Reducing Health Inequalities in Yorkshire and the Humber

A Systematic Way Forward

Version: Tuesday, 10 April 2007
Introduction

This report proposes a systematic approach to tackling health inequalities in this region.

It is intended to help a process of:

- Developing a shared commitment to and vision of a systematic, evidence based approach and a shared vision
- Supporting the creation of local, systematic action plans
- Informing a regional action plan to support local work

The first step in this process is a regional workshop on 19 April 2007, after which this paper will be updated as a statement of direction.

The approach rests on three principles:

- There are three levels of intervention with people to drive change
- Different approaches have different times for development and impact
- Initial impact has to be driven by the NHS, sustained change is only possible through partnership work led by other organisations

It asks three questions:

- Do you know what the health inequality picture is for your area and how it differs from that of others? What is killing your people?
- Do you know what you need to do to address it?
- What are you going to do that will have the biggest impact by 2010?
Reducing Health Inequalities in Yorkshire and the Humber

The challenge

In line with the rest of England the health of the region’s population has continued to improve, as measured by life expectancy and more recently by the Department of Health’s indicator All Age All Cause Mortality\(^1\).

Despite this improvement there remains a persistent and in some cases growing gap between the health of the most disadvantaged people and the best off.

The Department of Health has identified those districts that have a significant number of disadvantaged local areas compared to the national average and agreed to target action here to narrow the gap. These communities are designated as ‘spearhead’ communities. There are seven in Yorkshire and the Humber: Barnsley, Bradford, Doncaster, Hull, North East Lincolnshire, Rotherham and Wakefield.

The following chart shows that the districts with the worst overall all age all cause mortality are Hull, Barnsley and Rotherham. However, the chart also

\(^{1}\) Definition
illustrates the huge variations in mortality rate that exist within local authorities, between their most deprived and least deprived areas. As can be seen, this local scale of inequality does not mirror the pattern of overall rates and highlights the importance of addressing two key issues together: reducing the gap in those priority (Spearhead) areas and addressing the inequalities that exist within all districts in the region.

These two imperatives are reflected in Local Area Agreements:

- targets for Spearheads focus on reducing the gap between those districts and the England average
- targets for non- Spearheads focus on reducing the intra-area gap.

In the case of North Yorkshire for example this focuses on reducing the gap between the district council – Scarborough – with the largest number of deprived neighbourhoods with the district with least number of disadvantaged neighbourhoods – Hambleton.

**Action on health inequalities**

The region has seen a range of activity to address health inequalities including PCT based equity audits, service specific initiatives such as the West Yorkshire Cancer services audit, and a number of initiatives – many originating under Health Action Zones - which offer a reservoir of experience.

However, their impact has been limited and with a few exceptions - such as the Sheffield CIRC² project - have not resulted in mainstream change.

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² City Wide Initiative to Reduce Cardio Vascular Deaths
The Public Service Agreements (PSAs) on Health Inequalities require the achievement of percentage change in a health indicator eg life expectancy, cancer mortality; at population level eg Spearhead community; in a given time period - by 2010.

Achievement of such measurable change will require systematic action with interventions that are known to be effective. The requirement to produce Joint Strategic Needs Assessments provides an opportunity to develop a whole system approach to addressing health inequalities.

These interventions can be delivered at three different levels to drive change at population level ('public health'). These are illustrated in the following diagram:

<table>
<thead>
<tr>
<th>Population Health</th>
<th>Personal Health</th>
<th>Community Health</th>
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<tbody>
<tr>
<td>Some interventions can be instituted directly at population level. They are sometimes referred to as health protection measures. They are usually societal changes aimed at influencing behaviour or 'making healthy choices easy choices'. They include public policy; legislation and regulation; fiscal measures eg taxation; media and education.</td>
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<td>Some treatments, therapies and technologies are now highly effective at the personal level. Good examples are the use of low-dose aspirin and statins to reduce the risk of heart attack. As well as being effective at the individual level, such measures can also add up to a population level effect when interventions such as use of disease registers and</td>
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Incentive systems make the use of these measures systematic, so that they support as many people as possible who might benefit.

**Community Health**

Individuals will only choose to use and benefit from certain behaviours and treatments if they fit with the cultural and belief system of their own community. Community development is a process of facilitating communities awareness of the factors and forces that affect their health and quality of life, and ultimately help to empower them with the skills needed for taking control and improving those conditions in the community that affect their health and wellbeing.

In order to make a significant impact on health inequalities in the region we need to take a more coherent, systematic approach using an evidence base of what works and making full use of all of the levers that we have available.

Too frequently, activity has not been sufficiently systematic, relying on a mixture of comparatively weak performance management levers such as a focus on smoking cessation activity and work to address population behaviours and their outcomes such as physical activity, teenage pregnancy and obesity.

In Yorkshire and the Humber we will be promoting a whole system approach that has the following three strands:

<table>
<thead>
<tr>
<th>Area of activity</th>
<th>When they will impact</th>
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<tbody>
<tr>
<td>• Improving the availability and capability of front line NHS services who work with the most disadvantaged.</td>
<td>• Short to Medium Term</td>
</tr>
<tr>
<td>• Supporting the work of local organisations to engage and empower the most disadvantaged communities in improving their own health</td>
<td>• Short to Medium Term</td>
</tr>
<tr>
<td>• Working with local organisations to develop stronger actions that will address the underlying determinants of health such as housing, environment, transport and education</td>
<td>• Medium to Long Term</td>
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Critical here is the recognition of the different timescales and the significance of immediate action by mainstream NHS services.

**Implication for front line NHS services**

Time is short if we are to meet the 2010 targets. That means we must work through our existing services and give extra attention to extracting maximum
benefit from the delivery of interventions for which there is strong evidence of effectiveness.

**What is killing people?**

Analysis of the causes of death responsible for the mortality gaps between the most deprived communities and national averages will point to which interventions are most likely to have an impact on the gap. This work has been done for nationally for spearhead areas as a group, comparing them with the national average.

**What will reduce these premature deaths?**

Having identified the causes of mortality in excess of national averages, it is then possible to establish which interventions will have an impact, if applied efficiently and effectively to those individuals and communities identified as having the particular health needs.

The approach of the National Support Team for reducing health inequalities is that the emerging portfolio of interventions will then form the core of local action on health improvement, and, when appropriately targeted, the health inequalities programme.

**Some answers**

The national picture, which identifies the differences between the Spearhead communities as a group, and the national average are shown separately for men and women in the ‘scarf ‘diagrams below. The first ‘scarf’ shows what is contributing to the gap in life expectancy. Effective interventions are then listed and the second scarf quantifies the impact of each area of intervention.

Individual communities will vary somewhat from the national picture, and so it is worthwhile to do the analysis of the particular local area, to construct the local ‘scarf’ diagrams. This will allow local programmes to be appropriately tuned to local need. There are some issues in applying the model to small populations but that are being worked on via the PHO.

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3 So-called simply because they look like a scarf.
Having established which interventions are to be focussed on, it will then be important to ensure that everything is being done to extract maximum impact at population level from them.
A diagnostic tool, developed in South Yorkshire and now being used by the National Support Team for Health Inequalities, enables systematic appraisal of a range of contributory factors, that will influence outcomes. An outline of this tool is included in the appendix 1 below – *Commissioning Healthcare for Best Outcomes*.

It is proposed that this tool is used to identify gaps in current provision and use of services. An important component of what is often missing is the systematic application of social marketing. Effective use of these techniques can contribute to changing the behaviours of staff, patients and communities. See appendix 2 for a summary of the essential elements of social marketing.

**Timescales?**

All interventions will have a lead in time or gestation period before their impact is measurable. Thus, it may take ten years before a major reduction in tobacco use has a visible impact on lung cancer. However its impact on heart disease may be apparent in just a couple of years.

Only a specific set of interventions impact in time to meet a 2010 target. It will be important to concentrate very specifically on these in the short term.

That does not mean neglecting completely interventions with a longer gestation period, which will be needed to achieve sustainable change in the medium and long term. Fortunately, quite a number of the interventions we need to pursue in the short term will also pay slightly different and additional benefits in the medium term also eg smoking cessation; physical exercise.

**Some implications for how the NHS works with communities**

**Insight**

The traditional approach to population behaviour change has focussed on mass marketing campaigns which have had only a limited effect on changing behaviours.

To be effective we know that we need to develop strong collaborative working relationships within communities. However, we know that the capability and capacity of communities varies considerably and this affects their ability to work with us.

The Department of Health is now clear that a more targeted and collaborative approach is required. This approach recognises that there is a relationship between ownership of issues, empowerment and change. Generating genuine insight into people and communities and what could influence their behaviour, working alongside local partners, is essential, if we are to design and deliver effective services. Key partners here include local authority Neighbourhood Management leads and officers responsible for Neighbourhood Renewal and New Deal for Communities. Initial ideas to strengthen joint work include:
• Improving information flows between PCTs and Neighbourhood Management Leads in order to ensure that actions and outcomes are complimentary.

• Developing a benchmark to enable officers such as PCT Chief Executives to readily be able to assess which communities can respond to activity to reduce health inequalities and which will require further development support to do so.

Accountability, participation and representation

We know that successfully addressing Health Inequalities will require sustained activity over many years. In order to maintain this priority it is important that local communities are as concerned about this as health professionals are.

The Local Government Paper and the Local Government and Patient Involvement in Health Bill places clear responsibilities on local authorities to have in place structures to ensure a strong community voice. This includes:

• Providing information on service quality and resourcing
• Introducing Community Calls for Action
• Establishing LINKs in each community to ensure that the views that communities have about their health services are heard.
• Establishing effective scrutiny process.

We need to ensure that there is a continued focus to support local organisations – particularly local authorities - to understand the impact that they have on reducing health inequalities and maximise the effectiveness of their associated work.

Key dimensions to this are:

• How employees within the NHS engage with the other sectors – for example helping to target affordable warmth interventions.
• Ensuring that NHS organisations meet their corporate social responsibilities – such as employment strategies, transport policies, waste management policies etc.
• Jointly appointed Directors of Public Health providing leadership and expertise on health impact assessments on key local policies that affect health inequalities.

ACTIONS

For discussion and decision on 19th of April 2007
APPENDIX 1

Commissioning healthcare for best outcomes

The attached diagram is known colloquially as the ‘Christmas Tree diagnostic’, and is accompanied by a description of its numbered component principles. The framework balances two sets of factors which determine whether optimal outcome can be achieved at population level from a given set of personal health interventions.

**Challenge to Providers:** links the Factors that will influence health service outcomes i.e. how can we construct the most effective service.

However, optimal outcomes at population level will not be obtained without…….

**Population Focus:** this identifies those Factors which determine whether a community makes best use of the service provided.
### Commissioning healthcare for best outcomes

<table>
<thead>
<tr>
<th><strong>A  Population focus</strong></th>
<th><strong>B  Challenge to providers</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1 Known population need</strong></td>
<td>The PCT will work to ensure that the level and type of service is based on knowledge of the health care need of the population.</td>
</tr>
<tr>
<td><strong>2 Expressed demand</strong></td>
<td>The PCT will work to inform, educate and support the population to encourage them to take action to improve their own health and well-being and to access and utilise health services appropriately.</td>
</tr>
<tr>
<td><strong>3 Equitable resourcing</strong></td>
<td>The PCT will work to make resources available for the population to benefit according to need, by targeting distribution of its income.</td>
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<tr>
<td><strong>4 Responsive services</strong></td>
<td>The PCT will work to ensure that all patients will be afforded equal access to beneficial interventions according to need.</td>
</tr>
<tr>
<td><strong>5 Informed choice</strong></td>
<td>The PCT will ensure that, where appropriate, patients are empowered to make choices about their treatment and care plans on the basis of good information and are supported to utilise treatments and therapies to best effect.</td>
</tr>
<tr>
<td><strong>6 Known intervention efficacy</strong></td>
<td>The PCT will work to ensure that services are established, modified and maintained on the basis of best current knowledge of the efficacy of interventions and national guidance.</td>
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<tr>
<td><strong>7 Local clinical effectiveness</strong></td>
<td>The PCT will work to ensure that service providers maintain high standards of local effectiveness through education and training driven by systems of professional and organisational governance and audit.</td>
</tr>
<tr>
<td><strong>8 Cost effectiveness</strong></td>
<td>The PCT will work to ensure that the expenditure on health care is targeted so as to optimise the potential health gain available to residents from resource available.</td>
</tr>
<tr>
<td><strong>9 Accessibility</strong></td>
<td>The PCT will work with providers to develop appropriate models and configurations of service, balancing a drive to bring services closer to the patient with the need for efficiency and effectiveness of that service.</td>
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<tr>
<td><strong>10 Patient/public involvement</strong></td>
<td>The PCT will work with patients and communities to ensure that the services place their needs and requirements at the centre of their operation and that quality assurance systems are in place to ensure the acceptability of services to patients.</td>
</tr>
<tr>
<td><strong>11 Adequate service volumes</strong></td>
<td>The PCT will commission adequate service volumes to at least accommodate national referral-to-treatment targets.</td>
</tr>
<tr>
<td><strong>12 Balanced service portfolio</strong></td>
<td>The PCT will ensure a balance of services within patient pathways to avoid bottlenecks and delays.</td>
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## APPENDIX 2

**Social marketing benchmark criteria**

French, Blair-Stevens (2006) based on and adapted from original benchmark criteria developed by Andreasen (2002).

<table>
<thead>
<tr>
<th>Benchmark</th>
<th>What to look for</th>
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| 1. Clear focus on behaviour, with specific behaviour goals | • Intervention clearly seeks to impact on behaviour with specific and measurable goals  
• Key performance indicators have been established  
• Fuller approach adopted (beyond just changes in behaviour) |
| 2. Uses consumer and/or market research | • Formative consumer/market research used to identify audience characteristics and needs  
• Range of different research techniques and data synthesis methods used, from public and commercial sector sources, to inform development |
| 3. Is theory-based & informed | • Transparent use of theory – the theoretical underpinning for work is clear  
• Mixed theory-based approach used to underpin and inform the development of interventions |
| 4. Is insight driven | • Focus is clearly on gaining a deep understanding and insight into what moves and motivates the consumer  
• Approach based on identifying and developing ‘actionable insights’ using considered judgement, rather than simply generating more data and intelligence |
| 5. Uses exchange concept | • Clear analysis of the full cost to the consumer in achieving the proposed benefit (financial, physical, social, etc.)  
• Analysis of the perceived costs versus perceived benefits  
• Incentives, recognition, reward, and disincentives are considered and tailored according to specific audiences |
| 6. Uses competition concept | • Both internal and external competition addressed  
• Strategies employed to minimise the potential impact of competition |
| 7. Uses a segmentation approach (not just targeting) | • Beyond a simple demographic or epidemiological targeting  
• Segmented approaches that focus on what motivates the target audience using psycho-graphic data  
• Interventions tailored directly to specific audience segments  
• Future life-style trends addressed |
| 8. Integrates a mix of methods (‘intervention mix’ or ‘marketing mix’) | • Range of methods used to establish an appropriate mix of marketing methods  
• Avoids reliance on single methods or approaches used in isolation  
• Methods and approaches developed taking full account of any other interventions in order to achieve synergy and enhance the overall impact |

Please note: These criteria focus on specific aspects of social marketing that should be considered when developing or assessing an intervention. They do not cover elements that are considered best practice in programme and project management and development e.g. strategy planning, review and evaluation. These are clearly also essential in order to develop an effective intervention.
Social marketing: a starter for 10

1. Starts and ends with a focus on the person and what’s important to them
Whether as consumer, citizen, client, customer, patient, service user etc, social marketing does not approach people in isolation, but considers them in their wider social context.

2. Has roots in both best public and commercial sector practice
It is not just concerned with commercial marketing approaches, but draws on many years of social cause and social reform work across different sectors.

3. Is an adaptable approach that can be used with small and large budgets
It can be used strategically and operationally, supporting development work whether there’s a £200 budget or £20 million!

4. Does not compete, but integrates with best public health, health promotion and health communications’ practice
Its value is that it has demonstrable potential to enhance responsiveness and improve impact and effectiveness of different interventions.

5. Uses whole-systems, holistic and wider determinants thinking
It integrates a clear focus on the individual with the need to address wider influences and inequalities.

6. Has a broad inclusive theoretical framework
It draws on, and helps to integrate: biology; psychology; sociology; and environment or ecology theory.

7. Actively considers and is concerned with ethical issues and values
Its systematic approach means that ethical issues and values are examined. It recognises that anything that seeks to influence or promote particular behaviour presents a range of ethical issues that need to be addressed.

8. Is a great deal more than advertising and communications
It uses a broad marketing mix of methods. In some cases a message-based communication approach or advertising may not be used at all.

9. Challenges top-down paternalistic ‘we know what you need’ approaches
It starts where the person is at now, not where someone might think they are, or should be. Understanding what is important to the person is a crucial focus.

10. It works!
There is a growing evidence-base to show that social marketing can significantly improve impact and effectiveness.