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Foreword



Most people instinctively understand that poverty and poor health are very closely linked. However, it still comes as a shock in this day and age to find that people in some areas of the country can expect to live over ten years less than others, simply depending on their social background and where they live. After over sixty years of the National Health Service the health inequalities gap stubbornly remains unacceptably wide. Local authority areas from the traditional industrial areas of Britain that the Alliance represents have many of the worst problems.

This report covers much that is already well understood in the health service and in government departments. Nevertheless, if we are ever to close the gaps the government, the health service, local authorities and people themselves have to continue to focus on the issue. We have to say it loud enough and often enough until something is done.

There are many reasons for the continuation of such problems which are not easily rectified, but there should be no excuse for not trying harder. With the appropriate level of resources, understanding, and political will it should not be beyond us all to make much more progress than we have so far.

A handwritten signature in black ink that reads "J. Devon". The signature is written in a cursive, flowing style.

Councillor John Devon
Alliance National Chair



1. What is the problem?

Overview

Health inequality is not new, particularly in the older industrial areas of Britain. The Office of National Statistics (ONS) in 2008 pointed out that the highest mortality rates ***“are largely concentrated in the same geographical areas as a century ago.”***¹

The gap between the better off and poorer areas is historically compounded as a result of less service provision and lower resource allocations. This is perhaps best encapsulated in the ‘inverse care law’ - *the availability of good medical care tends to vary inversely with the need of the population served.*²

When this issue first became a concern it was industrialisation and the urban industrial environment that led to ill-health and shortened lives. De-industrialisation on the other hand has come with different health outcomes. Overall health and life expectancy has significantly improved but still the inequalities remain. The stark message is you are still likely to die younger in older industrial areas than in more prosperous areas.

The health of the local and regional economy has an important impact on health outcomes of the population. The more wealth inequality in society the more health inequality there is. Indeed it is argued by some that economic and social inequality, regardless of the relative wealth of any society, actually causes ill-health amongst the more deprived sections.³ The World Health Organisation pulls no punches: ***“Social injustice is killing people on a grand scale.”***⁴

This report

The purpose of this report, however, is not to examine in detail the relationship between the health of populations and socio-economic factors. It is generally accepted by governments that such a relationship exists and is of sufficient importance to require major policy responses.

What the report will do is:

- **Examine the problem**
- **Look at what is being done to address the problem**
- **Make some suggestions about what more could be done.**

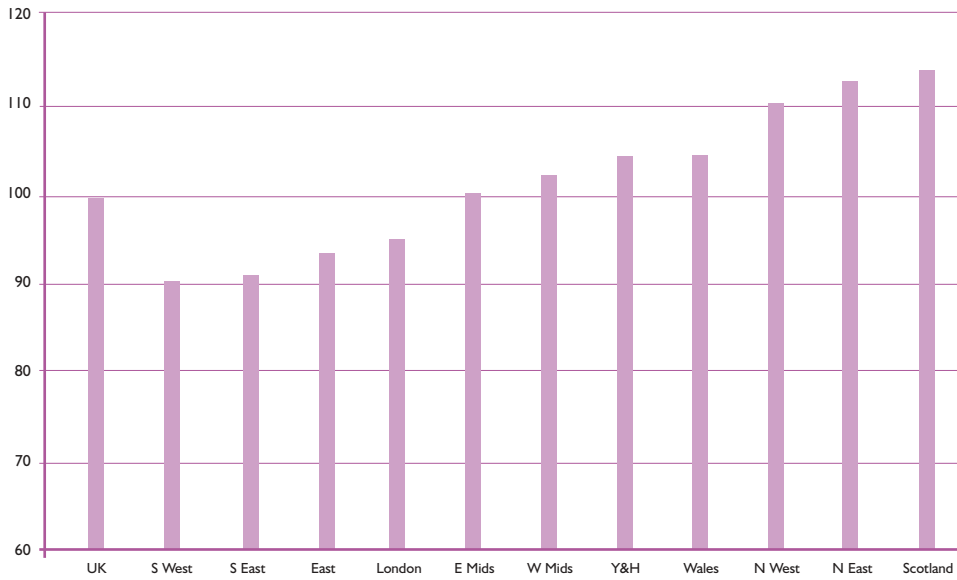
1 ONS 2008, Health Statistics Quarterly

2 J. Tudor Hart 1972. The Lancet.

3 R Wilkinson, 2005. The Impact of Inequality: How to make sick societies healthier.

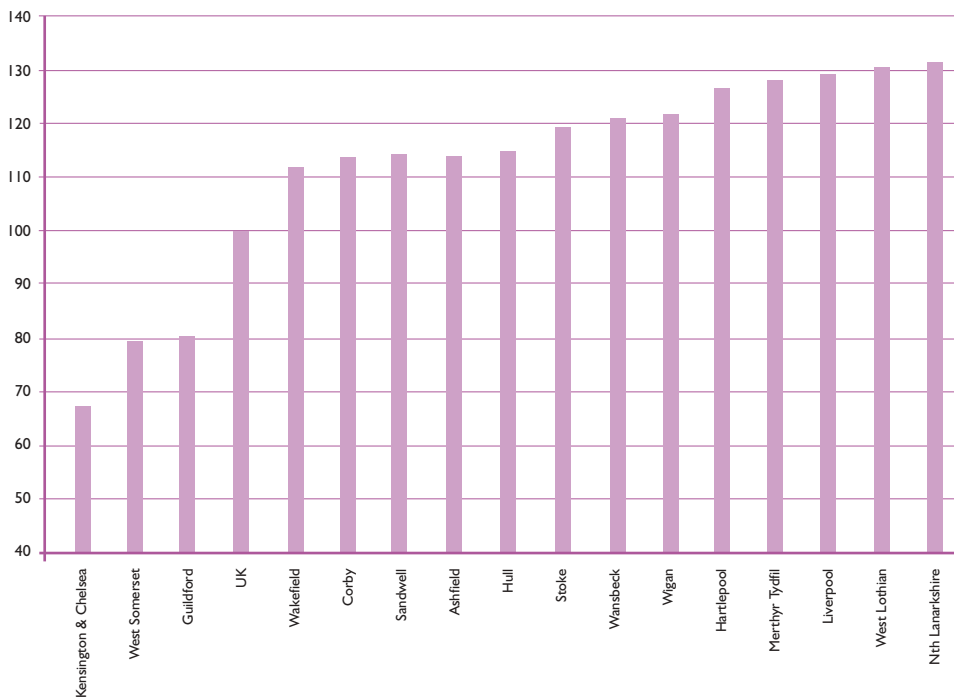
4 World Health Organisation, 2008. Final Report of the Commission on the Social Determinants of Health.

Figure 1: Standardised Mortality Ratios - Regions



Source: Regional Trends, 2006

Figure 2: Standardised Mortality Ratios - Selected Local Authorities



Source: Regional Trends, 2006

Community Profiles

Easington

Easington is on the North East coast in the County of Durham and was almost entirely dependent on coal mining and related industries. It has a population of around 94,000 dispersed in small towns and villages.

Within the least deprived areas of Easington men and women can expect to live five years longer than in the most deprived. Deaths from smoking, heart disease and strokes are significantly higher than the UK average. There is high rate of mental illness amongst the population.

Easington has prioritised promoting positive mental health, reducing alcohol abuse and tackling obesity.

Measuring health inequalities

The **Standardised Mortality Ratio** is an established way of measuring the relative health of populations (UK average = 100). From the graph (Figure 1 - page 7) the position of the regions, including Scotland and Wales, are illustrated. Generally areas south of a line from the Wash to the Severn Estuary have better rates than the UK norm whereas those to the north have worse. By this measure of health, Scotland and the North East are by some way the worst.

At the sub-regional level, older industrial areas are often amongst the worst. The local authority areas in the graph (Figure 2 - page 7) have some of the highest mortality ratios and compare poorly with some of the lowest.

Government, including the devolved administrations, have focussed on life expectancy and infant mortality as key indicators. This study makes use mainly of **life expectancy** as a measure of health inequality. Table 1 compares the life expectancy for most of the traditional industrial areas in England, Wales and Scotland.

There are significant gaps if certain local authority areas are compared. For example, men in Kensington and Chelsea live almost nine years longer than Knowsley and women nearly nine years longer than Hartlepool.

A report published in 2008 looked at the *highest and lowest* probabilities of survival to 75 years of age. From 2004 to 2006 men in Manchester had the least chance (around a 50%) of living until they were 75 years old and for women this was 68%. The best chance was in East Dorset where men had over a 78% chance of living to 75 and women around an 85% chance.⁵

In broad terms, the population of **Scotland** is less healthy than the rest of the UK. Scotland has the highest levels of mortality of any Western European country for both males and females and the rates of improvement are slower than other areas of the UK and Europe that have undergone similar industrial decline.⁶

The overwhelming majority of local authority areas in Scotland have populations with a life expectancy less than the UK average. As is often the case with Scottish statistics on various aspects of deprivation, Glasgow has the worst problems.

The government of Scotland and the NHS has an uphill task. Using the Scottish Index of Deprivation for 2006 for example - men in the worst 10% of deprived areas die over thirteen years earlier than men in the highest 10%. Women in the worst 10% fare a little better, but the difference is still over eight and a half years.⁷

In **Wales** the problems are very much the same. Men live nearly four years longer on average in the better-off areas such as Monmouthshire than they do in the less well off such as Blaenau Gwent. The difference for women is over four and a half years.

Life expectancy in Wales falls short of the UK average and in general the older industrial areas, such as the South Wales valleys, fare the worst.

5 ONS 2008, Health Statistics Quarterly.

6 Walsh Taulbut & Hanlon, 2008. The Aftershock of De-industrialisation.

7 General Register Office for Scotland, 2007 Life Expectancy for Administrative Areas within Scotland

Table 1. Life expectancy at birth - Selected Local Authority areas in the UK

	Men	Women		Men	Women		Men	Women
UK	76.96	81.29	Calderdale	76.1	81.4	South West	78.5	82.7
			Doncaster	75.8	80.4	Forest of Dean	77.1	82.2
North East	75.8	80.1	Hull	74.7	79			
Blyth Valley	75.5	80.1	Kirklees	76.2	80.5	Wales	76.64	80.98
Castle Morpeth	78.2	82	Leeds	76.7	81.6	Blaenau Gwent	74.8	78.7
Chester-le-Street	75.9	80.4	NE Lincolnshire	75.9	80.8	Bridgend	76	80.2
Derwentside	75.4	80.1	Nth Lincolnshire	76.8	80.9	Caerphilly	75.6	79.9
Durham	77.2	80.4	Rotherham	75.8	80.4	Cardiff	76.6	81.3
Easington	74.9	79.2	Selby	77.9	82.7	Carmarthenshire	75.8	81.1
Gateshead	75.3	79.9	Sheffield	77	81.2	Denbighshire	76.7	80.9
Hartlepool	74.5	78.3	Wakefield	75.9	80.3	Flintshire	76.7	81.2
Middlesbrough	74.5	79.2				Merthyr Tydfil	75.5	79.1
Newcastle on Tyne	75.2	80.3	East Midlands	77.3	81.3	Neath Port Talbot	76	80.2
North Tyneside	76.2	80.6	Amber Valley	77.7	81.4	Newport	76.7	80.7
Redcar & Cleveland	76	80.5	Ashfield	75.6	80.5	Powys	78.3	81.8
Sedgefield	76.2	79.6	Bassetlaw	76.7	80.3	Rhondda Cynon Taff	75.6	80.1
South Tyneside	75.2	80.1	Bolsover	75.9	80.1	Swansea	76.4	81
Stockton-on-Tees	76	80.2	Broxtowe	78.5	82.2	Torfaen	77.4	81.3
Sunderland	75.5	79.8	Chesterfield	76.7	80.6	Wrexham	76.9	80.5
Teesdale	76.7	82.1	Corby	74.5	79.9			
Wansbeck	76.2	79.5	Derby	76.8	81.7	Scotland	74.64	80.98
Wear Valley	75.7	79.1	Gedling	78.6	82.2	Aberdeen	74.9	80.1
			Hinckley & Bosworth	79	81.4	Edinburgh	75.8	80.9
North West	75.7	80.3	Mansfield	75.9	80.6	Clackmannanshire	73.2	78.8
Allerdale	76.6	80.6	Newark & Sherwood	77.8	81.3	Dumfries & Galloway	76.1	80.4
Barrow-in-Furness	75.4	80.7	NE Derbyshire	77.5	80.8	Dundee	73.6	79.3
Blackburn	74.2	79.2	NW Leicestershire	77.3	81.3	East Ayrshire	74.5	78.2
Bolton	75.2	79.5	Nottingham	74.3	79.8	East Lothian	76.3	80.7
Burnley	75.3	78.8	South Derbyshire	77.9	81.6	Falkirk	74.5	79.4
Bury	76.1	80.2				Fife	75.5	80.1
Chorley	76.7	80.8	West Midlands	76.6	81.1	Glasgow	70.5	77
Copeland	76.5	80.6	Birmingham	75.2	80.5	Inverclyde	72.2	77.8
Halton	74.3	78.4	Cannock Chase	75.6	80.8	Midlothian	75.1	79.7
Knowsley	74.4	79	Coventry	75.7	80.7	North Ayrshire	73.9	79
Liverpool	73.8	78.3	Dudley	76.6	81.3	North Lanarkshire	73	78.2
Manchester	73	78.6	Lichfield	78	80.9	Scottish Borders	76.5	80.5
Oldham	74.7	79.3	Newcastle-u-Lyme	76.9	81.5	South Ayrshire	75.8	80.5
Preston	75.1	79.5	Nth Warwickshire	77.7	80.8	South Lanarkshire	74.4	79.3
Salford	74.2	78.7	Nuneaton & Bedworth	76.2	80.1	Stirling	76.6	80.6
St Helens	75.3	80.2	Staffordshire Moorlands	77.5	81.3	West Dunbartonshire	71.8	77.7
Stockport	77.1	80.2	Stoke-on-Trent	74.5	79.6	West Lothian	75.2	79
Tameside	74.9	79.8	Tamworth	78.1	80.5			
Trafford	77.6	81.4	Walsall	75.7	80.8	Highest in UK		
Warrington	76.2	81	Wolverhampton	75.4	80.1	Kensington & Chelsea	83.1	87.2
Wigan	75.3	79.6						
Wirral	75.7	80.8	South East	78.5	82.4			
			Dover	77.6	81.7			
Yorkshire & Humber	76.6	81	Medway	76.4	80.8			
Barnsley	75.3	79.5	Swale	76.9	81			
Bradford	75.5	79.8	Thanet	75.8	80.5			

Source: Health Statistics Quarterly, Winter 2007

Community Profiles

Merthyr Tydfil

Merthyr Tydfil has a population of 55,500, some 5% lower than in 1996. It is the smallest local authority by population in Wales. Smelting iron was its main industry and back in 1845 Merthyr was the biggest single producer in the world. Coalmining sustained much of the local economy with new manufacturing jobs coming in the 1960s before further decline.

In 9 out of 12 measures of health, Merthyr is significantly worse than the Wales average. Life expectancy is 75.5 years for men and 79.1 for women. This is 1.8 years lower for men and 2.5 for women compared to the English average.

In 1991-93, Merthyr had the lowest life expectancy in Wales. Blaenau Gwent now has the lowest with Merthyr the second lowest but the pattern has remained much the same for decades.

Smoking rates are high with almost a third of the population identifying themselves as smokers. Early deaths from cancer and circulatory disease are particularly concerning.

Widening gaps

The health of the population is improving and people are living longer but that is not reducing the inequalities gap. Better-off areas are improving at a faster rate than many older industrial areas.

If life expectancy is compared by local authority area **in England** between the *highest* and the *lowest*, the differences are obviously greater. The difference, for example, for male life expectancy between Kensington & Chelsea and Manchester in 2004-06 is over ten years. Women in Kensington & Chelsea live nearly nine years longer than women in Liverpool.⁸

The bad news is that the life expectancy gap between the highest and lowest has widened since 1997 by two years for men and over two and half years for women.

There has been deterioration even where there have been targeted policy initiatives such as the Spearhead Group⁹ of local authorities. The Spearhead Group average for men and women has slipped back since 1995-1997 some 2.3 years compared to the highest life expectancy.¹⁰

For major killer diseases, such as cardiovascular disease, the trend in death rates indicated a widening of inequality in recent years. Using the Indices of Multiple Deprivation from 2004 the government has found that the most deprived fifth of areas in 1997 had a death rate around one and half times higher than the least deprived fifth. This has risen to over 1.7 times higher in 2006.¹¹

In Scotland, as in the rest of the UK, life expectancy for all people is improving. However, a comparison between 1994-1996 and 2004-06 indicates a worrying lack of progress in closing the gap between the highest and the lowest local authority area. In 1994 the gap for men and women combined was 6 years but this had increased to 6.2 years. The gap for men remained the same at 7.5 years whereas that for women increased from 4.4 to 4.9 years.¹²

In Wales in recent years the gaps in life expectancy have closed between the local authority with the highest life expectancy and that with the lowest. In 1995-97 the gap for men was 5 years by 2006 it was 3.9 years. For women the gap closed from 6.7 years to 4.6 years. However, the situation in 2004-2006 was worse than for 1991-1993.

8 DoH, 2007. Tackling Health Inequalities: Status Report on the Programme for Action.

9 Local Authority areas in England chosen for targeted policies on the basis of deprivation statistics.

10 DoH, 2007. Tackling Health Inequalities: Status Report on the Programme for Action

11 DoH 2007, Tackling Health Inequalities: Status Report on the Programme for Action

12 General Register for Scotland, Sept 2007. Life Expectancy for Administrative Areas within Scotland, 2004-06.



What is already being done?

Founded on the principles of universal health care for all, the National Health Service was the bedrock of government post-war policy to produce a more equal society. The aspirations to eliminate health inequalities ran through every aspect of the new policy. Although the key elements to the new health service was that it was free and open to all, the expectation was that equal access to the service would produce, in time, equal health. However, eliminating inequalities has proved much harder than the well-intentioned founders of the NHS first envisaged.

Since then there has been no shortage of intellectual effort to try to better understand the apparently intractable problems. The *Black Report* of 1980¹³ was unceremoniously buried by the government of the time. The report had two key messages. First, health problems need to be addressed by appropriate actions across the policy spectrum, not just within the health service. Second, there needed to be a radical overhaul of the distribution of resources to address health needs.

Policy development

Twenty years later the government revisited this policy area and commissioned the Acheson Report¹⁴. The *Wanless Report*¹⁵ commissioned by the Treasury and published in April 2002 attempted to provide an evidenced-based assessment of long-term resource allocation for the NHS. Both reports became core texts on which the government has built its policies on health and re-positioned health inequalities as a priority that needed to be tackled by the Department of Health and all other relevant departments.

As devolution progressed, delivery of the health service became a matter for the governments in Edinburgh and Cardiff. Different structures and priorities began to develop across Britain. The governments in Edinburgh and Cardiff have been less enthusiastic about a market approach. Massive financial backing from the Treasury was directed to improve services and raise the general health of the population. Great efforts have been made to close the inequality gaps but the results have been largely disappointing.

13 Black, 1980, *Inequalities in Health: Report of a Research Working Group*. DHSS

14 1998. *Independent Inquiry into Inequalities in Health*. Chair Sir Donald Acheson.

15 Wanless, D. 2002. *Securing our Future Health: Taking a Long-term View*.

Community Profiles

Salford

Salford, although a city, is part of Greater Manchester in the North West. It has a population of around 218,000 which has decreased by over 13% since 1981. The port of Manchester was located in Salford before closure. Coal mining was also an important part of the local economy.

Over the past ten years rates of deaths from all causes has decreased but remain above the UK average. Life expectancy for men and the early death rates from heart disease and stroke are the fifth worst in England.

Local priorities in Salford's Local Area Agreement include tobacco, alcohol, teenage pregnancy, obesity and mental health.

....in England

After six years in office the Labour Government published what was heralded as the 'first' national health inequalities strategy: *Tackling Ill-Health Inequalities - A Programme for Action*. In 2007 the most recent Status Report on that programme was published.¹⁶

The report accepted that "health inequalities are stubborn, persistent and difficult to change", the government committed itself to "addressing not only the short-term consequences of avoidable ill health, but also the longer term causes"¹⁷. This would require a coherent inter-departmental approach.

The Public Service Agreement target that was the key driver for policy in this area was: *By 2010, to reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth*.¹⁸

However, although the 2007 Status Report indicated that many of the departmental targets had been achieved, progress towards the PSA target was disappointing.

In terms of life expectancy, the relative gap between England as a whole and the worst fifth of areas was wider than in 1995-97 for both men and women. For men the position had deteriorated by 2% and for women 11%.

Policies on health inequalities in England have been channelled through Primary Care Trusts (PCTs) in the **Spearhead Group** of local authorities. These are the local authorities who fall within the worst fifth measured by a number of health and deprivation indicators. This targeting exercise is planned to run until 2010.

Of the 70 local authorities with Spearhead Group of PCTs, 41 are "off track" to achieve the PSA target for life expectancy for both men and women. This includes 13 Alliance local authorities. Of the 29 making some progress to close the gap on male and female life expectancy, 12 are Alliance local authorities (see Table 2 - page 13 for list of Spearhead local authorities and the 2004-06 status).

The Spearhead Group has received particular attention from specific policy initiatives, such as Neighbourhood Renewal Fund, across government departments. There has been no specific additional funding from the Department of Health. Funding that could be used to target inequalities is easily diverted to cover deficits in front-line care.

...in Scotland

Since Scotland's devolved administration was set up successive policies have been directed towards addressing health inequalities. Scotland has an unenviable reputation based on its poor health statistics. The most recent policy comes in the form of the *Better Health, Better Care: Action Plan* published at the end of 2007. There are of course many similarities with policy objectives in England. The key objective of the policy is to: "Help people to sustain and improve their health,

16 Department of Health, 2007. *Tackling Health Inequalities: Status Report on the Programme for Action*

17 DoH, 2007. *Tackling Health Inequalities: Status Report on the Programme for Action*

18 Op cit

Table 2. Local Authorities in Spearhead Group - 2004-06 status

LA	On track both	On track male	On track female	Off track both	LA	On track both	On track male	On track female	Off track both
Hackney	●				Tameside				●
Hammersmith & Fulham	●				Wigan				●
Haringey	●				Liverpool				●
Southwark	●				Wirral				●
Tower Hamlets	●				Barnsley				●
Derwentside	●				Rotherham				●
Hyndburn	●				North Tyneside				●
Blyth Valley	●				South Tyneside				●
Barking & Dagenham		●			Sunderland				●
Lambeth		●			Birmingham				●
Lewisham		●			Sandwell				●
Newham		●			Walsall				●
Manchester		●			Wolverhampton				●
Knowsley		●			Bradford				●
Redcar & Cleveland		●			Wakefield				●
Sedgefield		●			Hartlepool				●
Wear Valley		●			Middlesbrough				●
Burnley		●			Stockton-on-Tees				●
Wansbeck		●			Halton				●
Tamworth		●			Blackburn with Darwen				●
Greenwich			●		Blackpool				●
St Helens			●		Kingston upon Hull				●
Doncaster			●		North East Lincolnshire				●
Gateshead			●		Leicester				●
Newcastle upon Tyne			●		Nottingham				●
Coventry			●		Stoke-on-Trent				●
Warrington			●		Barrow-in-Furness				●
Carlisle			●		Chester-le-Street				●
Easington			●		Pendle				●
Islington				●	Preston				●
Bolton				●	Rossendale				●
Bury				●	Lincoln				●
Oldham				●	Corby				●
Rochdale				●	Nuneaton & Bedworth				●
Salford				●					

Community Profiles

Stoke-on-Trent

The city of Stoke-on-Trent forms a major part of the 'Potteries' conurbation in Staffordshire. Its population is about 240,000 which has fallen about 5% since 1984. The economy of the areas was based on the pottery industry, coal, steel and engineering. These industries have significantly declined or disappeared all together.

Men in the most deprived areas live around six year less than they do in the least deprived. Although death rates from all causes have fallen, they remain significantly higher than the UK average.

Stoke appears to have a particular problems with obese adults and a corresponding low proportion of physically active adults. Infant mortality is much higher than the average for the rest of the UK.

Health priorities for Stoke are focussed on pregnancy and early years as well as plans to reduce the obesity levels.

especially in disadvantaged communities, ensuring better, local and faster access to health care."¹⁹

A Ministerial Task Force on Health Inequalities has been charged with pursuing the objective which demonstrates high level commitment to maintain a strong focus. The key areas being concentrated on are: children's early years, mental illness, the 'big killers' (cardio-vascular disease and cancer), drug and alcohol problems.

Particular emphasis in Scotland has been directed towards the alignment of all services not just health. There is co-ordinated activity with a number of agencies, including local authorities and the health service, through community planning.

.....in Wales

The Welsh Assembly published *Improving Health in Wales* in 2001. Following on from his UK-wide report of 2002, Derek Wanless produced a similar report for Wales in 2003 - Review of Health and Social Care in Wales. The main thrust of the report was a plan for a radical redesign of health and social care services to meet the 21st century needs of Wales.

More recently a strategy has been put together with a time-frame up until 2015 - *Designed for Life*²⁰. In conjunction, a Public Health Strategic Framework is being developed for Wales which is hoped to provide cohesion and direction up until at least 2020.

The structure for delivery of health care is different to that of England with Local Health Boards (LHBs) providing a similar role to that of Primary Care Trusts. During 2008 radical proposals to restructure Health Service in Wales have been under consideration. There are proposals to reduce the number of Health Boards from 22 to 8. Options for a new central organisation have been consulted on as well as plans to abolish the internal market and replace it with direct funding from government.

The *Designed for Life* strategy specifically aims to 'join up' government policies that impact on health service delivery and the wider determinants of poor health associated with economic and social problems. As in England and Scotland the strategy encourages better co-ordinated activity with local authorities.

Resource allocation

Many areas are starting from a disadvantaged position in terms of resource allocation. The fair distribution of resources to match health needs appears more complicated than it should be.

In England this is particular the case for Primary Care Trust (PCT) funding. Leaving aside the disruption caused by successive rounds of 're-organisation', the needs-based formula for allocating resources is accepted by government and it is also well known that hitting the targets for this funding cannot be done overnight.

Record amounts of cash were earmarked for the NHS following successive Comprehensive Spending Reviews. Under pressure from areas with the worst

19 Scottish Government Dec 2007. Better Health, Better Care: Action Plan.

20 NHS Wales, 2005. *Designed for Life: Creating World class Health and Social Care for Wales in the 21st Century.*



Community Profiles

North Lanarkshire

North Lanarkshire has a population estimated at nearly 324,000 in the central belt of Scotland adjoining Glasgow. Its economy was based on steel, engineering and coal mining.

Like many traditional industrial areas, North Lanarkshire compares unfavourably with the rest of Scotland and the UK in terms of health. In particular, life expectancy is amongst the lowest in the UK. If you are a man living in North Lanarkshire, you are likely to die two years earlier than the Scottish average, and five years earlier than the English average.

Death rates from all causes and all ages for heart disease, cancer and stroke are all significantly worse than the Scottish average.

Expected years of good health are estimated at a 63.1 for men and 66.4 for women compare to a Scottish average of 66.3 and 70.2 respectively.

At the time of the 2001 census, 23% of the population had a limiting long-term illness, the second highest rate in Scotland.

problems, the government attempted to speed up the pace of change and get nearer the targets quicker. Funding rounds allocated up until 2008 had slightly higher proportions going to those furthest from target.

PCTs were reorganised in 2006 and subsequently comparative data has become more complex. However, even after the some progress was made towards the targets, there are still significant disparities. Figure 3 (opposite) illustrates some of the continuing shortfalls for traditional industrial areas in England compared with Kensington and Chelsea, the area with the longest life expectancy.

The attempt to speed up change was welcome but it has not been sustained. The funding allocation was followed by an across the board settlement up to 2009 resulting in no significant closure of the gap for those PCTs still below target. The outcome of the more recent deliberations of the Advisory Committee on Resource Allocation (ACRA) for funding up until 2011 is expected towards the end of 2008. There is no guarantee, especially with tightening budgets, that the redistribution of resources will continue.

In Scotland resource allocation has been recently revised by the NHS Scotland Resource Allocation Committee (NRAC). A new formula has been adopted to direct spending to where it is assessed to be most needed.

It is too early to say whether this new formula will ultimately prove fairer. NHS Board areas in Scotland are not co-terminus with local authority areas. However, if actual current spending and target spending based on need is compared, four traditional industrial areas are some way below target and four above target (see Figure 4 opposite).

In Wales the Townsend report²¹ on resource allocation was first published in 2001. The key recommendations were: to encourage action at local level by the Health Boards in collaboration with local authorities; to follow dual-track measures within the health service and other government departments and organisations; to speed up the implementation of annual resources towards agreed targets; to integrate government fiscal and other policies to change the socio-economic conditions which underlie unequal health.

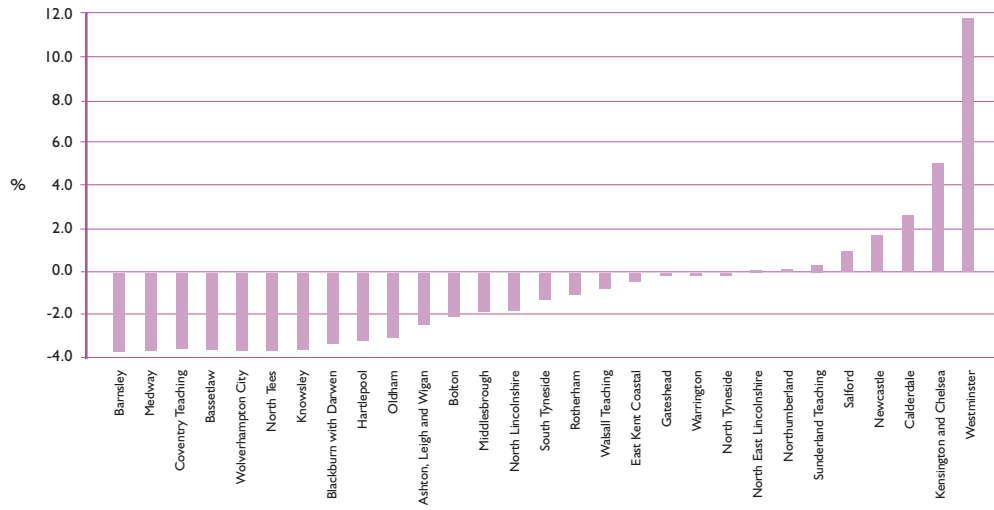
The recommendations were accepted by the Assembly and became policy. Implementation is overseen by the Welsh Assembly's National Steering Group on the Allocation of NHS Resources is the equivalent body to ACRA in England and NRCA in Scotland.

The *Direct Needs Formula* for the allocation of resources, although different to England, highlighted gaps between actual allocation and targets in much the same way. Consequently for Health Boards in Alliance areas alone, for example, seven out of ten LHBs fell short of their target allocation in 2005-6. This meant that Alliance local authority areas in Wales in that year received £48 million less than what they were assessed to need (see Figure 5 opposite).

The implementation of the new formula and the resulting distances from target mirror a similar policy outcome in England where funding allocation is still subject to entrenched historical circumstances and is difficult to change quickly. Because the formula is still evolving, it is difficult to judge if it will effectively bridge funding gaps. As in England, the fairness of any formula does not necessarily mean funding targets will be met.

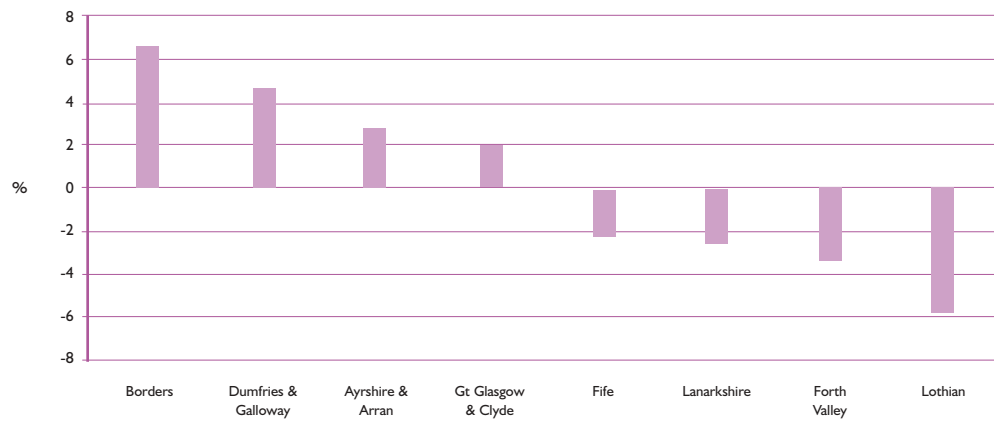
21 Townsend. P. 2001, Targeting Poor Health

Figure 3: Resource allocation - selected PCTs in England - below or above target 2007-08



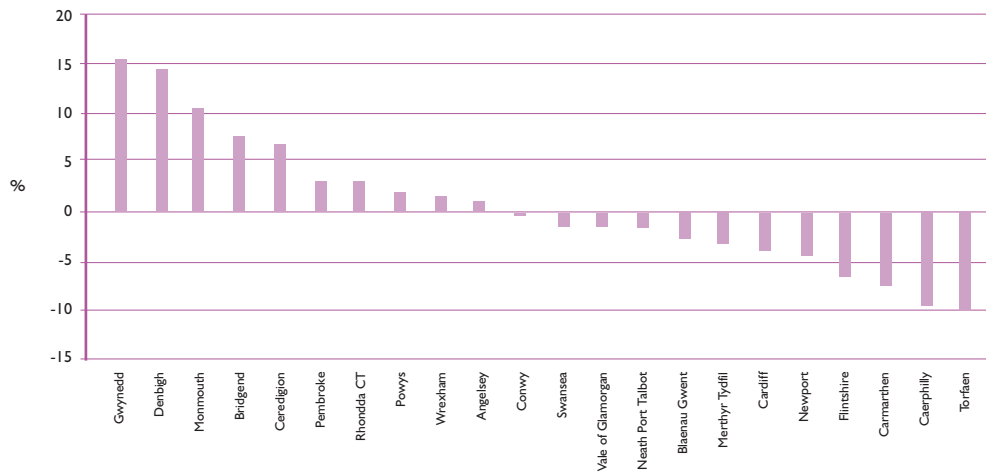
Source: Department of Health

Figure 4: Resource allocation - Scotland - below or above target 2007



Source: NHS Scotland Resource Allocation Committee, 2007

Figure 5: Resource allocation - Wales - below or above target 2005-06



Source: Welsh Assembly Government

Community Profiles

Bolsover

Bolsover is a shire district in Derbyshire that straddles what was a major part of the East Midlands coalfield area.

It has a population of 74,000 which is fairly dispersed in what were once coal mining villages.

The health of the people of Bolsover is significantly worse than the England average on a range of indicators.

Teenage pregnancy, obesity in adults, diabetes and early deaths from cancer, are worse than the England average.

Early deaths from cancer, heart disease and stroke have decreased but are still above the England average.

As the graph (Figure 5 - page 17) indicates, there is not a uniform split between areas with an industrial background and the more prosperous or rural areas. Nevertheless, it is the areas in industrial South Wales that mainly fall short of their needs-assessed allocations. In the North, Flintshire with a significant coal and steel past, is also well below target.

A great deal of time and effort has been put into deliberations in England, Scotland and Wales with regard to government needs-based formulas. Changing demographics and the goal of matching funding with need inevitably means that the process never stops. Refining the basis on which allocations are made to more accurately target and benefit those with the most problems is not an end in itself. The real issue is whether the actual funding matches the indicative allocation.

Primary care practitioners

Resource allocation is also about local doctors. One of the key features historically with regard to regional, sub-regional and local disparities in the health service is the number of General Practitioners (GPs). The 'inverse care law argument' was in part as much to do with the availability of doctors as it was about funding.

In England, despite improvements in terms of the number of GPs serving the population since 2002, there has been no narrowing of inequalities. The government itself admits:

*"The number of deprived Primary Care Trusts (PCTs) more than 10% below the England average number per 100,000 of weighted population has increased since September 2002."*²²

Consequently, most deprived areas are neither receiving their needs-based funding nor are they likely to have enough GPs on the ground to make the difference in terms of closing the health inequalities gap.

Scotland has similar problems to England and Wales with regard to maintaining sufficient numbers of top quality General Practitioners in the more deprived areas.

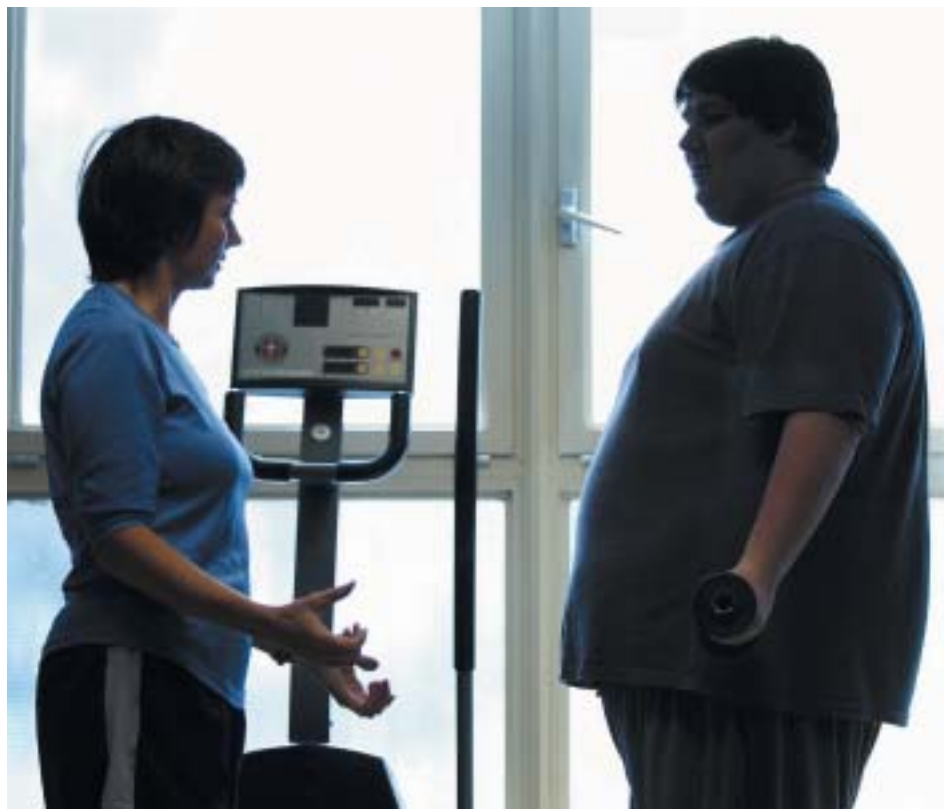
Overall between 2000 and 2007 the number of GPs in Scotland only grew by 3% which is significantly less than in other sections of staff. The British Medical Association has estimated that 21% of GPs will retire in the next five years.

At the same time funding to general practices has gone up by around 50% since 2003. As in England, the GPs contracts have resulted in significant overspend.

There are additional financial rewards available for practices that deliver agreed levels of care. However, there is no specific incentive to attract GPs to deprived areas.

In **Wales**, especially the Valleys, there have been chronic shortages of General Practitioners for reasons connected to poverty and remoteness. GPs in the Valleys tend to have longer patient lists than in the rest of Wales and are more likely to be

²² Department of Health, 2007. Tackling Health Inequalities: Status Report on the Programme for Action



single-handers. GPs surgeries are more likely to be older buildings in need of repair and doctors are less likely to be making use of information technology or the most modern NHS practices.

The GP service in the Valleys requires a long-term recruitment and retention strategy which needs to be broad enough to take in issues of technology and practice size. Specific funding streams will need to be found in order to provide the investment required to bring the infrastructure to a level which is on a par with the best in the UK.

Community Profiles

Doncaster

One of the South Yorkshire metropolitan local authorities, Doncaster has a population of around 290,000. The local economy was dominated by coal mining, rail and other engineering.

Gender and deprivation have significant impact on life expectancy. Men live nearly seven years less in the most deprived parts of Doncaster compared to the least deprived.

Although there have been some improvements with regard to heart disease and stroke compared to the UK average, the rate of deaths from smoking remains high. About 600 people die from smoking each year.

The Doncaster Local Area Agreement aims to improve the health of the population, reduce health inequalities and improve the quality of life of vulnerable and disadvantaged people.



What more needs to be done?

Best practice

There has been no shortage of government sponsored initiatives and pilots to try to better understand and how to eradicate health inequalities. The Spearhead Group of PCTs and local authorities in England is essentially an experiment to see what focussed activity can produce. Prior to that there were Health Action Zones. Parallel initiatives include Sure Start, aimed at early years intervention, or Neighbourhood Renewal Fund followed by the Working Neighbourhoods Fund aimed at removing economic and social disadvantage.

Leading up to the Spearhead Initiative, there have been 22 local authority-led *Communities for Health* pilots in England.²³ Dozens of projects have been supported by the Health Inequalities fund in Wales and a similar array of initiatives in Scotland.

There is no particular project on its own that can significantly improve the national statistics on, for example, life expectancy. By their very nature such projects will rely on local implementation. Local knowledge, local networks are at a premium because disadvantaged people need intensive support to improve their physical and mental health.

Leaving aside any debate about whether there has been any systematic evaluation of these projects, the general consensus is that targeted work with appropriate funding can make a big difference. In terms of the overall NHS budget, relatively modest sums can help reduce the health risks for poorer neighbourhoods. It is also understood, at least at local level, that it is the sustainability of this type of work that will make the real difference. Test-bedding ideas needs to be carried out and less effective actions weeded out. But where progress is being made, a long-term commitment is needed and that requires security of funding.

Co-ordination of local action

There are many examples of the NHS participating in inter-organisational initiatives. The current government has tried to progress towards 'joined up' policies between its own departments including the Department of Health (DoH) and local authorities. *Creating Healthier Communities: a Resource Pack for Local Partnerships*²⁴ is an example of joint aspirations for the

²³ DoH, NHS, 2007. *Communities for Health: Learning from the Pilots*.

²⁴ ODP, DoH, NHS, LGA 2005. *Creating Healthier Communities: a Resource Pack for Local Partnerships*.

former Office of Deputy Prime Minister, Department of Health, NHS and the Local Government Association. Health issues relating to poverty, employment, education, housing, transport and crime were addressed within the context of partnership working such as Local Area Agreements and Local Strategic Partnerships.

It is encouraging that the government, looking to the challenge after 2010 wants to “strengthen support to local areas”²⁵ through Local Area Agreements and Local Strategic Partnerships.

More recently a report by the Audit Commission assesses the impact of policy and points in the same direction²⁶. Nevertheless, there is still some way to go. The DoH and NHS has its way of doing things and local authorities have theirs. Despite a long history of municipal-based health services, ‘ownership’ of policies to tackle health inequalities is not yet embedded in co-ordinated local action.

Nearly all Directors of Public Health, in England, are now jointly appointed by the Health Service and local authorities. In time this will help co-ordination. Some structural and organisational changes are necessary, but health inequalities also needs to move up the agenda. Furthermore, all related policies need to be health inequalities ‘proofed’ to ensure any action taken does not inadvertently widen the gap. The inclusion of a “reducing health inequalities” principle in the National Institute for Clinical Excellence (NICE) guidance is a welcome step forward.²⁷

The culture and approach of the health service and local authorities needs to change. Inequality issues cannot be successfully addressed by the health service alone and they require cross-cutting action by a range of organisations including local authorities, NGOs and community groups. Local Area Agreement (LAAs) potentially can have a very important role in this.

Ring-fenced funding to address inequalities

The approach in Wales differs from England and Scotland. The Assembly set up an *Inequalities in Health Fund* in 2001 to promote and support outreach work including joint work with other agencies. The projects supported aimed to promote healthy lifestyles and more intensive population screening particularly with regard to coronary heart disease.

These projects have proven to be worthwhile and effective. There is no avoiding doing intensive work in communities if there are to be improved health outcomes for disadvantaged people. As is often the case with project-based work, the key issue is how to maintain the effort through sustained funding.

Although, by NHS standards, this ring-fenced funding stream is relatively modest, the signs are that it has been worthwhile. This is the case both in terms of targeting ill-health in more deprived sections of the community and providing a test bed for projects that could be scaled-up for more general use. Because the *Inequalities in Health Fund* is ring-fenced it cannot be siphoned off to fill some funding deficit elsewhere in the local health service.

25 DoH 2008, *Health Inequalities: Progress and Next Steps*.

26 Healthcare Commission & Audit Commission July 2008, *Are we choosing health?*

27 NICE, 2008. *Social Value Judgments: Principles for the development of NICE guidance*.

Community Profiles

Redcar & Cleveland

Redcar and Cleveland is on the Teesside. Its population in 2008 is about 139,500 which is some 5% less than in 1984. It is an area of heavy industry, including steel and chemicals.

Deaths from smoking, rates of early deaths from cancer, heart disease and stroke are all worse than the averages for England.

Life expectancy for the men in the least deprived areas compared to the most deprived is seven years longer for men and five years for women.

Breast feeding initiation and smoking in pregnancy are significantly worse than the UK averages.

Redcar & Cleveland have prioritised reducing early deaths from heart disease, strokes and cancer as well as reducing health inequalities within the authority and between the authority and England as a whole.

Mental health and health inequalities

The drive to reduce health inequalities has clear targets for life expectancy and infant mortality, for example, but little reference to mental health issues. However, it is well understood that poor mental health significantly increases the risk of poor physical health. Unhappy people with low self-esteem are much more likely to succumb to a range of illnesses such as heart and respiratory disease.

Tackling health inequalities requires a particular focus on mental health services. People in deprived areas on low incomes are much more likely to struggle with mental illness and require sustained and intensive support to break out of the downward spiral of poverty and poor health. The commitment to an additional £170 million for the Access to Psychological Therapies programme is welcome, but given the scale of the problem, is unlikely to have a major impact.²⁸



Some Alliance suggestions

The overall improvements in health and longevity are great achievements of the modern state. However, although the NHS has always aspired to universal health provision, access and use of the Service is skewed towards the better off. The 'worried well' in prosperous neighbourhoods attract the most resources. There needs to be additional resources and attention paid to the more disadvantaged areas of Britain to redress the balance.

The Alliance recognises there are no easy answers and as a local authority association would not want to enter into any debate about medical solutions or indeed try to address all the problems that the NHS faces in the 21st century. The focus in this report is health inequalities and the following observations and suggestions are made to try to help develop more effective policies.

Addressing the wider determinants of poor health

It is not practically or intellectually possible to fully separate health outcomes from the socio-economic determinants of health. The daily problems that weigh heavy on a family with low income and low self-esteem will always tend to produce poor health including poor mental health. It follows therefore that it is crucial to address the underlying determinants such as joblessness, low educational attainment and the living environment. Cross-departmental policies exist on paper at least, but a real shift in priorities towards levelling up at the local and regional level is less apparent.

There is also a much wider perspective that needs to be taken account of. All policies that are directed at reducing all forms of inequality, whether it is health service provision, education provision or closing the regional and sub-regional gaps in terms of economic prosperity will help close the health inequalities gap. It is not a medical problem it is an ingrained problem of unequal societies.

Helping those on Incapacity Benefit back to work is one way of addressing the wider determinants of health. There is the potential for significant health improvement outcomes for particularly difficult to reach sections of the population. It is important that work in this area is perceived as positive and not punitive.

Resource allocation

There are many complexities to funding in the health service and the position is different with the devolved institutions. The best and most effective use of funding is rightly seen as the only basis on which to proceed. However, in England, Scotland and Wales a great deal of time and effort has gone into determining a needs-based assessment for funding. Yet despite the aspirations to hit its own targets, government (throughout Britain) has not delivered. There is still unmet need compounded by historical under-funding.

Arguments can be made about the politics of this issue - votes matter to governments. There is also an argument about the local capacity to spend effectively. Yet there can be no excuse for not making allocations based on need. Under-funding the deprived areas below agreed targets will only result in more, not less, inequality.

More primary care resources

Fair distribution of resources also includes primary care professionals. In a written memorandum to the Health Select Committee in 2008 the Department of Health pointed out: *"There is a strong correlation between areas with the fewest primary care clinicians and those with the worst health outcomes and high levels of deprivation."*

Most GPs are not likely to take the difficult options and work in deprived areas with no additional support. Just as in education it takes the best educationalist to make an impact in the worst schools, it takes well-resourced primary care services to begin to make the much needed improvements in health for the more deprived sections of the community. The attraction and retention of more GPs in the more deprived areas of older industrial Britain should be given priority. Addressing this problem will require some incentives. For example, contracts for GPs could be revised to take account of inequalities and make working in more deprived areas more attractive.

Targeted funding

Ring-fenced funding to address health inequalities is needed to provide sustained support for initiatives at the local and regional level.

Using such targeted resources along with other government funding streams (such as Working Neighbourhoods' Fund, Sure Start etc.) should result in the effective use of what, in NHS terms, is relatively modest funding.

Tacking health outcomes for the disadvantaged has to be done at a local level where the practicalities of delivery are best understood. The key requirement, however, is to sustain work over a longer period to change peoples' lives and approach.

The *Inequalities in Health Fund* implemented in Wales could provide a good model. A ring-fenced fund that cannot be raided to fill in deficits in other service areas should ensure continuity.

Mental health

Mental health is often considered the 'Cinderella' of the health service. Although it is fully recognised as a significant problem for many thousands of people, the main focus of the NHS is medical care.

The incidence of mental health problems amongst Incapacity Benefit claimants serves to illustrate that mental health difficulties are widespread and often lead to poor physical health outcomes thereby contributing to widening the health inequalities gap. Self-perception and self-esteem are crucial determinants of health. For people struggling to make ends meet and with few opportunities to improve their lives, it is much harder to be positive about their role in society.

There is no option but to provide sustained intensive support. Once again this will require adequate funding and resources.

The role of local authorities - health inequalities 'proofing'

Local authorities have a long tradition and experience in helping to deliver better health. When focussing specifically on health inequalities they are crucial. Local authorities need to be encouraged to take ownership of the health inequalities agenda along with the NHS. Co-ordinated activity is vital to address issues of equity of access and equity of health outcomes. This is not about off-loading health care work and responsibilities onto local authorities, it is about genuine partnership.

The general health of the people of Britain has improved enormously since the NHS was founded 60 year ago. However, the vastly improved services based on advanced knowledge and technology tends to be used more by the advantaged groups in society. They have better access to resources because they have more time and money. They will take up health promotion advice. Less advantaged groups are harder to reach and have fewer options to change life styles.

Changes in personal behaviour are important but real change will only come when socio-economic inequality is reduced. If the health inequalities gap is ever to close, more effort and resources has to be shifted towards the areas that are socio-economically deprived. Many of these are the traditional industrial areas of Britain.



Who we are

The Alliance

The Alliance was formed in June 2007 to represent local authorities in the traditional industrial areas of England, Scotland and Wales.

The Alliance brings together two existing local authority associations - Coalfield Communities Campaign (CCC) and SteelAction - together with local authorities from textile and other industrial areas. It builds on ten years' successful collaboration under the banner of the Alliance for Regional Aid and, in the case of CCC in particular, a track record of successful lobbying extending back to the 1980s.

The aims of the Alliance are: to articulate the needs of Britain's traditional industrial areas; to attract resources for regeneration; to press for balanced growth within and between regions; and to provide a framework for information sharing between member authorities.

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