In addition to the two “headline” targets, there are other national targets that are central to supporting work on health inequalities. Three such targets deserve special mention:
- Child poverty
 - Smoking
 - Teenage pregnancy

Child poverty

- 2.10 To ensure progress in improving family income, the Government has set the following Public Service Agreement target:

To make substantial progress towards the eradication of child poverty by reducing the number of children living in child poverty by a quarter by 2004

- 2.11 The baseline for this target is 1998–99 and the latest information available for 1999–00 shows encouraging progress with 300,000 fewer children living in low income households. These data do not yet fully reflect the impact of announced policies, for example: the Working Families Tax Credit, further increases to the child allowances in income-related benefits, the Children’s Tax Credit and the planned introduction of an integrated system of support for children through the new tax credits.
- 2.12 By October 2001, all families with children will be better off by, on average, £1000 a year and couples on income support with two children under 11 will be nearly £1,700 better off a year compared to 1997.

Smoking

- 2.13 Smoking prevalence is strongly related to social class. Reducing smoking prevalence is central to the Government strategy to reduce inequalities. The numbers stopping smoking will affect morbidity and mortality across the board, strongly influencing life expectancy and infant mortality rates. In *The NHS Cancer Plan*, (<http://www.doh.gov.uk/cancer/cancerplan.htm>) the Government has set a target to cut smoking rates amongst manual groups:

Reduce smoking rates among manual groups from 32% in 1998 to 26% by 2010

- 2.14 Our challenge is to ensure that the action we take to reduce prevalence further is effective in reaching people who have not responded so well to previous strategies, especially those in the manual social groups.
- 2.15 The strategy is already producing results:

The “Help2Quit” initiative in Shropshire, funded as a part of the national tobacco campaign, provides services close to where the smoker lives – found to be particularly important for low-income smokers and for those in rural areas. The initiative has recruited nine times the expected number of smokers and maintained a 20 per cent quit rate

Teenage Pregnancy

- 2.16 Teenage pregnancy is important for health inequalities because:
- the risk of becoming a teenage mother is almost ten times higher for a girl whose family is in social class V (unskilled manual) than those in social class I (professional)
 - the infant mortality rate for babies of teenage mothers is 60 per cent higher than for babies of older mothers. The risk is higher still for mothers aged under 18. In 1999, there were 423 infant deaths to teenage mothers, accounting for 12 per cent of all infant deaths in England and Wales
 - 90 per cent of teenage mothers claim benefits, and all too often their children grow up in poverty. One in every 10 births is to a teenage mother
- 2.17 The Social Exclusion Unit report on Teenage Pregnancy, launched by the Prime Minister in 1999, sets out a 10-year strategy to halve the rate of teenage pregnancies and help more teenage parents back into education and work. The Government has set the following inequality target to support implementation of the *Teenage Pregnancy Strategy* (<http://www.teenagepregnancyunit.gov.uk/>):

By achieving agreed local conception reduction targets, to reduce the national under 18 conception rate by 15% by 2004 and 50% by 2010, while reducing the gap in rates between the worst fifth of wards and the average by at least a quarter

2.18 The strategy is already showing results:

Coventry's teenage pregnancy strategy forms part of the Health Improvement Programme and is jointly countersigned by the Chief Executives of Coventry Metropolitan Borough Council and Coventry Health Authority. The action plan will: develop sex and relationship education for young men and vulnerable groups; make it easier for all young people, including those in care, to access advice and contraceptive services; and help teenage parents return to education and provide housing with support for lone parents under 18 who are unable to stay at home. Between 1998 and 1999 the under-18 conception rate in Coventry fell by 11 per cent

What is already being done across Government

2.19 The Acheson Inquiry examined the determinants of health as “layers of influence”. At the centre are individuals, who are first affected by factors such as age, gender and genetic influences, which cannot be changed. The most immediate layer of influence consists of downstream factors, behavioural patterns such as smoking, diet and physical activity that can be altered directly by the individual. The next layer consists of social and community networks – mutual support within a community has the potential to sustain the health of an individual in otherwise unfavourable conditions. Then there are the upstream factors such as work environment, housing and living conditions, education, transport and access to health services. Finally there are the economic, cultural and environmental conditions present in society as a whole.

2.20 Tackling health inequalities will require us to address all of these “layers of influence” – to reduce smoking and promote access to a healthy diet, to work to develop communities and renew neighbourhoods, to improve working and living conditions, as well as ensuring that access to, and use of, health services improves among those who had previously been under-served.

2.21 The Inquiry report emphasised the need to work across Government to tackle this complex mix of factors. It gave a high priority to the health of mothers and young children and said:

While there are many potentially beneficial interventions to reduce inequalities in health in adults of working age and older people, many of those with the best chance of reducing future inequalities in mental and physical health relate to parents, particularly present and future mothers and children

2.22 Action on health inequalities was a feature of the first term and is a key priority for the second term of the Government. The Government's high level goals are focused on the multiple needs of individuals and communities, and are directed towards:

- reducing inequalities and promoting equality of opportunity, with respect to the key determinants of good health
- focusing on the needs of citizens from threats to health and well-being over which they have little control and
- providing modern, efficient public services which are co-ordinated so they make sense to users at the point of delivery

2.23 Action to improve health and to reduce health inequalities requires joined up working across Government and across sectors at national, regional and local levels.

2.24 As well as the commitment of the Department of Health and NHS to reduce health inequalities, many of the Government's priority programmes have improving health and tackling inequalities as core goals, especially by addressing the needs of children and young people. For example:

We are improving the NHS by:

- delivering *The NHS Plan*, the blueprint for the reform of the NHS;
- building on the development of **NHS Direct**
- putting in place **National Service Frameworks** (NSFs) aimed at raising quality and reducing unacceptable variations in service. NSFs have been published for mental health, coronary heart disease and older people. Diabetes is to follow later this year and NSFs for renal services, children and long-term conditions have been announced
- delivering improved primary care services through **Primary Care Trusts**
- linking to the wider community in some of the most deprived areas through **Health Action Zones**

We are tackling low incomes by:

- supporting families through the **Working Families Tax Credit**
- improving cash support for pregnant and nursing mothers and linking it to child care through the **Sure Start Maternity Grant**
- increasing **Income Support** for families and working in partnership to increase the take up of the **Minimum Income Guarantee** by pensioners
- increasing the **National Minimum Wage**
- recognising the additional costs of a new child in the first year of life through the baby credit in the **Children's Tax Credit**

We are improving educational and employment opportunities by:

- improving educational attainment through substantial extra investment in **Education and Lifelong Learning**
- continuing to build the *New Deal Programmes* to get people into work
- reducing occupational ill-health and disability by *Securing Health Together*

We are rebuilding local communities and supporting vulnerable individuals by:

- improving the coverage of *Sure Start* programmes for children up to four
- linking the needs of poorer communities through **Neighbourhood Renewal**
- investing in a *New Deal for Communities* covering some of the poorest neighbourhoods in the country
- helping pensioners and other vulnerable groups through *The UK Fuel Poverty Strategy*
- building a network of **Healthy Living Centres** to strengthen community based initiatives in health, education and environment
- implementing a strategy to reduce the number of people sleeping rough

Tackling health inequalities

- 2.25 These Government policies and programmes are addressing the determinants of health inequalities at local and national level. A major purpose of this consultation is to determine how we can ensure that this current action has the greatest possible impact on health inequalities.
- 2.26 We also recognise that there is still more to do in addressing the determinants of inequalities and improving health both within and outside the NHS. The next section describes proposals to take this work further and seeks your views on how to improve the reach and impact of these programmes.

3. Developing a plan for delivering action on health inequalities

This section sets out proposals for six priority themes as the building blocks for a plan of action to deliver the national health inequalities targets. It describes the potential range of actions at local and national level that fall within the scope of these priorities. We are seeking views on these proposed priority themes, and suggestions of local examples of effective action.

- 3.1 In setting the headline health inequalities targets, the Government has signalled its determination to take concerted action to deliver improvements. But it cannot do this alone. There is a great deal of work already going on all over the country, and there are many people who have been successful in making a difference by reducing health inequalities in their communities. We need to build on that good work, and share the information about what works more widely. Action to tackle health inequalities needs to be supported with appropriate resources, and the systems and structures to get the job done. This consultation is designed to give everyone involved the opportunity to say what is needed and to shape a national programme which will deliver through the six priority themes below:

Six priorities

- Priority 1: Providing a sure foundation through a healthy pregnancy and early childhood
- Priority 2: Improving opportunity for children and young people.
- Priority 3: Improving NHS primary care services
- Priority 4: Tackling the major killers: coronary heart disease and cancer
- Priority 5: Strengthening disadvantaged communities
- Priority 6: Tackling the wider determinants of health inequalities

We would welcome views on these proposed priority themes, and seek suggestions of other effective actions of equal priority, that could become part of a wider national programme as this work develops. Local examples of effective action would be welcome, together with contact details for any follow-up.

Priority 1: Providing a sure foundation through a healthy pregnancy and early childhood



- 3.2 Support for mothers with very young children was identified by the Acheson Inquiry report as one of the top three priorities for tackling health inequalities. Poor socio-economic circumstances in childhood have lasting effects. Poverty falls disproportionately on children, with one in three children living in poverty, compared to one in four of the total population. The Government has already stated its commitment to the eradication of child poverty within a generation and halving it within 10 years.

- 3.3 **Our aim** is to reduce inequalities in infant mortality by ensuring a healthy pregnancy, childbirth and early life among all social groups, and by continuing to provide greater support, education and information for families.
- 3.4 **National policies and local action** which are helping to reduce health inequalities and contribute to the targets include:
- reducing child poverty by continued reform of the tax and benefits system
 - improving midwifery and health visiting services, through an expansion in staff numbers, and by targeting modernised ante-natal and post-natal services to the most disadvantaged individuals, families and communities
 - tackling teenage pregnancy and improving support for pregnant teenagers through local implementation of the *Teenage Pregnancy Strategy*
 - helping mothers and families in disadvantaged areas by increasing the number of childcare places through the Neighbourhood Nurseries Initiative (<http://www.nof.org.uk/edu/temp.cfm?content=nursery>)
 - strengthening the support and services available to disadvantaged families with young children by extending *Sure Start* and disseminating *Sure Start* strategies (<http://www.surestart.gov.uk>)
 - improving nutrition for the most disadvantaged mothers and children by continuing to increase awareness of the benefits of breastfeeding, acting to prevent and reduce obesity, and reviewing the *Welfare Foods Scheme* to ensure that the investment made brings the greatest nutritional benefit
 - reducing smoking in pregnancy by developing and disseminating effective interventions targeting pregnant women and their partners
- 3.5 It can be done ...

In Sheffield's Foxhill and Parsons Cross districts, Sure Start schemes have been running to help parents with the healthy development of their children. Outreach workers have been contacting all families with young babies. One local parent said "The thing is, they really work. Like knowing what to ignore about bad behaviour and when to take action."

QUESTION: *What more can be done to reduce infant mortality and morbidity for families on low incomes? What more can be done to provide a sure foundation for parents and young children and contribute to reducing health inequalities?*

Priority 2: Improving opportunity for children and young people



- 3.6 A child's school years and early adult life represent a critical stage of development, and education is a key influence. Children from disadvantaged backgrounds tend to have lower educational attainment than other children. Low educational attainment is a predictor of both poorer job prospects and adult health. It is at school and in early adult life when patterns of behaviour are established which have a profound impact on health. This includes decisions young people make about smoking, drugs and alcohol use, and sexual activity. On all counts, children and young people from disadvantaged backgrounds are at greatest risk. A National Service Framework (NSF) has recently been announced which will look at how best to meet the health and social service needs of children and young people.

3.7 **Our aim** is to improve opportunity and reduce alienation among young people by strengthening and connecting services to improve school attendance and attainment, improve the development of skills for life to reduce harmful risk taking and empower young people.

3.8 **National policies and local action** helping to reduce health inequalities and contribute to the targets include:

- improving co-ordination of Government strategy for all children and young people aged 0-19 through the work of the Children and Young People's Unit (<http://www.dfes.gov.uk/cyfu/>)
- boosting support and employment opportunities for all 13-19 year olds through the *Connexions* strategy (<http://www.connexions.gov.uk/>)
- reducing youth unemployment which most affects young people with low educational attainment through the *New Deal* (<http://www.newdeal.gov.uk/>) and other active labour market measures
- improving the quality of services and support for children in care through the *Quality Protects* programme
- addressing the risks of social exclusion for vulnerable children aged 5-13 through the Children's Fund
- improving health awareness behaviour and educational attainment through the *Healthy Schools* programme
- targeting help for those most at risk and who smoke, take drugs or drink to excess through such programmes as *Positive Futures*
- improving access to healthy food in schools through breakfast clubs, school meals, and the *National School Fruit Scheme*, focusing on disadvantaged areas
- continuing to address the mental health of children and young people through implementation of the child and adolescent mental health services (CAMHS) strategy, and other mental health programmes
- reducing the incidence of suicide and deliberate self harm among young men from lower socio-economic groups through development of the *National Suicide Prevention Strategy*
- helping vulnerable young people avoid conception and teenage pregnancy and re-integrating teenage parents back into education through local implementation of the *Teenage Pregnancy Strategy*
- enforcing laws to restrict local access to tobacco and alcohol by young people
- ensuring that a holistic approach to drug use is taken with all 'helping' agencies working together to ensure that social exclusion is reduced among drug users, overseen by the new National Treatment Agency for Substance Misuse

3.9 It can be done ...

In Kent, the Careers Service has piloted Breakfast Clubs in deprived areas with high levels of school non-attendance and behaviour problems. The clubs have been very successful: many non-attenders are coming for breakfast and staying, and there have been marked improvements in attention span and behaviour, as well as improved nutrition.

QUESTION: *What more can be done to reduce the unequal health and education experiences of children and young people from different social backgrounds? What more can be done in childhood and adolescence to reduce inequalities in life expectancy?*

Priority 3: Improving NHS primary care services



3.10 Access to good primary health care services has been poor in many of the most disadvantaged communities. The Acheson report highlighted the difficulties of recruiting primary care staff in deprived areas – there are 50 per cent more GPs in Richmond and Oxfordshire than in Barnsley and Sunderland after adjusting for the age and health needs of the respective populations. Communities most at risk of ill-health also tend to experience the least satisfactory access to a full range of preventive services, such as screening, health promotion and immunisation. Improved access, and improved prevention and early intervention in health problems through primary care services, are central to ensuring that the NHS makes an optimal contribution to reducing health inequalities and achieving both targets. *The NHS Plan* has given priority to tackling these inequalities through primary care.

3.11 **Our aim** is to improve primary care services to disadvantaged populations through Primary Care Trusts (PCTs) so that access to and quality of services are more closely matched to need.

3.12 **National policies and local action** directed to reducing health inequalities and contributing to the targets include:

- improving access to primary care services by creating PCTs to ensure better quality and co-ordination of services across all care environments (<http://www.doh.gov.uk/pricare/pcts.htm>)
- addressing the needs of under-served areas by increasing the number of GPs and other members of primary care teams, particularly by encouraging the spread of personal medical services pilots to improve the delivery of existing services, and by improving the primary care estate
- addressing the wider needs of deprived communities by strengthening the public health capacity of PCTs and extending the reach and quality of services in primary care by extra funding
- meeting preventive health needs of all by ensuring that PCTs act as a focal point for the delivery of public health programmes and services, such as smoking cessation, immunisation, screening services, diet and nutrition advice, dentistry, exercise advice and occupational health
- providing services that are sensitive to the needs of those who have often been less well served, such as older people and those from black and minority ethnic groups. This may include improved translation and interpretation services and more extensive actions emerging from discussions within the Local Strategic Partnership (see also 4.12)
- addressing the needs of hard to reach groups such as young men and homeless people through NHS Walk-In centres

3.13 It can be done ...

Under Newham's "Health Prescription Scheme" low-income residents can be referred on medical prescription by local GPs to leisure facilities in order to improve their health. Benefits are inevitably long-term. But the initiative is well used and expanding, and those who are referred speak highly of the scheme.

The effective delivery of primary care services can make a difference to CHD rates. North Cheshire contains some of the most deprived communities in the country as well as some affluent areas – over a third of CHD rates are attributable to deprivation. Resources were targeted at primary care specifically for secondary prevention clinics, resulting in good practice in primary care. Deprived areas are now getting greater access to cardiac services within the district, according to the latest equity audit by the health authority.

QUESTION: *What more can be done at local level to improve the NHS primary care services in ways that contribute to the health inequalities targets?*

Priority 4: Tackling the major killers: coronary heart disease and cancer



- 3.14 Smoking, poor diet, and obesity and lack of physical activity are major contributors to the incidence of premature death from the big killers, coronary heart disease (CHD) and cancer. A reduction in smoking in high prevalence populations will make a very substantial impact on inequalities in life expectancy. Most smokers in all social groups say they want to quit. To this end we have to ensure that we are successful in reducing smoking in manual social groups.
- 3.15 The impact of health inequalities is starkly shown in the social gradient of CHD and cancer. The Acheson report showed that while death rates have improved over the last 20 years, the difference between those at the top of the social scale and those at the bottom has widened. In the early 1970s the mortality rate of working age men was almost twice as high for those in the lowest social group compared to the highest social group. By the early 1990s this gap had widened to almost three times, and it was reflected in the death rates from CHD and some cancers.
- 3.16 A large part of the life expectancy target can be met by successfully addressing social class differences in these major killers. Even disadvantaged older people have much to gain in terms of healthy life expectancy from action on the major killers. *The Saving Lives: Our Healthier Nation* White Paper sets challenging targets in reducing the rates of these diseases and National Service Frameworks – including one on older people – have been developed to carry forward some of this work.
- 3.17 **Our aim** is to reduce substantially excess mortality in CHD and cancer among disadvantaged populations by effectively tackling smoking, improving diet and nutrition, and promoting participation in sport and recreational activity. We can also improve access to quality services to diagnose and treat disease.
- 3.18 **National policies and local action** directed at reducing health inequalities and contributing to the targets include:

Action on Smoking

- a ban on tobacco advertising and promotion to be introduced as soon as Parliamentary time allows
- helping those with the highest rates of smoking by targeting national tobacco education campaigns to populations with highest prevalence
- dedicated cessation help for pregnant smokers at a local level
- removing the price barriers to those who want to quit among the most disadvantaged groups, by ensuring that nicotine replacement therapy is available on prescription
- continuing to improve the reach and impact of smoking cessation services and other local programmes
- action to target smokers in specific disadvantaged groups, such as prisoners
- work to identify the scope for requiring tobacco companies to alter their products to make them less harmful, for example by removing certain additives and reducing the level of carcinogens and other toxic components in tobacco smoke

Action on Diet, Nutrition and Exercise

- promoting healthy eating and tackling inequalities in diet and nutrition through the *National School Fruit Scheme* and by increasing awareness of and access to fruit and vegetables through the *Five-A-Day* programme
- improving access to nutritious foods – particularly by reducing salt, sugar and fats in processed foods – by working collaboratively with the food industry
- working with local organisations, including producers and retailers, to increase access to fruit and vegetables, for example through Healthy Living Centres
- increasing health service provision of advice and support on exercise and promoting sports to tackle the low levels of physical activity

Other Steps

- focusing NHS service improvements on those people who have the greatest need, and/or have previously been under-served, through continued implementation of *The National Service Framework on Coronary Heart Disease* (<http://www.doh.gov.uk/nsf/coronary.htm>) and *The NHS Cancer Plan*
- encouraging physical exercise and tackling the greater accident risk to pedestrians and other road users in deprived areas, by creating safer environments for walking and cycling

3.19 It can be done ...

In Waltham Forest a local GP is working with the Mauritian Islamic Welfare Association to improve access to information and screening for attendees of the local mosque, focusing on diabetes and coronary heart disease where rates are rising among this local population. Using a mix of a drop-in clinic and informal events, in its first eighteen months, over 900 people were seen at the drop-in clinic and 97 diagnosed with diabetes and 81 with hypertension.

QUESTION: *What more can be done at local level to promote action against the big killers of CHD and cancer and contribute to the targets on health inequalities?*

Priority 5: Strengthening disadvantaged communities



3.20 Some communities face multiple problems of material disadvantage that the Acheson Inquiry found to be associated with poor health. It found that the quality of the social and physical environment was worst where financial deprivation was greatest, such as the inner cities. Recent evidence also suggests that societies with a wide gap between rich and poor experience additional social problems and ill health. The factors that contribute to these problems include a poor quality and unsafe environment, high unemployment, low quality housing, limited amenities and high crime rates. These problems are compounded by a lack of social cohesion in many instances. The action plan *A New Commitment to Neighbourhood Renewal* (<http://www.cabinet-office.gov.uk/seu/2001/Action%20Plan/default.htm>) has set a bold agenda to tackle these problems.

3.21 **Our aim** is to work effectively with disadvantaged communities at a local level to improve services, and improve the social and material resources that represent local determinants of health inequalities. This will be achieved by better integration of nationally supported local initiatives alongside local actions to tackle specific local problems.

3.22 **Nationally supported local policies and action include:**

- improving the quality of health and other public services in deprived areas by spreading good practice through the work of Health Action Zones and emerging PCTs, and ensuring that PCTs play a full part in building Local Strategic Partnerships (<http://www.local-regions.dtlr.gov.uk/lsp/guidance/index.htm>)
- removing obstacles to local partnership working and better co-ordinated local plans
- working with disadvantaged communities by extending community development for health through the *Healthy Communities Collaborative*, and supporting community self-help activity
- supporting poorer mothers and families by increasing childcare, family support and health advice, and recognising their wider needs by linking *Sure Start* to regeneration programmes
- improving the quality of care for older people by addressing age discrimination
- implementing the Government's strategy on rough sleeping to reduce the number of people sleeping rough
- widening the scope for poorer owner-occupiers to improve their homes
- delivering drug and alcohol misuse prevention programmes that reduce crime and tackle the health related consequences of abuse, particularly through effective local Drug Action Teams
- tackling unsafe environments by reducing crime and the fear of crime in disadvantaged communities by delivering on targets to reduce burglary, robbery and vehicle crime
- improving planning, and locating new health facilities so that disadvantaged families have safe and easy access by a range of transport modes
- providing safe and easy access to food and other shops, public services and sport and recreation by a choice of transport through a better local transport system, which requires local authorities to consider land-use and transport planning together
- improving access to a range of sport and recreational facilities and programmes for all age groups, and promoting walking and cycling
- building a safer environment for disadvantaged communities by improving road safety for all road users including pedestrians, in line with the Government's *Road Safety Strategy*
- continuing to reduce home accidents and injury, and increasing home fire safety and protection, particularly for households with children

3.23 It can be done ...

In part of Falmouth, a dedicated effort by health professionals in partnership with tenants and residents, teachers, police, and local government has seen dramatic change to the largest and poorest housing estate in Cornwall. Within four years the crime rate has halved; the number of children on the child protection register has dropped from 23 to 8; children's examination results have improved – with a doubling of the rate of 10-11 year old boys achieving level 4 at key stage 2; the number of childhood accidents has fallen by half; and the number of mothers with postnatal depression has fallen from 18 to 4.

The “Cornwall Partnership” – comprising the local council, the health authority and housing associations – has improved heating and insulation in council homes occupied by families with children suffering from asthma. As a result there has been a significant improvement in the respiratory symptoms of the children affected.

Dudley's Wren's Nest estate suffered from a range of problems: empty properties, environmental decline, high levels of unemployment and crime, and poor health among residents. Through the initiative of a local tenants association properties have been improved, burglary routes blocked off, a gardening club has been set up for elderly and disabled people, and healthy eating promoted among elderly and disabled people and among schoolchildren.

QUESTION: *What more can be done at a local level to co-ordinate action in disadvantaged communities, engage citizens, and contribute to the health inequalities targets? What more can be done to empower local communities with lower life expectancy to improve health?*

Priority 6: Tackling the wider determinants of health inequalities through Government policy

- 3.24 The Acheson report emphasised the importance of the wider social and economic determinants, including poverty, housing and unemployment. Government has a key role in providing the resources and setting the framework.
- 3.25 **Our aim** is to address these root causes of poverty and material disadvantage.
- 3.26 Outside of the NHS, **the national policies** which are directed to reducing health inequalities and contributing to the targets include:
- improving the income and material conditions of the poorest by continuing reform of the tax and benefit system
 - continuing to improve the position of the poorest working families by increasing the National Minimum Wage (<http://www.inlandrevenue.gov.uk/nmw/index.htm>)
 - addressing inequalities in the most disadvantaged communities through implementing the *National Strategy for Neighbourhood Renewal*
 - reducing the risk of ill health and cutting the number of excess winter deaths among some of the most vulnerable groups, including older and disabled people, by implementing *The UK Fuel Poverty Strategy* (<http://www.defra.gov.uk/environment/consult/fuelpov/index.htm>)
 - addressing the housing needs of deprived areas by bringing all social housing up to set standards of decency by 2010
 - providing targeted help for those without work to find and retain jobs through the *New Deal* programmes, employment zones and Action Team for Jobs

- helping people of working age by introducing *Jobcentre Plus* to deliver an integrated and efficient labour market and benefit service
- reducing work-related ill-health and increasing opportunities for rehabilitation through the occupational health strategy, *Securing Health Together*

QUESTION: *What types of action can be taken to address the wider determinants of health inequalities?*

4. Delivering the priorities

This section focuses on the systems and structures that are required to get things done, to protect and nurture existing good practice, and extend the reach and impact of programmes and services. It is concerned with the NHS as well as the partnership between the NHS and local and regional government, and the community, voluntary sector and individuals.

Systems and processes to support delivery of the priority actions

- 4.1 To ensure that the priority actions are delivered, we need to put in place supportive systems and processes that mobilise resources, manage performance and support integrated working at national, regional and local level. Such systems need to be in place to protect and nurture existing good practice, and extend the reach and impact of programmes and services that will have further impact on health inequalities.
- 4.2 This consultation is taking place against a background of change in the organisation and structures of regional and local government and the NHS. This change is set out in *Shifting the Balance of Power within the NHS* and is aimed at modernising services and, as part of this, facilitating greater joint working (<http://www.doh.gov.uk/shiftingthebalance/shiftingthebalance.pdf>). This consultation is not about those changes, but is concerned to ensure that action to reduce health inequalities is addressed within these evolving structures, and is clearly embodied within the remit of new organisations as they emerge.
- 4.3 As well as the role of the NHS in creating conditions for success, we intend to identify more fully the role that can be expected of local and regional government, and the community and voluntary sectors in facilitating action.

QUESTION: *We would welcome views on these systems and processes, and seek suggestions of ways in which they can be strengthened further to support action to address health inequalities.*

The role of the NHS

At national level

- 4.4 An Inequalities and Public Health Taskforce has been established to steer the implementation of *The NHS Plan* commitments on health inequalities and public health, including the delivery of the health inequalities targets.
- 4.5 Other Department of Health actions that will help to create supportive systems and structures to enable local delivery of action to address health inequalities include:
 - completing a review of the NHS resource allocation formula intended to produce changes in the allocation of resources across the country and better reflect the burden of disease and the health needs of people living in the most disadvantaged areas

- ensuring that action to tackle health inequalities is part of NHS performance management systems, for example within the performance indicator set supporting the NHS Performance Assessment Framework (see section 5). Good practice in tackling health inequalities will be a factor affecting access to the Performance Fund through the NHS “traffic light” system
- introducing equity audits from Autumn 2002 which will build on current work and could include a health inequality impact assessment dimension

At regional level

4.6 *The NHS Plan* made a commitment to harmonise the public health resource at NHS regional level with the Government offices for the regions (GOs). Strong public health groups, headed by a regional director of public health will be established within each GO and will:

- develop an integrated approach to tackling the wider determinants of health at regional level
- inform regional work on economic regeneration, education, employment and transport from a public health perspective
- have an overview of the health contribution to Local Strategic Partnerships in their regions
- ensure the quality of the public health function, including the protection of health across the region and emergency and disaster planning and management

At local level

4.7 PCTs are being established throughout England during 2001-2. They will be responsible for improving health and ensuring the delivery of health services to meet the needs of their local community. There will be a public health team in each PCT with a Board level appointment to lead the work on health improvement. PCTs will be accountable to the Secretary of State through the new strategic health authorities and will work as partners with local government, and private, community and voluntary sectors in Local Strategic Partnerships.

4.8 Correspondingly, PCTs are very well placed to deliver change at local level, because they will have the best knowledge and information about local health needs, and have specific responsibilities for providing public health services that are essential to the achievement of the targets. PCTs can ensure that action to tackle health inequalities is brought within the mainstream of NHS modernisation and planning systems at local level, including annual Health Improvement and Modernisation Plans. Local Modernisation Reviews will identify local measures of success on health inequalities which support achievement of the national targets.

QUESTION: What more can be done to engage PCTs to improve health and reduce inequalities?

The NHS In Partnership

4.9 The Acheson report emphasised that the range of factors influencing inequalities in health extends far beyond the remit of the NHS and engages the whole of Government and beyond. Partnerships and joined-up working with a range of players nationally and locally will be crucial in advancing the health inequalities agenda and achieving the new targets. A great deal has already been done. This has involved other Government departments, local government and the voluntary and community sectors. We have valued and appreciated these efforts at every level – from other departments to the community groups and individuals who have played their part. More action is needed, and we want to encourage everyone engaged in this work to build on what has already been achieved.

- 4.10 At a national level, for example, we are engaged with other Government departments and agencies on current initiatives such as the *National Strategy for Neighbourhood Renewal*.
- 4.11 A Government cross-cutting spending review on health inequalities offers a unique opportunity to examine the impact on health inequalities of spending across at least seven other Government departments. This will result in an integrated approach to health inequalities and more effective cross-Government working.
- 4.12 Locally, the work of NHS strategic health authorities and PCTs will need to be aligned with Local Strategic Partnerships in ways that will maximise their capacity to take the actions described in the previous section. This can be done by:
- ensuring that Health Improvement and Modernisation Plans are aligned with local authority planning processes, and fit with local community strategies and neighbourhood renewal strategies
 - supporting Local Strategic Partnerships putting health inequalities at the core of their strategies and developing appropriate arrangements to monitor the delivery of health inequalities targets. Making sure that health inequalities are tackled by these Partnerships as they take forward their neighbourhood renewal strategies
 - ensuring committed NHS participation in Local Strategic Partnerships by bringing knowledge, expertise and resources to the partnership
- 4.13 Many local authorities will need to work in close partnership with PCTs and health authorities to deliver the ambitious targets set under their Local Public Service Agreements. These voluntary agreements between the Government and individual local authorities can help promote innovation and deliver better local services. They offer incentives and new administrative freedoms to help local authorities tackle local and national priorities, including those that relate to health.
- 4.14 Making changes to people's lives will require local action at community level. It will be crucial for the NHS through these partnerships to make the connections with local government, the voluntary sector and community groups. Other agencies, such as schools, can play a pivotal role in this work by acting as a bridge between public bodies like the NHS and the local community.

QUESTION: What more can be done across Government at national and local level to ensure co-ordination of effort, and to maximise the impact of initiatives that address health inequalities?

The NHS as a good corporate citizen in the local community

4.15 The NHS as a major employer and as a major business in virtually every locality has a role to play in tackling inequalities and addressing regeneration through its investment in staff and capital, the purchase of services, and the development and regeneration of local economies. This can be done by:

- ensuring that major decisions concerning NHS capital developments contribute to regional and local regeneration schemes, including the fit with local transport systems. The aim is to offer skills training and building work experience to local unemployed people
- ensuring that as a major employer the NHS makes a significant contribution to local employment schemes by working closely with local communities, the voluntary sector, Learning and Skills Councils and other parties involved in regeneration activities
- ensuring that NHS procurement of goods and services helps, wherever possible, to stimulate local economies and enhance the employability of vulnerable groups, especially in disadvantaged areas
- ensuring that the NHS uses health impact assessment, incorporating a health inequality impact assessment, to inform decisions regarding services and capital developments

4.16 This approach has worked ...

In Tower Hamlets, close working with the Bengali community to increase their knowledge about local job opportunities, particularly in the NHS, has resulted in over 50 local people training for a variety of jobs ranging from ward clerks to laboratory technicians.

In Liverpool the Health Action Zone staff have worked with local regeneration agencies to improve health through improved employment rates. Already 178 new jobs have been created in the most deprived areas of the city.

4.17 Taken together, these systems and structures are intended to release the resources, manage performance and support integrated working at national, regional and local level that will lead us towards the action necessary to deliver the targets.

QUESTION: We would welcome views on these systems and processes, and seek suggestions of ways in which they can be strengthened further to support action to address health inequalities.

5. Indicators to support action on health inequalities

This section describes the approach being taken to develop a “basket of indicators” to help us to track progress towards the achievement of the national health inequalities targets. These indicators will have to meet the needs of a diverse range of uses (and users). We are seeking views on the general approach proposed for the development of a basket of indicators, and help in identifying critical information gaps.

The indicators

- 5.1 The two headline national health inequalities outcome targets for the year 2010, on infant mortality and life expectancy, are complemented by national targets on child poverty, smoking and teenage pregnancy. To achieve these targets we must be able to assess whether the necessary systems and policies are in place and whether the action being undertaken is sufficient to succeed in reducing health inequalities and meeting the targets. We therefore need to monitor a broad range of indicators in order to gauge progress.
- 5.2 The indicators should reflect work going on in the NHS, across Government and across sectors, at national, regional and local levels, and should link with other relevant initiatives. To meet the needs of a diverse range of uses (and users) it is essential that the indicators cover the underlying determinants of health (eg poverty, education, environment), lifestyle factors (eg smoking, diet, exercise and nutrition) and health outcomes (eg mortality, morbidity), as well as measures of key activities designed to achieve health benefit and reduce health disparities. More specifically, the indicators must support the six priorities for action set out in this document. The aim is to bring all of these indicators together in a basket drawing, wherever possible, on indicators and targets that already exist for other purposes, such as those on sustainable development and Best Value. These indicators also apply to Local Public Service Agreements (the LPSA scheme) in which several local authorities have committed to achieving demanding targets on nutrition, reducing teenage pregnancy rates, improving educational attainment and the environment.
- 5.3 The basket will be designed to meet the needs of a wide range of users, both technical and non-technical, at national, regional and local level. It will serve a number of uses, including:
- giving information on the current state of health inequalities and identifying where action is needed (equity profiles and audits)
 - supporting the setting of specific local inequalities targets or establishing broader objectives
 - identifying measures of success, both nationally and locally, to support achievement of the national targets
 - providing indicators for incorporation into performance management and appraisal mechanisms
 - monitoring progress at national, regional and local level (including intermediate measures of activity and outcome)
 - influencing the joint actions of partner organisations
 - acting as the basis for reviews/reports/evaluations

QUESTION: We are seeking your views on the general approach proposed for the development of a basket of indicators. If you consider there are critical information gaps in this area, please let us know so that we can feed these into the Review of Public Health Information Sources (see Figure 7).

- 5.4 There are already in existence a large number of indicator and data sets which serve many different functions, both within and outside the NHS. Wherever possible we intend to build on and exploit these to produce a set of indicators that will support action to reduce health inequalities. We wish to ensure that all major dimensions of inequality are in due course represented in the basket (eg social class, ethnicity, gender, age, geography, groups with particular needs eg asylum seekers, people with disabilities, prisoners etc).

The framework

- 5.5 In compiling the basket of indicators we need to ensure consistency with, or read across to, other relevant initiatives, eg the performance assessment frameworks for the NHS and personal social services, health poverty index, and Best Value. The health poverty index was proposed in *The NHS Plan* and a scoping study is nearing completion and should be made available during the consultation period. The NHS performance indicators are currently the subject of a consultation exercise, and the responses to this health inequality consultation will feed in to that.
- 5.6 The basic framework could have different levels of indicators:
- national targets (infant mortality and life expectancy)
 - high level indicators (a small set covering key areas of delivery)
 - national/regional basket of indicators (broader set from which regions can choose their priorities)
 - local basket (from which local action programmes can choose)
- 5.7 We propose a framework set in terms of the major health priority areas and the wider determinants that are known to have an important impact on health inequalities. This would ensure that all key elements of the determinants and outcomes of health inequality were addressed and enable action within each area to be assessed and progress monitored. This generic approach would be supplemented by more detailed coverage of the six areas for action identified in section 3 of this document.
- 5.8 **Figure 5** provides a framework and illustrates a possible set of high level indicator areas to provide an overview of progress, currently oriented towards the national level. The structure and content will take account of the emerging findings from the health poverty index scoping study. The indicators will also need to reflect more closely *The NHS Plan* priorities as they evolve and ongoing work on the National Service Frameworks. The basket of indicators will build on the high level indicator areas and cover each of the major dimensions of inequality.
- 5.9 The basket of indicators will enable topic-specific selections to be made to inform on progress in particular areas. **Figure 6** illustrates one example of how a more detailed set of indicators could be compiled of particular relevance to someone working towards reduction in health inequalities from a local authority housing department setting. Choice of indicators will depend on local circumstances and the precise purpose for which the indicators are required. Issues such as confidentiality and small numbers will also be important factors to be considered. Note that the indicators are predominantly drawn from a wide range of pre-existing initiatives. This approach will be developed for each of the six areas for action identified in this document.

Figure 5

POSSIBLE HIGH LEVEL HEALTH INEQUALITIES INDICATOR SET (including previously specified national targets)	
<p>(Note: At this stage we have presented a mixture of specific Government targets, indicator areas and indicators – precise and consistent indicator formulations will be specified in the light of the consultation; some indicators may require further development).</p>	
<u>National targets</u>	
Life expectancy	
1.	Starting with health authorities, by 2010 to reduce by at least 10 per cent the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole.
Infant mortality	
2.	Starting with children under one year, by 2010 to reduce by at least 10 per cent the gap in mortality between manual groups and the population as a whole.
<u>Other related targets</u>	
Child Poverty	
3.	The Government is committed to halving child poverty in ten years and eradicating it within a generation.
Smoking	
4.	Reduce smoking rates among manual groups from 32% in 1998 to 26% by 2010, so that we can narrow the gap between manual and non-manual groups.
Teenage pregnancy	
5.	By achieving agreed local conception reduction targets, to reduce the national under 18 conception rate by 15% by 2004 and 50% by 2010, while reducing the gap in rates between the worst fifth of wards and the average by at least a quarter. NB The Teenage Pregnancy Unit will issue a national indicator set in October to support implementation of the <i>Teenage Pregnancy Strategy</i> .
<u>Supporting indicators</u>	
<u>Positive measures of health</u>	
6.	Healthy life expectancy.
<u>Lifestyle factors</u>	
7.	Smoking (other than (4) above).
8.	Diet.
9.	Nutrition.
10.	Obesity.
11.	Physical activity.
12.	Alcohol consumption.
13.	Drug misuse.
14.	Psychosocial.
<u>Health outcomes and treatments</u>	
15.	Cancer: Mortality and morbidity (including patient treatment rates, rates of use of appropriate treatment and 5 year survival rates).
16.	CHD: Mortality and morbidity (including patient treatment rates, rates of use of appropriate treatment).
17.	Mental health: Mortality and morbidity (including patient treatment rates, rates of use of appropriate treatment).
18.	Accidents: Mortality and serious injury.
19.	Children: Mortality and morbidity (including infant mortality rates for sole registrations); risk factors including smoking and breastfeeding; oral health.
20.	Older people: Mortality and morbidity.
<u>Service-related activities</u>	
21.	Access: primary care, emergency care and other areas.
22.	Workforce: representative of local communities.
<i>continued</i>	

Figure 5 continued

Wider determinants of health	
Low Income	
23.	A reduction in the proportion of people living in households with low incomes (in relative and absolute sense and persistently). A target has been set for children: Make substantial progress towards eradicating child poverty by reducing the number of children living in low income families by at least a quarter by 2004.
Education	
24.	Increase the percentage of pupils obtaining five or more GCSEs at grades A* to C (or equivalent) to at least 38 per cent in every LEA by 2004. A target to reduce the attainment gap at Key Stage 2 (age 11) in English and mathematics will be announced later in 2001.
25.	An increase in the proportion of 19-year-olds with at least a level 2 qualification or equivalent.
26.	Percentage of teenage mothers aged 16-19 in education, training or employment.
Employment	
27.	Over the three years to 2004, taking account of the economic cycle, increase the employment rates of the 30 local authority districts with the poorest initial labour market position, and reduce the difference between employment rates in these areas and the overall rate.
28.	An increase in the employment rates of disadvantaged groups (people with disabilities, lone parents, ethnic minorities and the over 50s) and a reduction in the difference between their employment rates and the overall rate.
Housing (and related)	
29.	Ensure that all social housing meets set standards of decency by 2010, by reducing the number of households living in social housing that does not meet these standards by a third between 2001 and 2004; with most of the improvements taking place in the most deprived local authority areas as part of a comprehensive regeneration strategy.
30.	Improve housing conditions, mainly in the private sector, by (a) renovating at least 200,000 homes; (b) adapting at least 85,000 homes to meet the needs of poor disabled households; and (c) improving the health and safety of people in their homes, with the Government setting a target for the number of occupied homes that fail to meet the statutory fitness standard and that are tackled by local authorities. It will set this target in 2001.
31.	End fuel poverty for vulnerable households by 2010.
32.	Reduce the number of people sleeping rough by two-thirds by April 2002, and keep the number at or below that level thereafter.
Transport	
33.	Reduce the number of people killed and seriously injured in road accidents by 40% by 2010 (compared with the average for 1994-98) and, within that, the number of children by 50%.
34.	Reduce the number of people finding access difficult to basic local services and amenities (eg supermarket, doctor, hospital).
Crime	
35.	Reduce the level of crime in deprived areas so that by 2005, no local authority area has a domestic burglary rate more than three times the national average; over the same period, reduce the national rate by 25 per cent.
36.	Reduce the long running rate of growth of crime, and to reduce the fear of crime.
Safety	
37.	Reduce the incidence of accidental fire-related deaths in the home by 20% averaged over the 5 year period to 31 March 2004 compared with the average recorded in the 5 year period to 31 March 1999.
Other wider determinants	
	For further development – to include sport and leisure, environment, working conditions.

Figure 6

Illustrative example of a topic-specific selection of indicators HOUSING	
EXISTING INDICATORS	
<u>Sustainable Development indicators</u> Proportion of all households living in non-decent housing (regional version available) [headline indicator] Temporary accommodation / Rough sleepers (local version available) Fuel poverty	
<u>Indices of Deprivation (ID 2000)</u> Housing domain includes homeless households in temporary accommodation, overcrowding and poor private sector housing	
<u>Other indicators</u> Provision of supported housing for teenage parents	
POTENTIAL INDICATORS	
Indicators relating to other aspects of housing relevant to health inequalities, offer scope for further development eg percentage of rough sleepers accessing health services via their GP or day centre in comparison to the national average	

- 5.10 There is scope to build the framework around a more flexible “matrix” approach to enable users to compile and access data to meet their specific needs. The basket could then act as a form of “menu” of health inequalities indicators. Electronic access gives particular scope to design a flexible system to facilitate access and use.

Figure 7

Review of public health information sources
Following on from the information recommendations in the White Paper <i>Saving Lives: Our Healthier Nation</i> and the <i>Independent Inquiry into Inequalities in Health</i> report, a review of public health information data sources is being carried out. The purpose of the review is to identify where data sources need to be strengthened to increase the department’s ability to assess public health, track progress in achieving targets and improve the capacity to monitor inequalities in health. As part of the review and to build on short-term pieces of work that have already been carried out (eg Review of Business Information Needs on Cancer, Race Equality and Performance Management, Review of Disease Registers), we are planning to hold a wide-ranging consultation with all those interested in health inequalities and public health information sources. This is due to take place in the winter.

QUESTION: *We are seeking your views on the general approach proposed for the development of a basket of indicators. If you consider there are critical information gaps in this area, please let us know so that we can feed these into the review of public health information sources (see Figure 7).*

6. We want your feedback

6.1 We want your feedback on the issues and the three key questions in this consultation document. Your views are sought on:

– **the proposed priority themes**, together with any suggestions of other effective actions, of equal priority, that could become part of a wider national programme as this work develops. Local examples of effective action would be welcome, together with contact details for any follow-up (Section 3), and in particular

- what more can be done to reduce infant mortality and morbidity for families on low incomes? What more can be done to provide a sure foundation for parents and young children and contribute to reducing health inequalities?
- what more can be done to improve the position of children and young people and contribute to the health inequalities targets? What more can be done in childhood and adolescence to reduce inequalities in life expectancy?
- what more can be done at a local level to improve the responsiveness of NHS primary care services and contribute to the health inequalities targets?
- what more can be done to promote action against the big killers of CHD and cancer and contribute to the targets on health inequalities?
- what more can be done at local level to co-ordinate action in disadvantaged communities and engage its members, and contribute to the health inequalities targets?
- what types of action can be taken to address the wider determinants of health inequalities?

– **the proposed systems and processes to support this work**, and ways in which they can be strengthened further to support action to address health inequalities (Section 4)

- what more can be done to engage PCTs to improve health and reduce inequalities?
 - what more can be done across Government at national and local level to ensure co-ordination of effort, and to maximise the impact of initiatives that address health inequalities?
- **the general approach proposed for the development of the basket of indicators** (Section 5)

Regional Workshops

- 6.2. Please join us at one of the regional workshops we will be organising during September and October to support the consultation process (subject to availability). Details are available on our website <http://www.doh.gov.uk/healthinequalities>, or from Jeff French at the Health Development Agency, telephone 020 7413 1926.

Responses

- 6.3 Responses should reach us by **Friday 9 November** and sent, by email where possible, to:
Healthinequalities@doh.gsi.gov.uk

or by post to: The Health Inequalities Consultation Team, Department of Health,
Room 534, Wellington House, 133-155 Waterloo Road, London SE1 8UG



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