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The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

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Footnotes

In the footnotes of this Report, references to oral evidence are indicated by 'Q' followed by the question number, and these can be found in HC 286–II. Written evidence is cited by reference in the form 'Ev' followed by the page number; Ev x for evidence published in HC 422–II, Session 2007–08, on 3 April 2008, and HI x for evidence to be published in HC 286–II, Session 2008–9.

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Summary

During the course of this inquiry, we heard widespread praise and support, both in this country and abroad, for the explicit commitment this Government has made to tackling health inequalities. This has involved a framework of specific policies, underpinned by a challenging and ambitious target. The Government has also continued to switch resources to the neediest areas; the neediest PCTs will receive 70% more funding than the least needy in 2009-10.

However, whilst the health of all groups in England is improving, over the last ten years health inequalities between the social classes have widened—the gap has increased by 4% amongst men, and by 11% amongst women—because the health of the rich is improving more quickly than that of the poor.

Health inequalities are not only apparent between people of different socio-economic groups—they exist between different genders, different ethnic groups, and the elderly and people suffering from mental health problems or learning disabilities also have worse health than the rest of the population. The causes of health inequalities are complex, and include lifestyle factors—smoking, nutrition, exercise to name only a few—and also wider determinants such as poverty, housing and education. Access to healthcare may play a role, and there are particular concerns about ‘institutional ageism’, but this appears to be less significant than other determinants.

Lack of evidence and poor evaluation

One of the major difficulties which has beset this inquiry, and indeed is holding back all those involved in trying to tackle health inequalities, is that it is nearly impossible to know what to do given the scarcity of good evidence and good evaluation of current policy. Policy cannot be evidence-based if there is no evidence and evidence cannot be obtained without proper evaluation. The most damning criticisms of Government policies we have heard in this inquiry have not been of the policies themselves, but rather of the Government’s approach to designing and introducing new policies which make meaningful evaluation impossible. Even where evaluation is carried out, it is usually “soft”, amounting to little more than examining processes and asking those involved what they thought about them. All too often Governments rush in with insufficient thought, do not collect adequate data at the beginning about the health of the population which will be affected by the policies, do not have clear objectives, make numerous changes to the policies and its objectives and do not maintain the policy long enough to know whether it has worked. As a result, in the words of one witness, ‘we have wasted huge opportunities to learn’. Simple changes to the design of policies and how they are introduced could make all the difference, and Chapter 3 of this report sets these out. Professor Sir Michael Marmot’s forthcoming review of health inequalities offers the ideal opportunity for the Government to demonstrate its commitment to rigorous methods for introducing and evaluating new initiatives in this area which are ethically sound and safeguard public funds.

Resource allocation and health inequalities

The Department of Health is responsible for allocating resources to the NHS. The funding

formula ensures that there is a major redistribution of funds to the neediest PCTs. However, too many PCTs have not yet received their full needs-based allocations. The Government must move more quickly to ensure PCTs receive their real target allocations.

Trade offs exist between redistribution of health resources to tackle health inequalities, and the NICE model of distribution, based on investing in the most cost-effective treatment for the whole populations. These trade offs have never been explicitly articulated and examined and we recommend that they should be. In addition, more needs to be known about the treatments and services which are displaced to fund the new treatments recommended by NICE. The Government must also track the money which is spent to tackle health inequalities and what it is spent on, both funds specifically allocated for health inequalities initiatives, and mainstream funding that is directed towards this.

Specific health inequalities initiatives

The Government has introduced specific policies to tackle health inequalities; two of particular importance were establishing health inequalities targets; and establishing Sure Start.

In aiming to reduce health inequalities by 10% in ten years, the Government has introduced a target which is arguably the toughest anywhere in the world, and which has received international plaudits. Despite the likelihood that the target will be missed, we believe that aspirational targets such as this can prove a useful catalyst to improvement, and we therefore recommend that the commitment be reiterated for the next ten years. However, a review of the measures used is needed to ensure that important areas of health inequalities—including age and gender related inequalities, and those relating to mental health—are not neglected.

We commend the Government for taking positive steps to place early years at the heart of policy to address health inequalities through Sure Start. Many witnesses were very positive about the benefits of Sure Start. National evaluation shows that it has enjoyed some success. However, Sure Start has still not demonstrated significant improvements in health outcomes or health inequalities for either children or parents. This policy, originally introduced to specifically target those in deprived areas, is now being extended, without any prior piloting, to all areas of the country regardless of level of deprivation. Early years interventions must remain focused on those children living in the most deprived circumstances and the impact of Children's Centres must be rigorously monitored.

The role of the NHS in tackling health inequalities

The NHS has the capacity to tackle health inequalities by providing excellent services targeted at, and accessible to those who need them. The NHS has introduced a number of interventions on a massive scale to reduce Coronary Heart Disease and identify cancers at an early stage. Whilst evidence exists to support the clinical effectiveness of some interventions, such as prescribing antihypertensive and cholesterol-reducing drugs, less is known about their cost effectiveness, and in particular about how to ensure they are targeted towards those in the lowest socio-economic groups so that they actually have an impact on health inequalities. The Government is to introduce vascular checks; we urge it to do so with great care, and according to the steps outlined in chapter three, so that it does

not waste another crucial opportunity to rigorously evaluate the effectiveness and cost effectiveness of this screening programme.

Getting people to adopt a healthy lifestyle is widely acknowledged to be difficult, and evidence suggests that traditional public information campaigns are not successful with lower socio-economic or other hard-to-reach groups—in fact we were told that these interventions can actually widen health inequalities because richer groups respond better to health promotion messages. Social marketing is heralded as an approach that allows messages to be communicated in more tailored and evidence based ways, but more evidence is needed in this area. We make recommendations below about measures to change lifestyles.

Primary care services are at the frontline of tackling health inequalities; we received many suggestions for additions to the QOF points system. It is clear that the QOF needs radical revision to fully take account of health inequalities. In particular, the QOF should be redesigned so that more points are awarded for success with smoking cessation, rather than merely identifying a smoker. However, additions to the QOF may be costly and this can only be done if other things are removed.

In solely focusing on primary care, there is a real risk that inequalities in other NHS services will persist, and that the opportunities which exist in secondary care and specialised services to tackle inequalities will be missed. We recommend that the role of secondary care in tackling health inequalities should be specifically considered by Professor Sir Michael Marmot's forthcoming review; this should include an examination of how the Payment by Results framework and the Standards for Better Health might address health inequalities.

We have been told repeatedly that the early years offer a crucial opportunity to 'nip in the bud' health inequalities that will otherwise become entrenched and last a lifetime. While there is little evidence about the cost-effectiveness of current early years services, it seems odd that numbers of health visitors and midwives are falling, and members of both those professions report finding themselves increasingly unable to provide the health promotion services needed by the poorest families, at the same time as the Government reiterates its commitments to early-years' services.

Lack of access to good health services does not appear to be a major cause of health inequalities. Nevertheless, some groups do receive poorer treatment than others. In particular, charges of institutional ageism need to be investigated.

Tackling health inequalities across other sectors and Departments

Measures to enable people to adopt healthier lifestyles involve a range of Government Departments. These other Departments could do far more than they do at present and the Department of Health should take a stronger lead in getting them to do so. We list below a number of areas where improvement is required as a matter of priority.

Nutrition

We are appalled that, four years after we first recommended it, the Government and FSA are continuing to procrastinate about the introduction of traffic-light labelling to make the

nutritional content of food clearly comprehensible to all. In the light of resistance by industry, and given the urgency of this problem, we recommend that the Government legislate to introduce a statutory traffic light labelling system. A traffic light labelling system should also be introduced for all food sold in takeaway food outlets and restaurants as well; currently food purchased from such outlets, despite often having a very high calorie content, does not have any nutritional labelling at all.

Health promotion in schools

We welcome the introduction of compulsory PSHE. However to date the effect of DCSF initiatives, including the Healthy Schools programme, on health or health inequalities has not been assessed. We recommend that the Department of Health and DCSF collaborate to produce quantitative indicators and to set targets for the *Healthy Schools* programme.

The built environment

The built environment affects every aspect of our lives. During the inquiry we heard many concerns: high streets awash with fast food outlets, flagship health centres located 'at random' and planning policies which have created towns and cities dominated by the car, with out-of-town supermarkets and hospitals, which have discouraged walking and cycling. In our view, health must be a primary consideration in planning decisions. To ensure that this happens, we recommend

- The publication of a Planning Policy Statement on health, which should require the creation of a built environment that encourages walking and cycling and should enable local planning authorities to restrict the number of fast food outlets
- that PCTs should be made statutory consultees for local planning procedures.

The Government should also increase the proportion of the transport budget currently spent on walking and cycling.

Tobacco control

Smoking remains one of the biggest causes of health inequalities; we welcome both the Government's ban on smoking in public places, and its intention to ban point of sale tobacco advertising, as evidence indicates that both of these measures may have a positive impact on health inequalities. Unfortunately, tobacco smuggling, by offering smokers half price cigarettes, negates the positive impact of pricing and taxation policies. Tobacco smuggling has a disproportionate impact on the poor, particularly young smokers. Some progress has been made in this area but not enough; there has been no progress at all in reducing the market-share of smuggled hand-rolled tobacco, which is smoked almost exclusively by those in lower socio-economic groups. We recommend the reinstatement of tough targets and careful monitoring of them following the transfer of this crucial job to UKBA, to ensure that it remains a sufficiently high priority. We also recommend that the UK signs up to the agreements to control supply with the tobacco companies Philip Morris International and Japan Tobacco International as a matter of urgency.

1 Introduction

1. The health of people in England has improved markedly over the last 150 years. In 1841 life expectancy at birth for men was 40.2 years and for women 42.2. By 1948 it was 66.4 and 71.2 years respectively. In 2000 the figures were 75.6 and 80.3.¹ However, despite these huge improvements, there are marked differences in the health of different groups. Such health inequalities show themselves in many ways. The most notable English statistics relate to the life expectancy of different social groups; the higher an individual's social group, the longer he or she is likely to live. There are striking differences between rich and poor areas. In 2006 a girl born in Kensington and Chelsea has a life expectancy of 87.8 years, more than ten years higher than Glasgow City, the area in the UK with the lowest figure (77.1 years).²

2. Health inequalities can be found in many aspects of health; for example, poor people not only live less long than rich, but also have more years of poor health. Access to health is also uneven. The old and disabled receive worse treatment than the young and able-bodied. A recent report has described the NHS as institutionally ageist.³

3. Inequalities are pervasive throughout the world. They are apparent in all developed countries, including ones with highly developed welfare systems such as Norway and the Netherlands which we visited.

4. Health inequalities have been studied for decades. Key works include the Black Report (1980), the Acheson Report (1998) and more recently the final report of the WHO Commission on the Social Determinants of Health (2008). Governments have made serious efforts to address the problem. Since the 1970s poorer areas have received more funds per head than richer ones. The present Government has made tackling health inequalities a priority, introducing "the most comprehensive programme ever seen in this country to address health inequalities"⁴. In 2003 it established the first ever national Public Service Agreement (PSA) target for health inequalities:

By 2010 to reduce inequalities in health outcomes by 10 per cent as measured by infant mortality and life expectancy at birth.

This is perhaps the toughest target adopted by any country in the world. In addition, to this target, the Government has introduced a series of policies which are expected to reduce inequalities, including Health Action Zones and Sure Start. The Department of Health has continued the policy of allocating funds to PCTs according to need with major differences in allocations per head: in 2009-10, Mid-Essex PCT is to receive £1,269 per head, City and Hackney Teaching PCT £2,136, (£867 per head more than Mid-Essex) and Liverpool PCT £2031.

1 Office of Health Economics, *The Economics of Health Care*, <http://www.oheschools.org/ohesch6pg4.html>

2 Office of National Statistics, Life Expectancy by Local Authority 1992–2006

3 See <http://news.bbc.co.uk/1/hi/health/7850881.stm>

4 See http://www.dh.gov.uk/en/Publichealth/Healthinequalities/Healthinequalitiesguidancepublications/DH_064183

5. Unfortunately, despite these efforts, health inequalities have continued to increase. This is not because the poor are getting less healthy; life expectancy of the poorest quintile of the population is now as high as that of the richest quintile 30 years ago. However, richer people are getting healthier more quickly. Many think it unlikely that the Government's targets for 2010 will be met.

6. In view of the failure to reduce inequalities, we decided to hold an inquiry, mainly to see what more the Government could do to improve outcomes. Given our remit our focus was the contribution the NHS and the Department of Health could make. Our terms of reference were:

- The extent to which the NHS can contribute to reducing health inequalities, given that many of the causes of inequalities relate to other policy areas e.g. taxation, employment, housing, education and local government;
- The distribution and quality of GP services and their influence on health inequalities, including how the Quality and Outcomes Framework and Practice-based Commissioning might be used to improve the quality and distribution of GP services to reduce health inequalities;
- The effectiveness of public health services at reducing inequalities by targeting key causes such as smoking and obesity, including whether some public health interventions may lead to increases in health inequalities; and which interventions are most cost-effective;
- Whether specific interventions designed to tackle health inequalities, such as Sure Start and Health Action Zones, have proved effective and cost-effective;
- The success of NHS organisations at co-ordinating activities with other organisations, for example local authorities, education and housing providers, to tackle inequalities; and what incentives can be provided to ensure these organisations improve care
- The effectiveness of the Department of Health in co-ordinating policy with other government departments, in order to meet its Public Service Agreement targets for reducing inequalities; and
- Whether the Government is likely to meet its Public Service Agreement targets in respect of health inequalities.

7. During this inquiry, in November 2008, the Department of Health commissioned Professor Sir Michael Marmot, Chairman of the WHO Commission on the Social Determinants of Health, to advise the Secretary of State on the future development of a health inequalities strategy post 2010, both for the short to medium term, and the long term. The review is expected to report in late 2009. We very much welcome this review. We make recommendations to be taken into account by the review team and will carefully monitor its findings.

8. We received 143 memoranda and held eleven oral evidence sessions. Witnesses included academics, representatives of PCTs, local authorities and charities, clinicians, planners, chefs, members of the HM Revenue and Customs, the Border Control Agency and the

Food Standards Agency, Baroness Morgan of Dreflin, Parliamentary Under Secretary of State at the Department of Children, Schools and Families and the Rt Hon Alan Johnson MP, the Secretary of State for Health. We undertook a visit to Glasgow which was arranged by the MRC Social and Public Health Sciences Unit. We would like to thank the Director Professor Sally Macintyre and her team for organising it. We also went to the Netherlands. In the Hague we met civil servants and the Foundation for Responsible Alcohol Use and affiliated organisations, in Rotterdam, Professor Mackenbach, the leading expert in international comparisons of health inequalities. Our visit to Norway enabled us to meet a series of important figures, including the State Secretary, officials from the Ministry of Health and Care Services, the Ministry of Finance, the Norwegian Institute of Public Health, the Directorate of Health, and academics. We also visited a child health centre. We would like to thank all those in the FCO who organised these visits and also Tysse Anders Lamark and Tone Poulsson Torgersen who put together such an impressive programme. We are especially grateful to our specialist advisers, Sheila Adam, retired director of public health, Alan Maynard Professor of Health Economics, University of York and Chair, York Hospitals NHS Foundation Trust, and Dr Alex Scott-Samuel, Director, EQUAL (Equity in Health Research and Development Unit), Division of Public Health, University of Liverpool, for their expertise and assistance.⁵

9. In the following report, chapter two examines the extent and causes of health inequalities. The causes of inequalities are broad and some of them reach beyond the capabilities and responsibilities of both the Department of Health and the NHS. Many of our witnesses emphasised the importance of policies to address these wider, social determinants of health and health inequalities. We do not doubt the impact of these wider determinants, but we do not directly address them in this report for two reasons. First, we do not have the expertise to consider what changes in tax and benefits and general public policies might be most desirable and, secondly, we received no compelling evidence to suggest that anybody knows at present what changes would be most effective at lowering health inequalities. Our report therefore focuses on the effectiveness of the policies of the Department of Health and the NHS.

10. Chapter three examines the Department of Health's role in ensuring the robust design and evaluation of policies through its Research and Development function. It is essential that the Department ensures that lessons are learnt and that there is an appropriate evidence base to inform future policy making.

11. The Department also allocates resources to the NHS to ensure that areas of high deprivation which have consequently high health needs receive the funding they need to deliver services properly. This is the subject of Chapter four.

12. In addition, the Government has introduced specific policies to tackle health inequalities; including the ten-year health inequalities targets, community-based initiatives (*Health Action Zones, Sure Start, Healthy Towns*), and the *Health inequalities intervention*

5 Professor Alan Maynard and Dr Alex Scott-Samuel declared no interests. Dr Sheila Adam retired from the NHS in April 2007; currently working part time with Newham University Hospital NHS Trust; husband (John Mitchell) a partner in Mitchell Damon, a consultancy which works with the NHS, other parts of the public sector, and the voluntary sector; and worked with Professor Ian Jacob on "engagement" with the Comprehensive Biomedical Centre (unremunerated) from May 2007

toolkit, which provides guidance to PCTs on specific clinical measures which will help them make progress towards the target. Chapter five considers these issues.

13. The NHS has the capacity to tackle health inequalities by providing excellent services which are accessible to those who need them by ensuring NHS organisations provide treatment, screening, and health promotion services; Chapter six looks at the role of:

- SHAs and PCTs, particularly in providing local leadership, undertaking public health initiatives and improving access to services;
- General Practice, including the place of the Quality and Outcomes Framework;
- Secondary care and specialist services; and
- Early years NHS services.

14. In chapter seven we consider the role played by the NHS and the Department of Health in respect of policies outside their direct area of responsibility, in particular by providing leadership across all sectors and government departments to promote joined up working to tackle health inequalities; we examined a number of specific policy areas which are likely to have an impact on health inequalities, including nutrition, health promotion in schools, the built environment, and tobacco control.

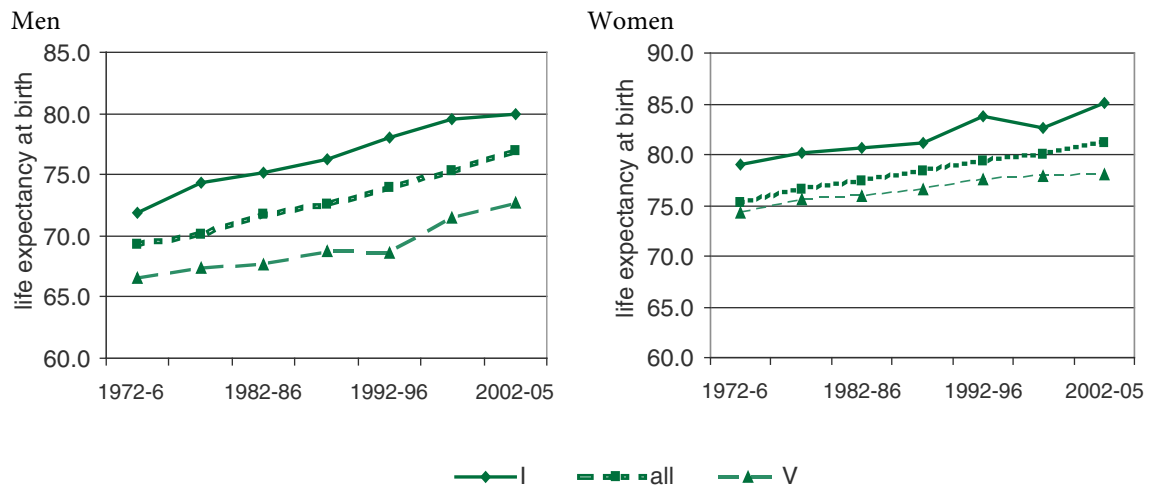
15. Finally, chapter eight brings together the recommendations in this report which aim to set out a new policy to tackle health inequalities.

2 Health inequalities – extent, causes, and policies to tackle them

The extent of health inequalities

16. The last ten years have witnessed large improvements in health for everyone.

Life expectancy at birth for men & women in social class I (professional), social class V (unskilled manual) and all, 1972–2005, England & Wales

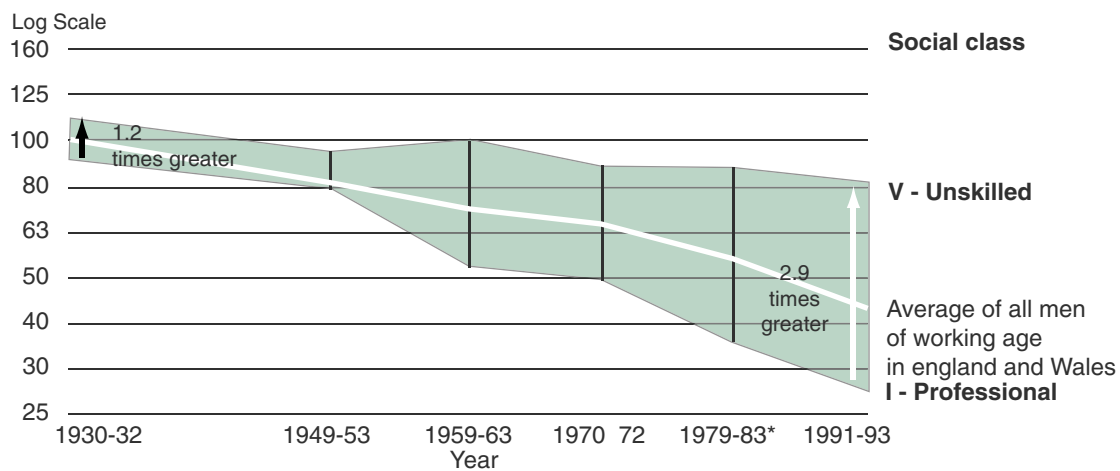


Source: Professor Hilary Graham⁶

The figure above shows that although life expectancy increased for all social groups between the periods 1972–6 and 2002–05, health inequalities—gaps in life expectancies between social groups—have persisted.

The widening mortality gap between social classes

Standardised Mortality Ratios, indexed to 1930–32

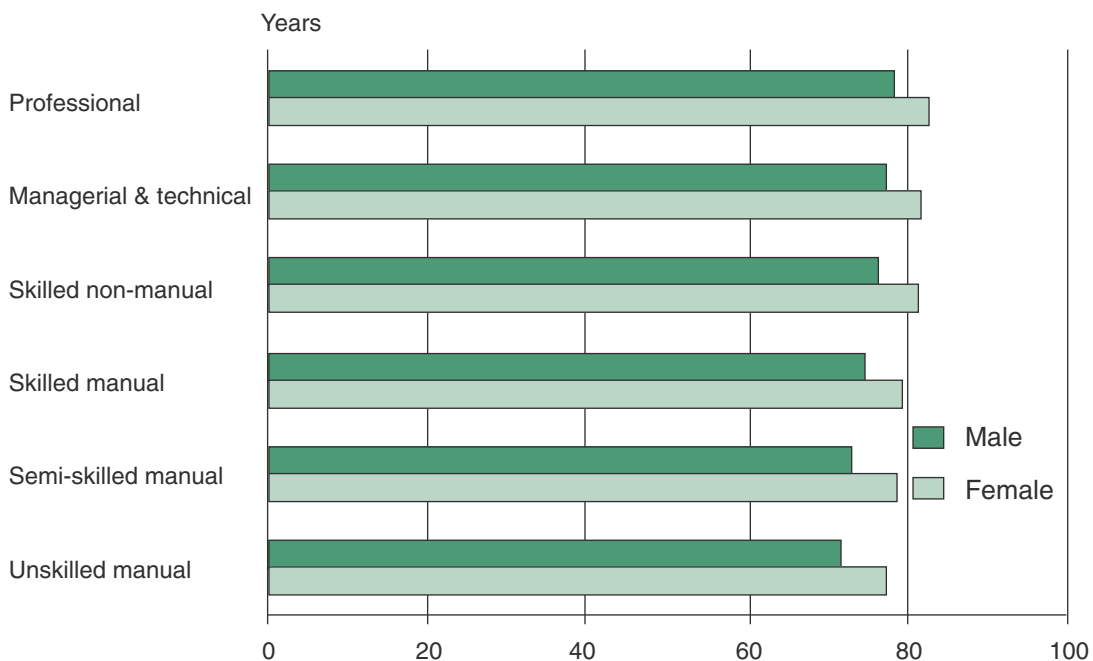


*1979-83 excludes 1981

England and Wales. Men of working age (varies according to year, either aged 15 or 20 to age 64 or 65)

Note: These comparisons are based on social classes I & V only.

Source: Office for National Statistics (see References Section)



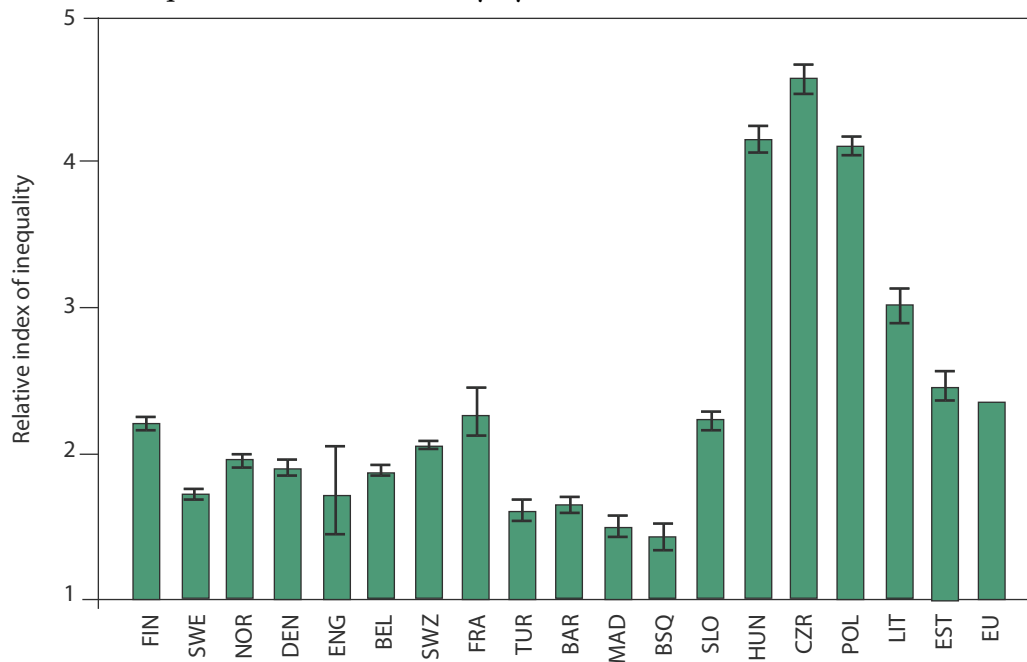
Life expectancy at birth by social class and sex, 1997–99, England and Wales⁷

17. In fact, since the baseline period when the Government began to measure progress towards its target to reduce health inequalities (1995–97), the gap between the ‘routine and manual’ groups and the population as a whole has widened. The gap in men’s life expectancy in the period 2005–07 was 4% wider than the baseline period, while for women,

this gap was 11% wider. From 2005–07, infant mortality in routine and manual groups was 16% higher than in the population as a whole, compared to 13% in the baseline period.⁸

18. The UK is not alone in suffering from pervasive health inequalities, which have been defined as ‘systematic differences in health status between different socio-economic groups’.⁹ The following graphs show the relative inequalities¹⁰ in mortality, by level of education, across European countries:

Relative inequalities in total mortality by level of education in Men



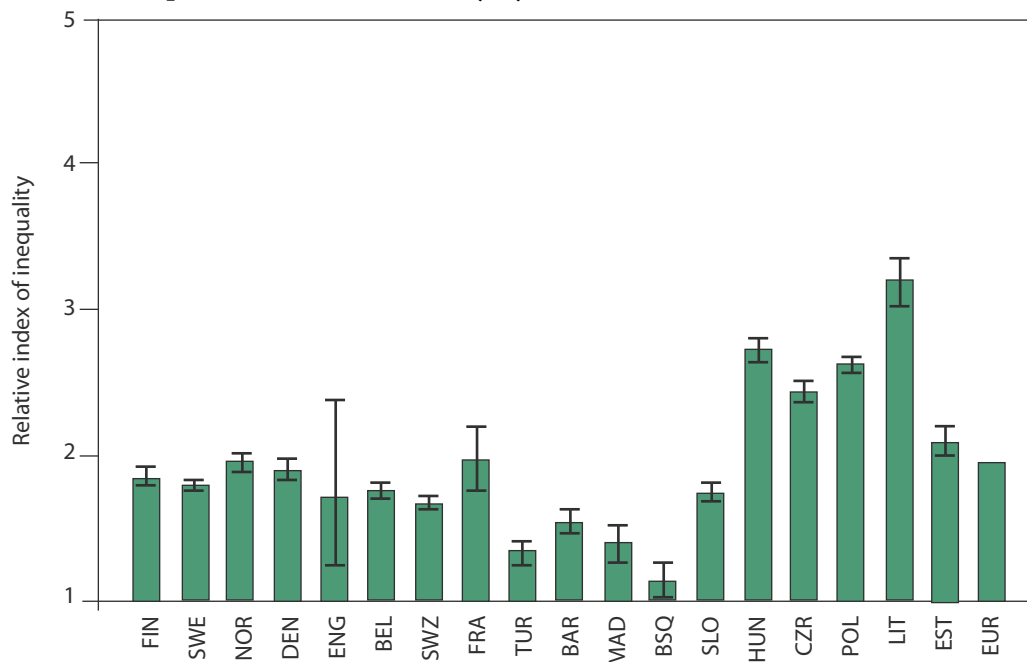
Source: Eurothine report 2007

8 Tackling Health Inequalities: 2005-07 Policy and Data Update for the 2010 National Target, DH, 2008; http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091414

9 Levelling Up: 'Social inequalities in health concern systematic differences' in health status between different socioeconomic groups', Dahlgren and Whitehead, WHO, 2007

10 The relative index of inequality is a summary measure comparing the risk of death between different socioeconomic groups

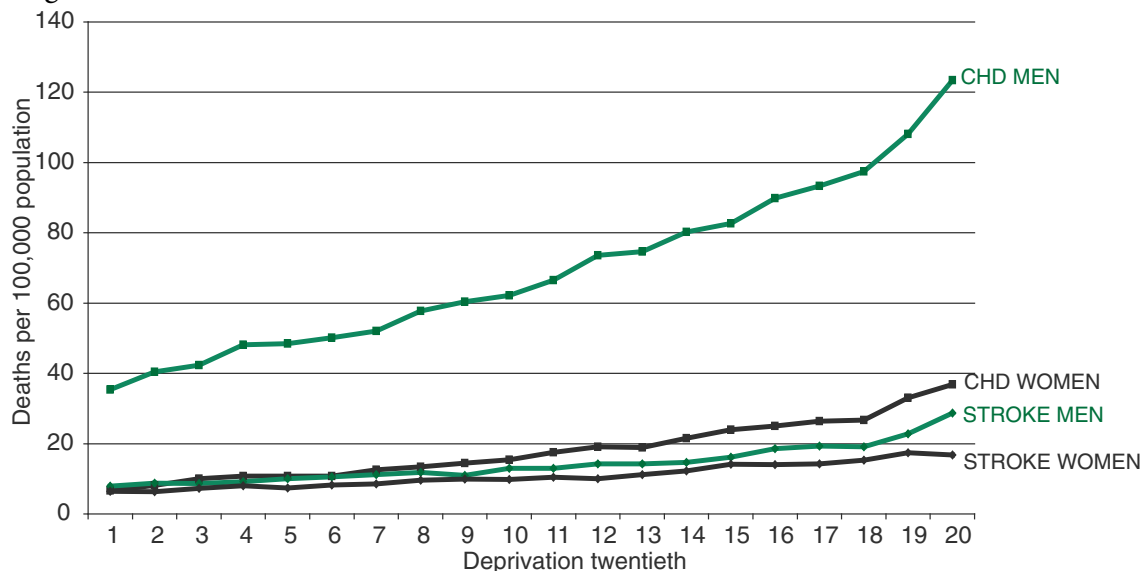
Relative inequalities in total mortality by level of education in Women



Source: Eurothine report 2007

19. Unsurprisingly, the major causes of mortality, including coronary heart disease, also follow a socio-economic gradient:

Age-standardised death rates for CHD and stroke, adults aged 15 to 64, 1993 to 2003, England and Wales



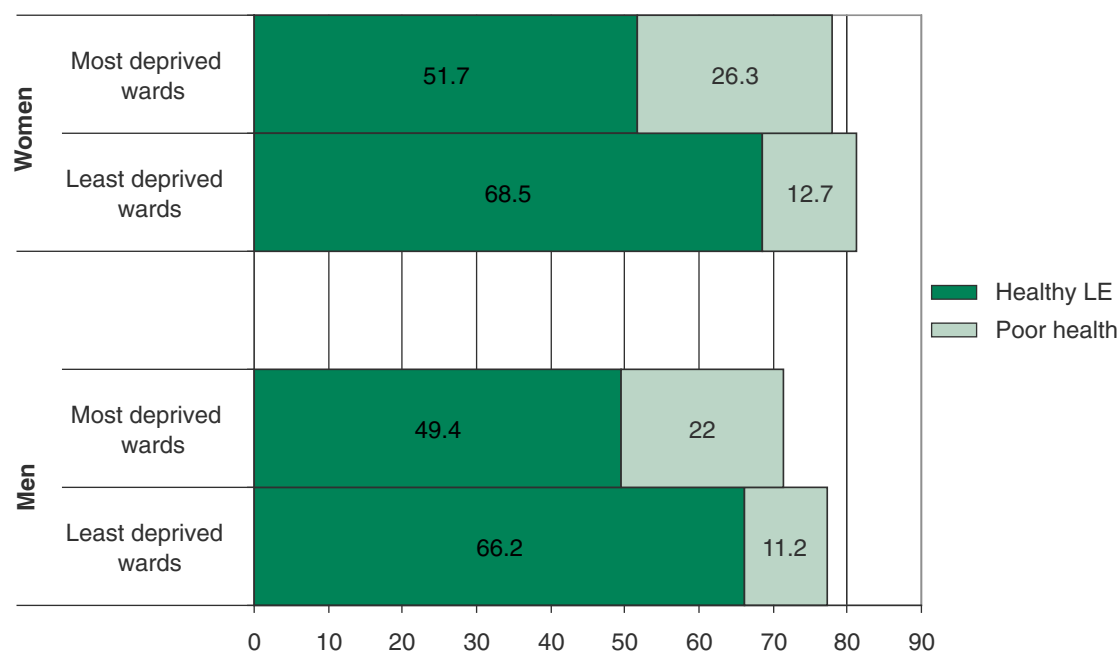
Source: British Heart Foundation¹¹

20. The following data from ONS demonstrates that there are differences in England not only in life expectancy, but in health—with women in the most deprived wards on average succumbing to poor health on average 13.6 years earlier than their counterparts in the least

11 <http://www.heartstats.org/temp/Tabsp1.9spweb07.xls>

deprived wards. Years of healthy life expectancy are dark shaded and years of poor health are light shaded:

Years of healthy life expectancy (LE) and poor health by deprivation level



Source – HI 101, Professor Kay-Tee Khaw

For infant mortality, the picture is similar. The infant mortality rate has fallen significantly throughout the twentieth century in response to improved living conditions, availability of healthcare and other factors—even the last 30 years have seen dramatic improvements (in 1978 the infant mortality rate was 13.2/1000, compared with 4.8/1000 in 2007).¹² Despite this, differentials still exist by father's socio-economic status, birthweight, marital status of parents and mother's country of birth. For babies registered by both parents, the infant mortality rate is highest for babies with fathers in semi-routine and routine occupations—5.4/1000 compared to the national average of 4.9/1000. Moreover, the decrease of 5% in the infant mortality rate for this group between 1994 and 2002 was far smaller than the 16% fall in the overall infant mortality rate.

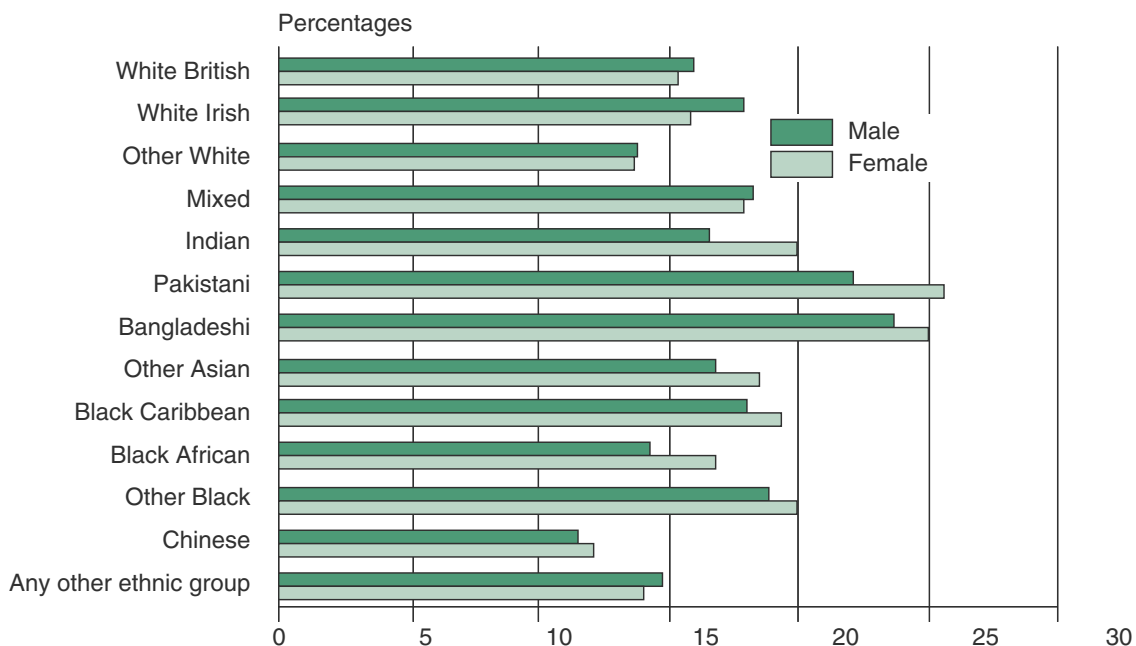
21. Health inequalities can be defined as either absolute or relative. Absolute inequalities are calculated by subtracting one figure or rate (e.g. deaths or death rate in social class 1) from another (e.g. deaths or death rate in social class 5). Relative inequalities are calculated by dividing one number or rate by another. Thus, absolute inequalities are simple arithmetic differences, while relative inequalities are ratios.

22. In England, health inequalities are generally measured in terms of socio-economic class, and action is targeted towards tackling this specific aspect of health inequalities. But there are many other dimensions of health inequalities, which are arguably just as valid candidates for measurement and targeting.

23. There are differences in health between ethnic groups. In April 2001 Pakistani and Bangladeshi men and women in England and Wales reported the highest rates of both

12 Source – ONS - <http://www.statistics.gov.uk/CCI/SearchRes.asp?term=infant+mortality&x=27&y=6>

poor health and limiting long-term illness, while Chinese men and women reported the lowest rates. The figure below shows the percentages of people in different ethnic groups suffering from poor health and limiting illness in 2001.



Age-standardised limiting long-term illness: by ethnic group and sex, April 2001, England and Wales
Source - ONS¹³

- South Asian people are reported to have high rates of heart disease and of hypertension;
- Black Caribbean people are reported to have high rates of hypertension, but not of heart disease;
- All ethnic minority groups are reported to have high rates of diabetes, but low rates of respiratory illness;
- Black Caribbean people, particularly young men, have high rates of admission to hospital with severe mental disorders (psychosis).¹⁴

24. It is claimed that inequalities in health exist between young and old, and that the old receive poorer treatment and are denied access to certain procedures.¹⁵

25. Gender inequalities also exist. The Men's Health Forum argue that men's life expectancy is more severely affected by deprivation than that of women, and point out that gender inequalities exist in many different health outcomes:

- Three quarters of all suicides are by men.
- 67% of men are overweight or obese compared to 58% of women.

13 Source – ONS - <http://www.statistics.gov.uk/CCI/nugget.asp?ID=1007&Pos=6&ColRank=2&Rank=1000>

14 HI 120 – Professor James Nazroo

15 Ev 194–196

- Men are almost twice as likely to develop and to die from the ten most common cancers that affect both sexes.¹⁶

26. Those suffering from a range of physical and intellectual impairments and disabilities also experience poorer health outcomes than other parts of society. Those with schizophrenia are 90% more likely to get bowel cancer, 42% more breast cancer, have higher rates of diabetes, coronary heart disease, stroke and respiratory disease, and on average die 10 years younger than counterparts without mental health problems.¹⁷

27. Health outcomes also vary by geographical area—there is a substantial but not complete overlap with social class, with some evidence of the impact of place independent of other factors. There is some evidence that poorer people living in a deprived area suffer worse health than those in a mixed community.¹⁸

Measuring health inequalities

28. While the statistics presented above provide a broadly accurate view, it should be noted that measuring health inequalities is a complex and inexact science. This section discusses some of the difficulties associated with it. These difficulties do not negate the importance of collecting these data, but serve to illustrate why such measurements need to be treated with caution.

29. Data on socio-economic status and health are available from a number of sources, including the decennial census, government-sponsored household surveys, and birth and death records. Some of the most important information comes from an ONS longitudinal cohort which represents 1% of the population of England and Wales. The class to which individuals are allocated is determined by their job. In longitudinal data the individual's earliest known point of employment is used for this purpose, supplemented if necessary by the socio-economic status of other household members.

30. Most statistics on inequalities are disaggregated by age and gender. National figures on inequalities by disability and ethnicity are not easily available. ONS publishes limited figures on inequalities at regional and local authority levels, while PCTs and other organisations sometimes monitor these aspects of health inequalities at a local level.

31. Life expectancy is one of the target areas chosen by government; for geographical breakdowns it is measured by place of residence at death. We did hear concerns about the impact of population mobility on life expectancy calculations, but as the great majority of moves are within a local authority area, this is unlikely to have a large impact. The exception to this may be with recording and targeting health inequalities related to ethnicity, where large-scale migration, and the loss to studies of individuals who have left the country, might be a factor.

16 Ev 72

17 Ev 302–304; Q 477

18 Neighbourhood deprivation and health: does it affect us all equally?, Stafford M, Marmot M, *International Journal of Epidemiology*, 32 (3), 357–366

32. Infant mortality is the other aspect of the Government's health inequalities target. The first problem with this is that the measure of infant mortality only takes account of children born to parents where the father's occupation can be registered. Where a mother registers as a sole parent, that baby falls into another category which lies outside the target, and as sole-registered births have higher infant mortality rates even than those babies born to fathers who are in the manual and routine occupations, this means that current measures of infant mortality are likely to underestimate the true scale of inequalities in this area.¹⁹

33. As numbers of infant deaths are now so low, it is very difficult to discriminate between areas in a statistically sound way, as only a couple of random occurrences of infant deaths are needed to alter the picture.²⁰

34. Comparing health inequalities internationally is also fraught with difficulty. This is because different countries may use different data sources that are not comparable: there may be differences in recording health statistics and differences in recording socio-economic status, with some countries using different measures altogether; education, for example, is commonly used in Europe. The best source of data for international comparisons remains the Eurothine project²¹ but the caveats listed above apply to this as well.

Causes of health inequalities

35. While health inequalities are generally described in terms of socio-economic class, it is also possible to consider health inequalities using the 'Human Capital' model: each individual is born with a certain amount of "physiological stock", which is affected by genes, and by antenatal factors. This stock depreciates over the course of an individual's life, and can be augmented or not over life by lifestyle behaviours (including diet, stress, smoking, exercise).²² The inter-generational causes of health inequalities are also crucial. Inequalities in health are passed from one generation to the next. This is not only to do with genetic factors, but the mothers' health behaviours during pregnancy and circumstances and behaviour as they raise their children.²³ Equally, health behaviours may be learnt by children from their parents at a young age.

36. This section considers lifestyle factors, and then their underlying causes socio-economic causes. But first we consider what role is played by access to health care in causing health inequalities.

19 Q 117

20 HI 143

21 Tackling health inequalities in Europe: an integrated approach, Eurothine, Rotterdam 2007

22 "The human capital model", Michael Grossman, Handbook of Health Economics, volume 1 A, chapter 7, pages 367–408 edited by AJ Culyer and JP Newhouse North Holland-Elsevier, 2000, Amsterdam, Oxford and New York

23 Fetal origins of adult disease, DJP Barker(ed), BMJ Books, London 1992

Access to healthcare

37. Some specific aspects of inequalities in health are attributed to differential access to, and standards of, health care. These matters are considered more fully in Chapter 6. The most compelling concern is about access related to age-related inequalities.²⁴ However most of our witnesses agreed with Margaret Whitehead, Professor of Public Health at the University of Liverpool, that “inadequate access to health services is only one of many determinants of the observed inequalities in health, and a relatively minor one at that”.²⁵

Lifestyle factors

38. The lifestyle factors which influence health inequalities are sometimes referred to as the “proximate” causes of health inequalities, because they are the immediate precursors of disease, as opposed to the ‘distal’, ‘upstream’ or ‘wider determinants’, such as poverty, housing or education. They include:

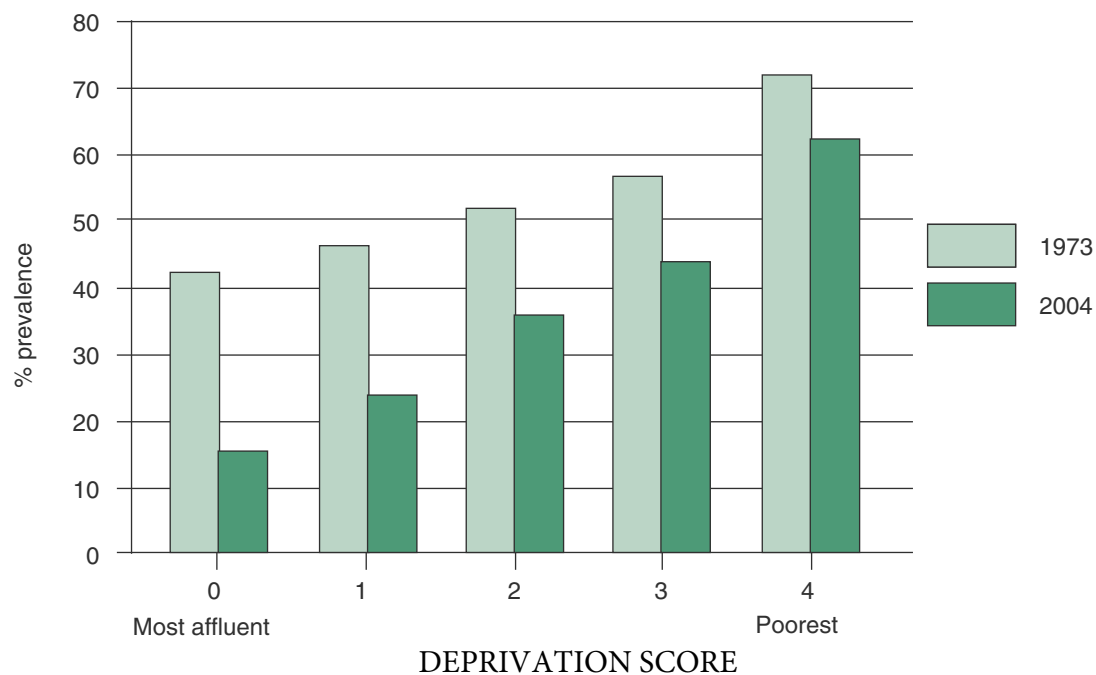
- smoking
- alcohol consumption
- nutrition
- exercise
- weight
- drug use
- sexual behaviour
- stress

39. As the figures below show, lifestyle factors such as smoking, nutrition and obesity follow the same socio-economic gradient that is evident in the distribution of mortality and of the major causes of mortality.

24 Age Concern argued that too often the organisation of health services directly discriminates against people on the grounds of age, resulting in health inequalities. These include: Mental health services, which are often focused on ‘adults of working age’ and may exclude older people; breast and bowel cancer screening programmes are still not extended upwards to the maximum ages at which people can achieve health gains. HI 59.

25 HI 106 – Margaret Whitehead

Smoking prevalence and socio-economic disadvantage
CIGARETTE SMOKING BY DEPRIVATION IN GREAT BRITAIN: GHS 1973 & 2004



Fruit and vegetable consumption by sex and socio-economic group, 2001, England

| | Socio-economic group of household reference person | | | | |
|---------------------------------|--|--------------------------|---------------------------------------|---|------------------------------------|
| Fruit and vegetable consumption | Managerial & professional occupations | Intermediate occupations | Small employers & own account workers | Lower supervisory & technical occupations | Semi-routine & routine occupations |
| (portions per day) | % | % | % | % | % |
| Men | | | | | |
| None | 5 | 8 | 8 | 9 | 12 |
| All with 5 portions or more | 28 | 24 | 25 | 22 | 18 |
| Women | | | | | |
| None | | 4 | 6 | 6 | 8 |
| All with 5 portions or more | 35 | 25 | 27 | 26 | 21 |

Source: British Heart Foundation

Trends in Obesity Prevalence 1993–2004 by Social Class I and V



Source: Foresight Tackling Obesity: Future Choices—Modelling Future Trends in Obesity and Their Impact on Health

40. The potential for behavioural changes to affect health inequalities is borne out by research described to us by Kay-Tee Khaw, Professor of Clinical Gerontology at the University of Cambridge, which indicates that certain health behaviours, irrespective of socio-economic grouping, have an impact on health outcomes:

In EPIC-Norfolk, we observed that men and women who had four health behaviours—not smoking; not being physically inactive, moderate alcohol intake (more than 1 and less than 14 units a week: a unit is half a pint of beer or a glass of wine); and eating five servings of fruit and vegetables a day as estimated using blood vitamin C level—had a quarter the subsequent death rate and survival equivalent to men and women 14 years younger who did not have any of these behaviours. This relationship was consistent irrespective of age, social class or obesity. These behaviours are entirely achievable: 30% of this free living population were already practising all four behaviours.²⁶

Socio-economic factors

41. However, these lifestyle-related causes of health inequalities reflect what are frequently referred to as the underlying causes—income, socio-economic group, employment status and educational attainment. There are many reasons why the poorest in society are less likely to adopt beneficial health behaviours. Firstly, information about how to behave healthily may not reach some groups of society; secondly, they may lack the material resources to live healthily, and the environments in which they live may make this doubly hard; behaviours such as smoking tend to be more heavily entrenched in those from lower socio-economic groups which makes positive change harder; and finally, for people living

26 HI 101 - The EPIC-Norfolk (European Prospective Investigation into Cancer in Norfolk) <http://www.epic-norfolk.org.uk> is a prospective population study of 25,000 men and women aged 40–79 years resident in East Anglia first surveyed in 1993–97 and followed up to the present for changes in health

difficult lives, who may be faced with pressing problems with income, employment or even personal safety, changing health behaviour is unlikely to be a major priority.

42. Sir Michael Marmot, Professor of Epidemiology and Public Health, University College London, and Chairman of the Commission on Social Determinants of Health, set out for us in simple terms why having sufficient resources is essential for health:

Professor Jerry Morris, I think after his 90th birthday, calculated the minimum income for healthy living for a pensioner and he did it by consensus. He went round to the various experts and said, “How much does it cost to eat a healthy diet?”, and, “Is it reasonable to expect people to buy presents for their grandchildren and make visits to friends and so on? How much would all that cost?”, and he summed it up. Then he looked at what a single pensioner gets with the state pension and there is a huge gap. People who rely on the state pension who are pensioners do not have enough money to lead a healthy life. That is the clear judgment and it is the same for a couple. They do not have enough money to live a healthy life. We can give all the health education we like. If people cannot actually afford to do the things they need to do to remain healthy then they are not going to be healthy. That has to be a key issue in inequalities and we have not solved that one.²⁷

43. Socio-economic circumstances can also have a negative effect on health behaviour as future health is not a high priority for people who face much more immediate and serious problems, such as crime and unemployment:

Smoking is not a key issue for people living in relative poverty when they have a number of other key issues that concern them more immediately ...If you look at Washington DC, young black men have a life expectancy of 57. Young black men also have a one third probability of being incarcerated for drug dealing between the ages of 18 and 24, so they are either going to die early or they are going to be put in prison. You go to those young men and say, “You know, you really shouldn’t smoke because you might get lung cancer when you are 60” ... I do not think you would get a very welcome reception. That is an extreme case but I think some of that goes on if people have multiple problems and smoking does not rank so highly on their list of problems that they are willing to do something about it.²⁸

44. Richard Wilkinson, Professor of Social Epidemiology at the University of Nottingham, expanded on this point, arguing that ‘health-related behaviour is all about resolutions to give up the things you do not want to give up and to do the things you do not want to do. You cannot do that, you cannot make the resolutions and stick to them, unless you are feeling on top of life.’²⁹

45. But socio-economic factors appear to go beyond the direct influence socio-economic circumstances may have on lifestyle, as these graphs demonstrate, which reveal that people from high socio-economic classes who smoke live longer than those from lower socio-economic classes who smoke:

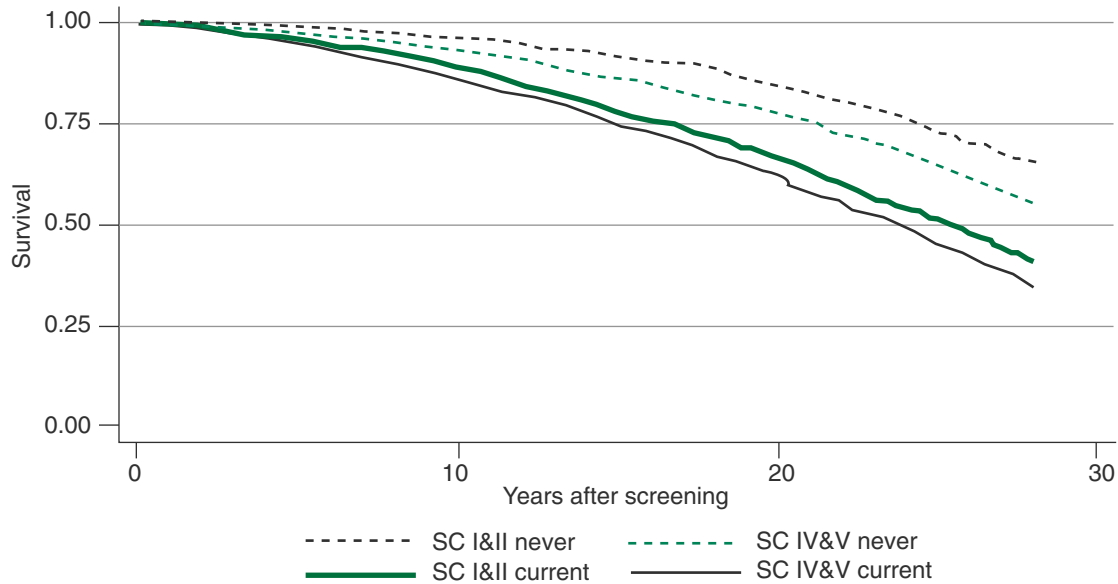
27 Q 155

28 Q 156

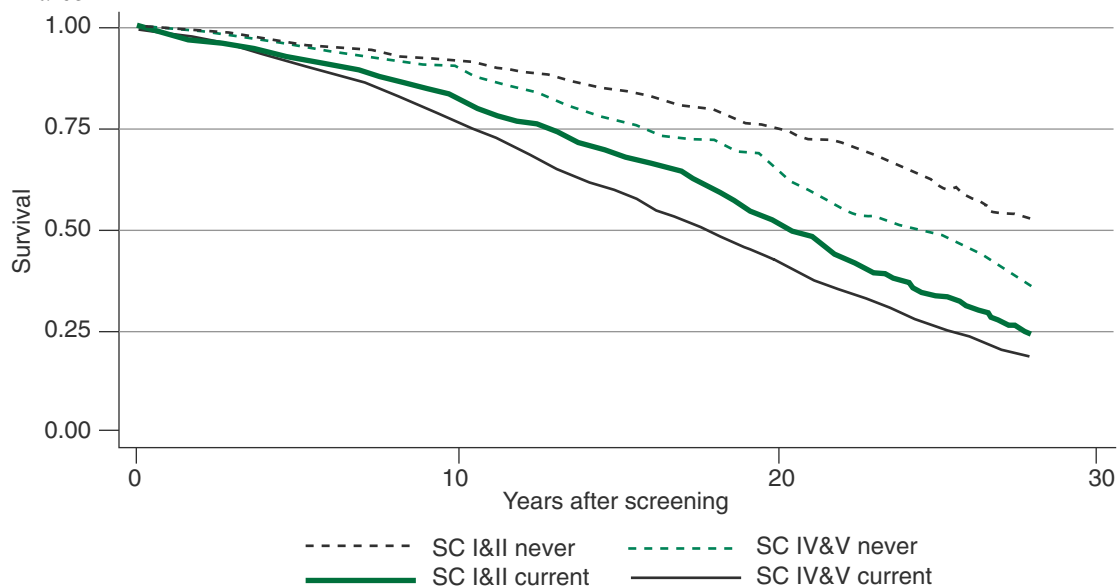
29 Q 156

Smokers survival by social class

Females



Males



Source – Gruer et al³⁰

46. Much debate has centred on whether health problems are more common in lower socio-economic groups because they are absolutely poorer—as in Professor Marmot's example of a pensioner who could not afford to live a healthy life—or because they are relatively poorer. According to Professor Marmot, relative differences are also crucial:

30 Gruer L, Hart CL, Gordon DS, Watt GCM. Effect of tobacco smoking on survival of men and women by social position: a 28 year cohort study. *BMJ* 2009;338:b480 doi:10.1136/bmj.b480. Available online at: http://www.bmj.com/cgi/content/full/338/feb17_2/b480

Relative differences matter because even though our children all now have enough to eat they do not all have the latest Nike trainers or latest mobile phone, which is really very important. That is not trivial, that is central. If a kid does not have what the other kids have, even though he has got all the basic material provisions he needs, that is really terribly important, he is on the outside, and the evidence is that he is relatively deprived in the space of income but absolutely deprived in the measure of what he can do, of his capability to lead a healthy, flourishing life.³¹

47. There is also a hypothesis, called ‘competing causes of death’, which argues that irrespective of advances in health care and lifestyle the poor will continue to die earlier than the rich unless ‘fundamental’ or ‘upstream’ causes of inequality like income inequalities are tackled. In the 1930s the main cause of inequalities was infectious diseases; now it is chronic diseases arising from lifestyle factors, such as cancer and coronary heart disease. The consequence of eliminating the present major causes of death, such as heart disease or lung cancer, will be that the poor will continue to die earlier than the rich but from other causes which will inevitably replace today’s major diseases.³² In other words, it is argued that inequalities in health between rich and poor persist irrespective of the diseases which happen to be currently most prevalent. There is a large research literature referring to this phenomenon, but, while this literature discusses the fact that when one cause of death becomes less prominent, others take its place, there is no published research on the social class distribution of this phenomenon.

48. Although associations between socio-economic inequalities and health inequalities are apparent, controversy remains in this area, as seen by a recent publication in *Health Economics* which did not find a highly significant relationship between socio-economic inequalities and health inequalities.³³ Moreover, while the view that reducing relative income inequalities was the key to reducing health inequalities has many enthusiastic proponents, we did not see any conclusive evidence that suggested changing tax and benefit policies to reduce income inequalities would lead to a reduction in health inequalities. Such claims tended to centre on theoretical assertions rather than be supported by robust evaluative evidence. We note that the Government has commissioned research, to be carried out by Professor Sir Michael Marmot, into the evidence about these wider determinants of health.

49. Health in the UK is improving, but over the last ten years health inequalities between the social classes have widened—the gap has increased by 4% amongst men, and by 11% amongst women. Health inequalities are not only apparent between people of different socio-economic groups—they exist between different genders, different ethnic groups, and the elderly and people suffering from mental health problems or learning disabilities also have worse health than the rest of the population. The causes of health inequalities are complex, and include lifestyle factors—smoking, nutrition, exercise to name only a few—and also wider determinants such as poverty, housing and

31 Q 177

32 Scott-Samuel A. What the Renfrew / Paisley data really tell us about tackling health inequalities: the need to refocus upstream. *BMJ* 2009 (Rapid response) Available online at: http://www.bmj.com/cgi/eletters/338/feb17_2/b480

33 INCOME, RELATIVE INCOME, AND SELF-REPORTED HEALTH IN BRITAIN 1979–2000 *HEALTH ECONOMICS*, Hugh Gravelle and Matt Sutton, *Health Econ.* 18: 125–145 (2009)

education. Access to healthcare may play a role, but this appears to be less significant than other determinants.

3 Designing and evaluating policy effectively

“I fear that over the last ten years or so, despite fantastically good expectations and intentions, we have wasted huge opportunities to learn and we have got to do better in the future.”³⁴ [Ken Judge]

“Few interventions are rolled out in ways which permit rigorous evaluation: often they lack clear or measurable goals, baseline information, cost/benefit data, and control or comparison groups or areas”.³⁵ [Sally Macintyre]

“What happens more often than not is we pour large amounts of money into these interventions and we end up with rich descriptions of what people are trying to do. These rich descriptions are then used as evidence of good practice because we do not have anything else and we slide inexorably from setting these things up essentially to the production of propaganda.”³⁶ [Ken Judge]

50. Our first aim in this inquiry has been to assess the Government’s policies to tackle health inequalities. This task has been complicated by the fact that we have heard repeatedly, from almost every witness, that despite a ten-year push to tackle health inequalities and significant Government effort and investment, we still have very little evidence about what interventions actually work. This is in large part due to inadequate evaluation of the policies adopted to address the problem. In this chapter we look at:

- The lack of evidence about which policies are effective;
- Inadequate evaluation, which is a major cause of the lack of evidence; and
- The case for, and how to achieve, better evaluation.

Lack of evidence

51. Primary Care Trusts are responsible for spending NHS funds to reduce inequalities. Witnesses from these organisations clearly indicated the difficulties they faced in having to make decisions with insufficient evidence. Dr Jacky Chambers, Director of Public Health at Heart of Birmingham Teaching PCT, told us that there was good evidence about a few interventions, such as preventing coronary heart disease and reducing smoking, which had informed much of her PCT’s approach, but:

We have taken some views without much evidence that we need to put a large investment into tackling childhood obesity. We have put a large investment into working with schools and parents, under 5s, nurseries and with Aston Villa Football Club to actually provide a whole generation of children with a completely different

34 Q 351

35 HI 112, Professor Sally Macintyre

36 Q 353

environment in their schools and experience around physical activity and nutrition. We do not know necessarily that that is going to work because there is not much evidence around obesity, but we have got to do something in terms of the rising trends we are seeing in obesity and doing it on a large scale.³⁷

Alwen Williams, Chief Executive of Tower Hamlets PCT, reported similar dilemmas:

I am looking for the year ahead at investing considerably in improving the population's awareness of diabetes on an industrial scale. I think it is acknowledging we do take risk in terms of the judgments we have to take about what we are trying to achieve, the longer term impact that will have and what investment we put into that. I guess what we are going to have to do increasingly as PCTs is share some of that together so we are learning. I think it is fair to say we are, to some extent, in new territory in trying to bring about some new creative ways of doing these things and we have not necessarily got the body of research or evidence behind it.³⁸

Inadequacy of evaluation

52. What is the reason for this lack of sound evidence? Professor Sally Macintyre, Director of the Medical Research Council Social and Public Health Sciences Unit, told us of several initiatives which have been introduced without any prior evaluation at all:

Examples of interventions rolled out with no evaluation include the Expert Patient Programme which was launched without any plan to evaluate it; subsequently randomised controlled trials on self-management using expert patients, conducted quite independently of the expert patient programme, demonstrated a lack of clinical benefit. NHS health trainers were also introduced without evaluation.³⁹

Other witnesses provided similar evidence. The Healthy Schools initiative is a prime example of a large-scale government initiative which has no research evidence to support it, even ten years after its first introduction. Yet PCTs have continued to take part in it.⁴⁰

53. Even when funding has been provided for the evaluation of schemes, as there was for HAZ, it has often been inadequate. In the view of Michaela Benzeval, who was a member of the HAZ evaluation team, the budget was only sufficient to evaluate whether the right processes were undertaken, which could not and did not answer the question 'what works?'.⁴¹

37 Q 227

38 Q 234

39 HI 112A

40 Q 229 - Dr Jacky Chambers

41 HI 112B

Difficulties in evaluating complex interventions

54. Both the Minister for Children and the Permanent Secretary of the Department of Health argued that achieving rigorous evaluation of multi-stranded policies such as HAZ and Sure Start could be difficult.⁴² We were told of several difficulties:

- the impact of complex interventions may span well beyond health, and research teams do not always give priority to evaluating health outcomes and the costs of improving them: according to Sally Macintyre, a review of randomised controlled trials of income supplementation found 10 trials, but only one of these looked at health outcomes.⁴³ The Extended Schools programme was cited by the Department of Children, Schools and Families as evidence of efforts to tackle health inequalities, but its recent evaluation had only examined its impact on exam results and attendance levels, rather than the health dimension.⁴⁴
- Where there are many variables, there can be difficulty isolating and establishing causal links with specific outcomes.
- Very large sample sizes may be needed to establish differential effects on different sectors of society.
- Policies may take a long time for effects to be detectable, and may be changed before the effect of the ‘first wave’ can be identified.

55. The difficulty of evaluating outcomes may lead to ‘softer’ measures such as inputs, throughputs and customer or professional satisfaction being substituted for genuinely robust evidence of effects. Professor Ken Judge, Head of the School of Health at the University of Bath, who was commissioned to carry out analysis of the Government’s Health Action Zone policy, told us that sometimes what is passed off as ‘evaluation’ and evidence is in fact no more than simple description of process:

What happens more often than not is we pour large amounts of money into these interventions and we end up with rich descriptions of what people are trying to do. These rich descriptions are then used as evidence of good practice because we do not have anything else and we slide inexorably from setting these things up essentially to the production of propaganda.⁴⁵

Poor design and introduction of interventions

56. According to several respected academics, including Professors Judge and Macintyre, the main reason for the difficulty in evaluating complex interventions lies at a far earlier stage in the policy process. Professor MacIntyre told us that the Government was now more aware of the importance of carrying out policy evaluations and setting aside funding for them, but this had not necessarily produced satisfactory results. Quite simply,

42 Q 1078; Q 1219

43 HI 112 – Sally Macintyre

44 <http://www.everychildmatters.gov.uk/ete/extendedschools/?asset=News&id=67542>

45 Q 353

insufficient thought is given to the design and introduction of these policies, making meaningful evaluation impossible. Professor Judge supported this view:

Over the last ten years or so I have been involved in the evaluation research activity associated with a number of complex community based interventions, smoking, Health Action Zones, Scottish health demonstration projects, New Deal for Communities. Most of these initiatives have been driven by people like yourselves with a clear recognition of the problems we face and a desire to do something about them, but these well-meaning intentions have got in the way of learning anything useful because we have raced into action too quickly ...the key word for me, the single word I want to impress upon you in this area is evaluability. Design these interventions in a way that gives them some decent prospect of generating learning.⁴⁶

57. It is crucial for policy and plans for evaluation to be designed thoughtfully and in conjunction with one another, but this rarely happens. Michaela Benzval described these problems in relation to the HAZ policy:

The evaluation started after the initiative so there was little chance to influence the design to improve the evaluability of either the overall initiative or specific interventions within it. Even within a process evaluation of a complex systems change initiative like HAZ, it could/would have been possible to employ outcome evaluation, including experimental designs, of specific interventions, but as well as issues of time and resources there was limited commitment on the ground to the idea of evaluation, they just wanted to get things going to try to achieve change.

I think crucial to learning from such initiatives is to assess and plan from the start ways of ensuring their evaluability, eg be clear re outcomes, developing understanding of the underlying theories of change/logic models, so know what to measure, etc, developing genuine commitment of practitioners to evaluation as well as initiative goals...⁴⁷

Baseline data, clear objectives and time to achieve them

58. Despite being introduced on a national basis, the details of many government interventions are often left largely to local determination, meaning that what evidence there is to support an intervention may not be taken into account, and evaluation is all the more difficult because the interventions are so variable.

59. The academic witnesses we asked were adamant that rigorous evaluation required clearly defined objectives, which need to be determined in advance of the intervention's introduction, not least so that good baseline data can be collected. Unless it is clear what the situation is, for example the health of the population, when a policy is introduced, it will be impossible to know whether the policy has been successful.

46 Q 351

47 HI 112B

60. All too often, this has not been the case and policies have been rushed in, and programmes have been manipulated, to meet political and other constraints. The situation has been made worse by endless fiddling. Michaela Benezeval told us of HAZ:

They were set impossible policy goals, with minimal budgets and no time to show results; then policies governing them and their targets constantly changed and eventually they were killed off before they really got going.⁴⁸

Professor Macintyre described an initiative in Scotland where the evaluation had to be stopped because there had been ‘such rapid changes in the intervention that it becomes impossible to know what is being evaluated.’⁴⁹ Alongside setting and evaluation of health benefits, it is also crucial that this is complemented by assessment of programme costs.

61. According to Margaret Whitehead, Professor of Public Health at the University of Liverpool, the ‘continual procession’ of changing initiatives means there is insufficient time for programmes to get going and function properly before they are replaced by another initiative:

There are many area-based initiatives that are introduced one after the other. They are only given a few years to prove themselves and then, when they cannot prove themselves within that short period, they are stopped and something new comes along. There is a continual procession of area-based initiatives and that in itself is quite disruptive. Nothing is given time to really bed in and function.⁵⁰

62. Pauline Naylor, Programme Manager for Barkerend Sure Start, told us of the problems she had faced in implementing the programme:

Recruiting staff, training staff, embedding them, building a sustainable team, engaging with clients and creating major outcomes in a year/18months/two years has been a real challenge. It takes about two years to try something. If it does not work, rethink it, review it, try something else, and, if it does not work, try something else. We have not had the time to really make mistakes, try things and embed good practices, before we have been expected to change the strategy, change the targets and work towards different outcomes. I think that has been really challenging and it has resulted in quite a lot of waste of funds as well. If I could have done things differently, had the space and time to design and think about it and implement it, I think it would have been more cost effective than it has been.⁵¹

Randomisation

63. Having a ‘control’ group or project to which an intervention or treatment can be compared is a fundamental tenet of good research; so is randomisation of the intervention, so that people (or places) have an equal chance of being selected as subjects or controls in the research. Some government policies have been implemented universally, not allowing

48 HI 112B

49 HI 112A

50 Q 100

51 Q 398

time for sufficient evaluation. However, others, for example the Sure Start programme, have been introduced selectively into only a minority of areas. But even these have not had the benefit of randomisation to ensure the robustness of their evaluation, as Alistair Leyland, who was involved in the Sure Start evaluations, explained:

When there is non-random assignment of the intervention to areas, as was the case with Sure Start, the problem is finding out what the mechanism was that resulted in those areas getting the intervention so that such differences can be controlled for. In the case of Sure Start we used 85 area-based variables to try to distinguish between the Sure Start areas and our comparison areas so that we could adjust the analyses for any differences. Although this may seem fairly comprehensive, our adjustment can only be as good as the information we have on areas. So it is still possible that there was a fundamental difference between areas that was not captured in any of those 85 variables, and that this difference affected both to the receipt of the intervention and to the outcomes. We would then have (incorrectly) ascribed such differences in outcomes to Sure Start.⁵²

64. The latest Department of Health initiative, Healthy Towns, is yet another example of a policy which, although being introduced in only a handful of areas and thus a prime candidate for rigorous evaluation, is again being introduced in a way which is likely to make this impossible. Rather than being allocated to random towns, the funding has been allocated to those which put together the strongest bid, indicating that they are probably atypical in terms of motivation and resources in this area. Alistair Leyland and Sally Macintyre informed us:

... the Healthy Towns initiative has those towns with the strongest bids as the intervention group, but this again is non-random assignment—what made some towns put in stronger bids than others? The factors that determined the strength of the bid may lead to differential outcomes independently of the intervention.⁵³

On the healthy towns design, if they have picked the ‘best’ on whatever criteria to be the intervention sites how are the ‘control towns’ matched?—they either were not considered as ‘ready enough’ or resourced enough to be an intervention—which makes them different to the intervention towns or they didn’t even bid—same problem.⁵⁴

65. Professor Judge summed up the government’s track record in learning from its health inequalities interventions with a sombre evaluation:

I fear that over the last ten years or so, despite fantastically good expectations and intentions, we have wasted huge opportunities to learn and we have got to do better in the future.⁵⁵

52 HI 112A, Annex A

53 HI 112A, Annex A

54 HI 112A

55 Q 351

Better evaluation

The ethical case for evaluation

66. The PCTs we took evidence from were in the difficult position of being obliged to take action to tackle health inequalities, but with a totally inadequate evidence base to inform their decision making—leading them to invest in both evaluated and unevaluated interventions. While lack of research is not a justification for inaction, as PCT officials told us, the Nuffield Council of Bioethics' recent report on public health intervention puts forward a strong ethical case for the obligation to research interventions. Introducing unevaluated interventions into communities exposes those communities to risks, in much the same way as those participating in trials of new drugs or surgical procedures are exposed to risks. The risks in this case are that the intervention may have unintended negative consequences, as the following example shows:

Public health interventions such as education and behaviour change programmes are not invasive and might be viewed as unlikely to cause any harm. However, there is evidence that some may do so. For example, training children in bicycle safety has been shown in some instances to have increased accident rates among children who cycle (probably because they or their parents became more confident after the training and they were then exposed to more risks). The 'Bike ed' programme in Australia, designed to reduce cycle injuries, actually increased the risk of injury overall, doubling it in boys. Furthermore, the most adverse effects were observed among younger children, children from families with lower parental education, and children who lacked other family members who cycled, hence increasing socio-economic and gender inequalities which are particularly marked in any case for childhood injuries. The implications of this observation are that well-intentioned and plausible interventions, even of a non-invasive kind involving only education, can do unanticipated harm. This suggests that there is a duty on those introducing such measures to monitor their actual impact over appropriate timeframes, rather than simply assuming they are beneficial.⁵⁶

67. Beyond direct negative impacts, interventions may also have wider ill effects on the community in terms of opportunity costs—diverting resources from other areas to this new, unevaluated intervention.

68. Ethical concerns, for example that it is unfair to offer an intervention which may lead to advantages to people in one area but not another, are sometimes cited as an argument against randomising government interventions, but Professor Macintyre provides a robust defence against these claims:

Political or ethical considerations, or public lack of acceptability, are often cited, but given a circumstance of restricted resources in which not every person, town, or community can receive the intervention, it seems more ethical to take for example the worst 200 communities and then randomise them so that a hundred receive the

56 Public Health: the ethical issues, Nuffield Council on Bioethics, 2007

intervention in a step wedge⁵⁷ design while the other hundred act as controls (and subsequently receive the intervention if it works). It seems more unethical to spend public money on ineffective (and possibly expensive and harmful) interventions and inconclusive evaluations.⁵⁸

Solutions

69. How can policies be better evaluated? Professor Judge made an eloquent plea for more thought to go into policy development:

When government departments rush to develop these new initiatives—the latest one would be in relation to obesity with the Foresight study: there is clearly a clamour for action, to do something about childhood obesity—let us stop and think about how to spend the money in a thoughtful way that might generate some real evidence.⁵⁹

70. We were very pleased to hear that problems with the design, introduction and evaluation of interventions to tackle health inequalities are not insurmountable, and that a positive way forward does exist. The relevant evaluative methods have been set down in standard textbooks for decades.⁶⁰ Professor Macintyre gave a simple and convincing explanation of the relatively basic steps that could be taken before introducing policies, to make learning from them far more robust and meaningful, which are set out in the box below:

57 Stepped wedge randomised trial designs involve sequential roll-out of an intervention to participants (individuals or clusters) over a number of time periods. By the end of the study, all participants will have received the intervention, although the order in which participants receive the intervention is determined at random.

58 HI 112A

59 Q 354

60 for example Cook and Campbell(1971) and Torgeson and Torgeson (2008)

Principles for policy design and evaluation

- * importance of a counterfactual—usually provided by a control group (i.e. what is likely to have happened without the intervention);
- * choose a design according to the specific features of the evaluation (e.g. likely size of effect, proportion of the population affected, and risk of bias) rather than general assumptions or traditions in a particular field
- * consider the whole range of possible experimental designs; cluster randomised, stepped wedge, comprehensive cohort, interrupted time series etc
- * always consider randomisation as the most robust method of preventing bias, as it works against unknown and unmeasured confounders as well as known/measured ones
- * the need for prospective methods—with a baseline to be established and data collected before the intervention is rolled out;
- * the need for the primary outcomes to be established and agreed a priori (to prevent post-hoc selection of those that look good when the participants do worse on the main outcomes);
- * appropriate lengths of follow-up, relative to the outcomes of interest;
- * objective assessment of both positive and negative outcomes;
- * building in methods of measuring long-term and potentially adverse consequences, such as obtaining consent to follow-up, gathering supplementary information to enable tracking, flagging participants in health service registries;
- * non-suppression of unhelpful negative findings;
- * importance of measuring direct and indirect impacts—not just the obvious direct impacts (e.g. urban renewal may improve the infrastructure in a target area, but local residents may not be able to afford to live there any longer and may have to move out);
- * explicit statements/theories/evidence about how the intervention is expected to work;
- * collect information about how the intervention is actually implemented (as opposed to how it was expected to work);
- * in particular in relation to inequalities, collect about impact by gender, age, ethnicity and socio-economic status;
- * include an economic evaluation.⁶¹

71. Randomisation is held up as the gold standard in the MRC's guidance on evaluating complex interventions. This states that "randomisation should always be considered because it is the most robust method of preventing selection bias." Many interventions abroad have been the subject of randomised controlled trials, which suggests that such trials are not inherently impossible⁶², and indeed there has been a randomised controlled trial as part of Sure Start, which indicates that randomisation is possible, although there it was the children who were randomised rather than areas.⁶³

72. Although Alistair Leyland admitted 'some sympathy with the idea that it is not possible to come up with a randomised town', he explained that 'the idea of randomisation is that any fundamental differences between towns (areas, schools) will be balanced between intervention(s) and controls—this is why there will be a large number of towns in each group'.⁶⁴

73. However, if for any reason randomisation is not possible, there are many other ways in which interventions and their evaluations can be designed to ensure maximum evaluability, as detailed in the MRC guidelines which are shown in the box below:

Experimental designs for evaluating complex interventions

Individually randomised trials—Individuals are randomly allocated to receive either an experimental intervention or an alternative such as standard treatment, a placebo, or remaining on a waiting list. Such trials are sometimes dismissed as inapplicable to complex interventions, but there are many variants, and often solutions can be found to the technical and ethical problems associated with randomisation

Cluster randomised trials are one solution to the problem of contamination of the control group, leading to biased estimates of effect size, in trials of population level interventions. Groups such as patients in a general practice or tenants in a housing scheme are randomly allocated to the experimental or control intervention

Stepped wedge designs may be used to overcome practical or ethical objections to experimentally evaluating an intervention for which there is some evidence of effectiveness or which cannot be made available to the whole population at once. It allows a trial to be conducted without delaying roll-out of the intervention. Eventually, the whole population receives the intervention, but with randomisation built into the phasing of implementation⁶⁵

74. Finally, whilst driving up the standards of evaluation of large-scale initiatives is clearly a key priority, it is essential that other, smaller scale opportunities for learning about health inequalities are not missed. We heard from several witnesses that the NHS itself is the source of many innovative new initiatives, and Kay-Tee Khaw, Professor of Clinical

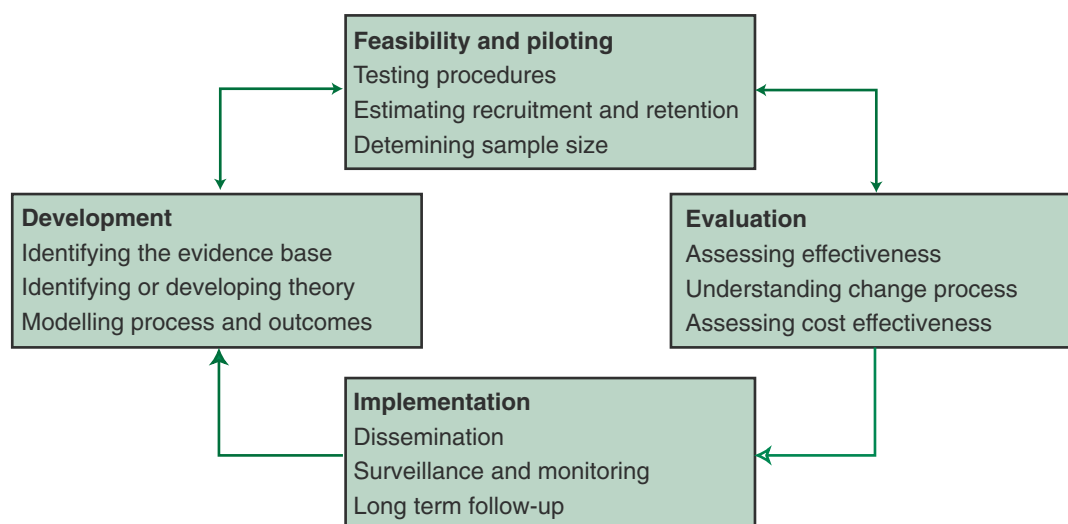
62 <http://www.sphsu.mrc.ac.uk/files/File/library/occasional/OP019.pdf>

63 Parenting intervention in Sure Start services for children at risk of developing conduct disorder: pragmatic randomised controlled trial, Hutchings et al, BMJ 2007;334:678; originally published online 9 Mar 2007;

64 HI 112A, Annex A

65 <http://www.sphsu.mrc.ac.uk/files/File/library/occasional/OP019.pdf>.

Gerontology at the University of Cambridge, described the NHS as ‘a huge test bed’.⁶⁶ We heard that harnessing the most promising of these local innovations and selecting the best for further, more rigorous evaluation, should be an essential part of the cycle of evaluation and learning:



Key elements of the development and evaluation process

Conclusion

75. The most damning criticisms of Government policies we have heard in this inquiry have not been of the policies themselves, but rather of the Government’s approach to designing and introducing new policies which make meaningful evaluation impossible. As one witness described, “there is a continual procession of area-based initiatives and that in itself is quite disruptive. Nothing is given time to really bed in and function” Even where evaluation is carried out, it is usually “soft”, amounting to little more than examining processes and asking those involved what they thought about them. All too often Governments rush in with insufficient thought, do not collect adequate data at the beginning about the health of the population which will be affected by the policies, do not have clear objectives, make numerous changes to the policies and its objectives and do not maintain the policy long enough to know whether it has worked. As a result, in the words of one witness, ‘we have wasted huge opportunities to learn’.

76. Governments have spent large sums of money on social experiments to reduce health inequalities, but we do not know whether these experiments have worked or whether the money has been well spent. The latest initiative on Healthy Towns has all the failings of previous policies, indicating that the Government has learnt nothing from past mistakes.

77. There is an ethical imperative to develop and use evidence-based policy. All the reforms we have discussed are experiments on the public and can be as damaging (in terms of unintended effects and opportunity cost) as unevaluated new drugs or surgical procedures. Such wanton large-scale experimentation is unethical, and needs to be

superseded by a more rigorous culture of piloting, evaluating and using the results to inform policy.

78. Simple changes to the design of policies and how they are introduced could make all the difference. We recommend that all future initiatives to tackle health inequalities initiatives must, prior to their introduction, demonstrate adherence to the basic set of research guidelines we have detailed in this chapter, which include:

- Piloting;
- randomisation and pairing of controls;
- use of quasi-experimental methods with controls where randomisation would be too costly;
- collection of adequate baseline data; and
- monitoring and measurement of pre-determined health-related outcomes within a set period of time, and in relation to cost.

79. Professor Sir Michael Marmot's forthcoming review on health inequalities offers the ideal opportunity for the Government to demonstrate its commitment to rigorous methods for introducing and evaluating new initiatives in this area which are ethically sound and safeguard public funds.

4 Funding for health inequalities

80. This chapter explores the funding available to tackle health inequalities. It considers

- how policies which redistribute health resources towards those in most need may in fact run counter to the NICE approach which seeks to prioritise cost-effectiveness.
- how PCTs are funded to tackle health inequalities, including both the resource allocation formula, and other sources of funding, and, finally
- how PCTs spend their allocations to tackle health inequalities.

Finally, we look at:

- potential solutions to some of these issues.

To what extent should health spending be redistributed to tackle health inequalities?

Tensions between the redistributive model and the NICE approach

81. There appears to be a significant tension between two different ways in which health spending is determined. On the one hand, the Department of Health aims to spend money on reducing health inequalities without regard to whether the money might be more cost-effectively spent in other ways. The resource allocation formula aims to direct resources to areas with the highest health need; in addition, money has been provided for specific initiatives to tackle health inequalities. On the other hand, the NICE methodology, which makes recommendations on whether certain treatments should be funded on the basis of their clinical and cost-effectiveness, is based upon calculations which take into account total health gain to the whole population, rather than to a specific, disadvantaged sector of society.

82. To set out for us the conflicts inherent between these approaches and the ethical dilemmas arising from these different ways of allocating health resources, we took oral evidence from an eminent philosopher and ethicist and two health economists.

83. To begin with we asked the witnesses about the legitimacy of redistributing health resources away from the health of the greatest number and the most effective interventions, specifically towards lower socio-economic groups. Peter Smith, Professor of Health Economics at the University of York responded that such a policy enjoyed public support:

We have done some research on what the public thinks about narrowing health inequalities. Although the public is quite split about this—some people really think the Health Service should just be about promoting health; others think its prime aim should be reducing health inequalities—on balance, they did support quite a lot of

the NHS efforts going towards reducing health inequalities and they would be prepared to see some sacrifice of overall health gain to reduce those inequalities.⁶⁷

84. However, 40% of the population included in Smith's research were not persuaded that traditional NHS activity should be sacrificed in order to address inequalities. Mark Sculpher, Professor of Health Economics at the University of York, argued that this was ultimately a political decision, but that explicitly recognising the trade off between these competing aims was crucial, as was providing sufficient evidence about that trade-off—who exactly are the winners and losers.⁶⁸

85. When we asked the Secretary of State for Health how much he thought it was reasonable to spend on reducing health inequalities, he could not provide an answer, either in terms of a proportion, or an absolute amount:

I do not think I can answer that question in terms of an amount. It is just integral to everything you do in health. I think there was a time when there were pots of ring-fenced money labelled "health inequalities". There was a time when no one even worried about health inequalities, when it was not even on the agenda. But those times have gone. It is integral to everything we do.⁶⁹

86. We were surprised and disappointed to receive so vague an answer to what appeared a pertinent question about such a high priority Government target. Nor did the Secretary of State for Health appear to see the tensions that exist between spending money to improve the health of the poorest, and spending to maximise the health of the whole population:

That balance is there, with everyone receiving money, because our aims are to improve the health of everybody in society and also to tackle health inequalities, so I cannot differentiate between the two.⁷⁰

NICE and health inequalities

87. John Harris, Professor of Bioethics at the University of Manchester, told us that in his view, the NICE approach, based on Quality-Adjusted Life Years (QALYs) was fundamentally flawed since it was impossible to state that a NICE-recommended treatment was more cost-effective than the treatment it was replacing:

The problem is that the Health Service cannot know where money saved on any particular application will be put. It is as likely to go on white lining the car park or, as I understand it, the tens of millions of pounds that are spent in the Health Service on paracetamol and laxatives, as on something that we, the community, would regard as a better use of that money. If rationing is inevitable, let us ration in some fair way but not dress it up as if we are somehow preserving the public purse for better uses ... you have to look at the whole range of health care.⁷¹

67 Q 657

68 Q 657

69 Q 1178

70 Q 1178

71 Q 658

88. Professor Sculpher agreed with Professor Harris on the importance of knowing more about what treatments and services are displaced by funding new NICE-recommended treatments. While Professor Sculpher did not think at the moment that the NICE technology appraisals that have been carried out to date had had a significant impact, either positive or negative, on health inequalities,⁷² as the decisions had mostly been about end-of-life treatment for relatively rare conditions, he did think that there was the potential for NICE decisions to worsen health inequalities by displacing certain important services:

What we do have is anecdotal information that particular services in some areas, like the care of the elderly, the care of the mentally ill, may suffer as a result of funding the new technologies. We need to know a lot more about what is displaced, as I think this Committee itself has said in the past, as a result of NICE decisions.⁷³

89. We questioned the witnesses about the introduction of “equity weighting” into the QALY process. According to Professor Sculpher, there is currently no set of weights that could be used, and developing them would be difficult and highly contentious. [668]. However, Professor Smith did recommend one positive step towards ensuring NICE guidance did not have a detrimental impact on inequalities, which would be to research the cost for PCTs of implementing NICE guidance:

I think one thing we could do is to cost up for every PCT how much the implementation of NICE guidelines is. My guess would be that it is quite variable between different PCTs, how much they are going to have to spend on NICE guidelines, mandatory work. That being the case, this has some relevance to your inquiry, because it implies an inequality in the residual part of the budget if the guidelines are taking up different proportions of the budget in different PCTs. I think that could be done. I think that it is feasible, to make some stab at costing out how much the guidelines would cost each PCT and then seeing what the residual looks like across PCTs.⁷⁴

How PCTs are funded to tackle health inequalities

The Resource Allocation formula

90. The main source of funding for health services, and the most important element of funding for health inequalities, is the allocation which PCTs receive each year which is determined by the Department of Health’s resource allocation formula.

91. The Government has made a commitment to tackling health inequalities by shifting NHS resources which would otherwise be spent on general services and interventions which are of benefit to the entire population towards those people who have the worst health outcomes. The funding formula which is used by the Department of Health to allocate resources to PCTs is ‘weighted’ to allow for the extra health needs faced by disadvantaged areas, as the Department of Health described:

72 Q 647

73 Q 662

74 Q 690; NICE provides budget estimates for the cost to the NHS of its new technologies but we do not know how closely these equate to what individual PCTs actually spend on implementing the guidance.

The Department of Health resource allocation seeks to ensure there is sufficient funding to provide equal access for equal need in all parts of the country, and to reduce avoidable health inequalities. Allocations are made to PCTs on the basis of the relative needs of their populations through a weighted capitation formula. This formula is weighted to include each PCT's "crude" population according to their relative need (age, and additional [not clear what 'additional is—define) need) for healthcare and the unavoidable geographical differences in the cost of providing healthcare (market forces factor).

The development of the weighted capitation formula is continuously overseen by the independent Advisory Committee on Resource Allocation (ACRA). ACRA makes recommendations to Ministers on possible changes to the formula, prior to each round of PCT revenue allocations.⁷⁵

92. The Secretary of State for Health gave us some more detailed figures:

In terms of what we spend on health per person, it now stands, on average, at £1,449. It was £426 in 1997. In a deprived area like Tower Hamlets it will be nearer to £2,000. That balance is there, with everyone receiving money, because our aims are to improve.⁷⁶

75 Ev 3

76 Q 1178

93. The table below shows for 2009–10, in the first column, the actual allocations per head which a number of PCTs are to receive; in the second, the target amount they ought to receive according to their level of need and, in the third, notional figures, showing ‘weighted capitation target per weighted head’.⁷⁷

| PCT | Actual allocations per head (£) | Weighted capitation target per unweighted head £ | Weighted capitation target per weighted head £ |
|------------------|-------------------------------------|---|---|
| | (i.e. the amount each PCT receives) | (i.e. the amount PCT ought to receive –known as ‘the target’) | (this figure which is weighted according to need is in fact close to the average) |
| Bedfordshire PCT | 1,293 | 1,340 | 1,537 |
| Mid Essex PCT | 1,269 | 1,316 | 1,535 |
| Kingston PCT | 1,414 | 1,242 | 1,535 |
| Knowsley | 2,007 | 2,020 | 1,535 |
| City and Hackney | 2,136 | 2,009 | 1,535 |
| Teaching PCT | | | |
| Tower Hamlets | 2,014 | 1,917 | 1,535 |

Source: Department of Health

As this table shows City and Hackney receives 68% per head more than Mid-Essex, which receives the lowest per capita funding.

94. Professor Smith told us that the resource allocation formula “does a pretty good job at being even-handed and systematic in splitting up the cake between the PCTs”.⁷⁸ The one area he felt in major need of improvement was data about relative population needs to inform the resource allocation process:

77 As a reminder of the context, a weighted capitation formula is used to determine each primary care trust’s (PCT’s) target share of available resources, to enable them to commission similar levels of health services for populations in similar need. The formula is made up of the following components:

- a count of the population served by the PCT;
- an adjustment (or weight) to reflect differences in the age of the population;
- an adjustment (or weight) to reflect other factors that affect the need for health care, such as deprivation;
- an adjustment (or weight) to reflect unavoidable differences in cost (the market forces factor); and
- an adjustment (or weight) to reflect health inequalities.

The formula determines the target allocation for each PCT, it does not determine PCTs’ actual allocations. PCTs do not receive their target allocation immediately, but are moved to it over a number of years in order to minimise financial instability in the NHS and recognise that there are unavoidable cost pressures that all PCTs will need to meet. Actual allocations therefore depend on how quickly PCTs are moved towards their target allocation through the distribution of additional funding – the “pace of change” policy. Pace of change policy is decided by Ministers for each allocations round.

Weighted capitation target per unweighted head – while this is the correct technical description, it might more simply be described as each PCT’s target allocation divided by the number of people in each PCT.

Weighted capitation target per weighted head - this is each PCT’s target allocation divided by the number of people in the population, where the number of people has been weighted for healthcare need due to age, deprivation etc. according to the weighted capitation formula

The measure weighted capitation target per weighted head gives a very similar figure for each PCT to the average for England. This is because each PCT’s weighted need is included in both their weighted target and weighted population.

The big scope for improvement is in improving information. At the moment, the researchers who developed the formulae are very hamstrung by the limited data they have available. In other countries which have universal electronic records of their citizens, they can work out which citizens should be allocated more expected finance than others, and so, from an individual perspective, they can create, if you like, almost an insurance premium.⁷⁹

95. Professor Smith did caution that allocations although perhaps fair are not necessarily sufficient to meet need:

In common with almost all resource allocation methods, the English funding formula effectively gives PCTs the amount of money they would need if—given their local characteristics—they were to deliver the national average package of health care to their citizens, using national average levels of efficiency. In short, local allocations reflect the current national pattern of health care being delivered on the ground. Current resource allocation methods are therefore intrinsically conservative.⁸⁰

96. In addition to this, not all areas currently receive what they should receive according to the resource allocation formula. This is because historically many areas have received less funding than they need, but rather than taking away large amounts of funding from some over-funded areas to compensate more needy areas, the Government has adopted a more gradual approach to shifting resources over a number of years, meaning that some PCTs are still receiving funding below their 'target' amounts. This means that these areas, some of which are spearhead areas, are essentially carrying forward a 'backlog' of under-resourcing, meaning services have been under-invested over the course of many years. London PCTs are most likely to be above target in 2009–10. Westminster PCT will be 22.3% above target, receiving £1,776 per head when its target is £1,452. More deprived London PCTs are also above target; Islington is to receive £2,143 per head whereas its target is £1,913. Bassetlaw is furthest from target at -8.6%, receiving £1,529 against a target of £1,673. Outside London, some deprived areas such as Liverpool are above target (by 1.2%) and others, like Knowsley below (-0.6%). Some of the areas with the lowest per capita allocations such as Mid-Essex (£1,269) are below target, others above, for example Wiltshire (£1,336) are above.⁸¹

97. The Secretary of State told us that in future the resource allocation would be determined using the more subtle tool of "person-based allocation". Such formulae are in use in other countries (including the US, Germany and the Netherlands), and rely on 'diagnoses' of individuals, based on inpatient and outpatient encounters and prescribing data. Thus comparative use of services is used as a proxy for "relative need". Professor Smith, who is currently involved in a scoping study for a person-based allocation formula for use in this country, suggested that it would be some time before it could be introduced but told us that as an interim measure it might be feasible to devise more specific allocations based only on hospital data, but cautioned that NHS diagnostic coding in

79 Q 701

80 HI 129 – Professor Peter Smith

81 Information provided by the Department of Health

hospitals is often poor quality, and that we are some way off having adequate GP activity data, although prescribing data in primary care was good.⁸²

PCT spending on tackling health inequalities

Allocation of funds by PCTs

98. Several witnesses were critical of the failure of PCTs which received a large allocation under the funding formula to direct their funds to those in greatest need. Dr Dixon argued that programme budgeting data, which shows the breakdown by PCT on how money is spent on different areas including mental health, cancer, coronary heart disease and public health, showed that there was “very little correlation between what PCTs are spending on particular areas of health care and the needs of the population”.⁸³

Choosing Health money

99. PCTs failure to spend money on preventive measures to reduce inequalities is seen by what happened to funds promised by the Department of Health in 2004 in its White Paper on public health, *Choosing Health*.

100. However, several submissions argued that money promised to tackle the causes of inequalities, under the auspices of the *Choosing Health* initiative, had not materialised:

Choosing Health in England set out the government’s commitment—including financial—to tackling the major causes and consequences of inequalities. Yet the financial crisis which engulfed the NHS in 2006–07 has seen the money promised to the NHS under Choosing Health subsumed into general PCT budgets.⁸⁴

This view was reiterated by Dr Dixon:

There were additional monies supposed to be allocated as part of the Choosing Health White Paper but these were not earmarked funds and there is clear evidence that quite a lot of that money was spent on other priorities and was not spent on public health ...⁸⁵

Professor Alan Maryon-Davis, President of the Faculty of Public Health, told us:

The figures we have were based on the figures of the Choosing Health investments of two or three years ago now, where, of course, if you remember, there was a crisis in the NHS, there was a massive deficit, and there was a bit of panic in the system. Inevitably, the first things to get chopped, to put it bluntly, are these preventive health promotion soft targets really. You can wave the shroud around heart disease or heart disease services or cancer services or any kind of patient care. It is more difficult to wave the shroud in terms of prevention and health promotion and these

82 HI 129A

83 Q 110

84 Ev 66 – Faculty of Public Health

85 Q 97

initiatives tend to get the chop. We do have hard figures that show a lot of the Choosing Health monies, in particular, simply disappeared.⁸⁶

Cost effectiveness

101. The problems relating to the design and evaluation of policies to tackle health inequalities, which we discussed in the last chapter, are particularly pertinent to the failure of many PCTs to spend more on tackling health inequalities. Professor Smith told us that a major reason that PCTs did not spend more in this area was simply that they did not know how best to spend the money. This was especially the case when the alternative was expenditure on other priority areas where sound evidence of value for money interventions may exist:

More generally, it is not at all clear how PCTs should best spend any 'health inequalities adjustment' funding. The most immediate instinct might be to seek to improve access to health services for disadvantaged groups. However, this may not be the most efficient use of resources, especially if the main causes of health inequalities are mainly due to personal characteristics (such as lifestyle) rather than access problems. If so, the emphasis might shift to health promotion strategies for improving the health of disadvantaged groups. Alternatively (though this may be difficult to implement) policy might consider giving privileged access to health care for disadvantaged groups.⁸⁷

Solutions

102. Professor Julian Le Grand, Chair of Health England, which is currently preparing a ten-year plan for preventive health spending, told us that he supported the re-introduction of ring-fencing to prevent public health monies from being siphoned into other aspects of NHS services:

I am becoming increasingly of the view that you have to either ring-fence some form of public health spending or engage in an explicit incentive mechanism to encourage PCTs or local authorities to spend on public health measures. We have been looking at ideas such as matching grants, for which the Department of Health holds back some money and then offers a matching grant to PCTs to engage in public health programmes of various kinds. I think we have to consider that kind of thing; otherwise, public health monies will always get swallowed up by the acute sector in a way that has happened historically.⁸⁸

103. Kaye Wellings, Professor of Sexual and Reproductive Health at the London School of Hygiene and Tropical Medicine and author of the national evaluation of the Teenage Pregnancy Strategy, which has arguably had more success in meeting its objectives than efforts to reduce health inequalities (achieving a 15% reduction in under 16 conceptions

86 Q 424

87 HI 129 – Professor Peter Smith

88 Q 423

during the same period that health inequalities have increased), agreed that initially at least, ring-fencing was important:

I think it is right that the teenage pregnancy strategy had four or five years of uninterrupted ring-fencing and that really motivated people to get all the targets, the aims and the goals into Local Area Agreements, into the Strategic Health Authority plans, they have been very successful in that.⁸⁹

104. Dr Jacky Chambers, Director of Public Health at Heart of Birmingham PCT, argued that PCTs' inability to carry forward surpluses, and their one-yearly financial cycle, made it much more difficult to invest in long-term interventions for tackling health inequalities. In contrast, foundation trusts and local authorities do not face such constraints and are able to retain surpluses, and have three-year funding cycles.⁹⁰

Conclusion

105. Trade offs exist between redistribution of health resources to tackle health inequalities—as happens through the formula which the Department of Health uses to distribute funds to PCTs, and the NICE model, which influences PCTs' spending by recommending certain treatments and interventions on the grounds of cost-effectiveness on a population basis. These trade offs have never been explicitly articulated and examined and we recommend that they should be. Professor John Harris said “if rationing is inevitable, let us ration in some fair way ... you have to look at the whole range of health care”. How far the majority of the population is willing to forgo health care to switch resources to the most needy is a moral question which requires a wide debate.

106. As we have stated in previous reports, more needs to be known about the relative cost effectiveness of treatments and services that are displaced to fund the new treatments recommended by NICE. A first step in this process would be to research the cost of implementing NICE guidance in each PCT in England—which we recommend the Government should fund immediately.

107. The resource allocation model used by the Government seeks to equalise the funding available to PCTs in relation to proxies for need. It has had a major effect on the funding PCTs receive; the neediest PCTs receive almost 70% more money per head than the least needy. However, many PCTs have not yet received their full needs-based allocations. The Government must move more quickly to ensure PCTs receive their real target allocations.

108. Furthermore, money that was intended to be spent on preventive health promotion programmes which may have reduced health inequalities has instead been spent by PCTs on the acute sector in times of financial difficulty.

109. Suggestions for protecting the NHS public health budget included a return to ring fencing, or relocation of public health budgets in local authorities rather than PCTs.

89 Q 789

90 Q 254

We also heard that PCTs' current funding constraints, including one-year financial cycles and inability to retain and invest surpluses, should be removed in the interests of enabling more long-term investment in health inequalities. We did not receive enough evidence on these specific points to be able to recommend them.

110. The Government has not made even basic calculations about how much has been spent on tackling health inequalities. We recommend that the Department of Health find out both how far PCTs spend the funds they received under the resource allocation formula on tackling health inequalities and what funds specifically allocated for health inequalities initiatives are spent on, and the health outcomes achieved. As a first step the Department should commission an in-depth study of health inequalities funding in a small sample of PCTs.

111. PCTs do not have adequate knowledge about how money should be spent to best tackle health inequalities, and we recommend investment in the systematic evaluation of policy initiatives with a focus on relative cost effectiveness, following the principles set out in chapter three, to inform these difficult choices.

5 Specific health inequalities initiatives

112. Health inequalities have been known about for many years. Beveridge acknowledged the problem. The Black Report (1980) documented persisting inequalities. The Acheson Report, published in 1998, called for action on a broad front to tackle the problem⁹¹ and prompted the Government's efforts to tackle inequalities over the past ten years.

113. **During the course of this inquiry we heard widespread praise and support, both in this country and abroad, for the explicit commitment this Government has made to tackling health inequalities. This commitment has involved a framework of specific policies, underpinned by a challenging and ambitious target. We would like to emphasise our support and commendation for the Government for taking specific actions to tackle health inequalities, although, as we have written, we are critical of aspects of planning and evaluation.** The Box below lists the Government's main initiatives to tackle health inequalities since 1997. This chapter considers these initiatives.

Chronology: Key reports and health inequalities initiatives

Acheson report - 1998

HAZ - 1998

Sure Start - 1999

Targets - 2000

Cross cutting review - 2003

Spearhead areas - 2004

National support team - 2006

Health inequalities intervention toolkit – 2006

Health Action Zones

114. Health Action Zones (HAZs) were the Government's first flagship policy to reduce health inequalities. HAZs were multi-agency partnerships located in 26 areas of England. The first wave of zones was launched in 1998 (15 areas) followed by a second wave (11 areas) in 1999. They varied greatly, ranging from large conurbations such as Merseyside and Tyne and Wear to largely rural areas such as Cornwall and North Cumbria. They were provided with fairly modest resources (approximately £4–£5 million per year per zone at 2004 prices), but expected to develop local programmes and activities to improve health and reduce inequalities during a seven-year lifespan.⁹²

115. The three broad strategic objectives of HAZs were to:

- identify and address the public health needs of the local area;
- increase the effectiveness, efficiency and responsiveness of services; and

91 Independent Inquiry into Health Inequalities, TSO, 1998 - <http://www.archive.official-documents.co.uk/document/doh/ih/contents.htm>

92 HI 34 – Professor ken Judge

- develop partnerships for improving people's health and relevant services.

116. The majority of initial programmes sought to improve health by promoting healthy lifestyles, improving employment, housing, education and tackling substance abuse. Another important set of activities focused on the health of particular population groups and/or specific health problems. But there was hardly any aspect of population health improvement or community regeneration that at least one of the HAZs was not concerned with in one way or another.

117. However, the HAZ programme was abandoned in 2003. Professor Ken Judge, who led the evaluation of Health Action Zones, opened his memorandum to the Committee with a stark summary:

Health Action Zones were conceived and implemented too hastily, were too poorly resourced and were provided with insufficient support and clear direction to make a significant contribution to reducing health inequalities in the time that they were given.⁹³

He went on to describe the difficulties they faced:

HAZs were born at a time when anything seemed possible for a New Labour Government desperate to make things work and quickly. But the tide of enthusiasm for change outran the capacity to deliver it. Too many hugely ambitious, aspirational targets were promulgated. The pressure put on local agents to produce 'early wins' was debilitating. A sense of disillusionment began to set in relatively early in their lifespan, and HAZs soon lost their high profile as the policy agenda filled with an ever-expanding list of new initiatives to transform public services and promote social justice. By the beginning of 2003, much earlier than expected, they were to all intents and purposes wound up.

The evaluation found that the sheer complexity of the initiative and the extent of policy change that HAZs experienced meant that drawing simple conclusions about their impact was difficult. It suggested that there were some benefits: HAZs made a valuable contribution to building partnerships and raising awareness about inequalities in health and progress was made with individual programmes and projects. However, in general, the conclusions were negative, finding that HAZs made little impact in terms of measurable improvement in health outcomes during their short lifespan. HAZs did not—probably could not—do what they set out to achieve:

this was supposed to be a seven-year initiative, launched by one secretary of state, dramatically changed by the next, abandoned by the third, subject to different parliamentary and political timetables, where guidance from the centre was not clear, [or was] ...contradictory. People competed with each other in terms of their aspirations. One of the Health Action Zones, which covered an entire conurbation and was given £4 million or £5 million a year, proposed to transform the life

expectancy of the entire population such that it was in the top 10% for Western Europe in seven years. These things are simply not achievable.⁹⁴

118. Professor Judge argued that the HAZ experience clearly demonstrated that there was a need to think more carefully about the focus of such initiatives, their objectives, their timescales, the support that they need both locally and nationally and the space, trust and time that is required to make any kind of sustainable change possible:

The notion that an injection of relatively modest resources accompanied by guidance—more evangelical than practical—from central government might result in the speedy resolution of major social problems, that had proved largely intractable for generations, would not find so many advocates today as was probably the case a decade ago. But HAZs were put under considerable pressure to demonstrate that they were ‘making a difference’ within a relatively short time period even though, as one contemporary commentator observed, ‘early hits are not always evidence of accurate shooting’.

The overwhelming problem—evident in much contemporary policy research—is that the voracious appetite for intelligence by policymakers too often encourages the production of simple descriptions of activity, which are passed off as evidence of “good practice” without adequate discussion of the strengths and weaknesses of what is being presented. While undertaking the evaluation of HAZs we had serious concerns about the pressure to generate and use learning at too early a stage in the cycle of data collection, analysis and reflection. Simply documenting activity, which is frequently demanded and regularly served up, is not evidence of good practice and the growing tendency to pretend that it does yields little more than propaganda. Too many users of policy research still expect clear answers about impact when a more realistic product of evaluations is that they contribute to a process of enlightenment about highly complex processes that are interpreted by different actors in multiple ways.⁹⁵

Conclusion

119. Health Action Zones were an ambitious initiative that could not achieve the extremely challenging targets that were set for them in the short time they were in existence. We have heard that they were a victim of many of the problems with policy design and implementation documented previously—they were both under funded in relation to their objectives, and ill-thought through.

Sure Start

120. According to many of our witnesses, the impact of the early years on health inequalities cannot be overstated. A mother’s lifestyle whilst pregnant can affect her child’s future health. Lifestyle factors once a baby is born, including breastfeeding, diet, and smoking in the home, can also impact upon future health. Postnatal depression can have

94 Q 360

95 Ev 103

long-term effects on children's behaviour and parenting skills can influence later educational performance, which itself affects their later life.

121. The importance of early years was emphasised in the Acheson report, and the Government has set an ambitious target to halve the number of children living in poverty by 2010 and to eradicate child poverty by 2020. The extent of child poverty is roughly defined as the children in households which have below 60% of 'median incomes'. Although rates of child poverty are reducing, the 2004–05 target was missed, and projections suggest that the 2010–2011 target will also be missed.

122. The Sure Start programme was launched in 1999 to provide support to disadvantaged families in the crucial early years. It aims to achieve better outcomes for children, parents and communities by:

- increasing the availability of childcare;
- improving health and emotional development for young children; and
- supporting parents as parents and in their aspirations towards employment.

The evidence that informed the creation of Sure Start came from the United States, where early years programmes had demonstrated a decrease in the incidence of behavioural problems, psychological disorders and special educational needs, usually apparent by adolescence. However, there are fundamental differences between Sure Start as it was eventually implemented and the American programmes on which it was loosely based.⁹⁶

123. Below we look at a number of aspects of Sure Start, namely:

- Has Sure Start worked?
- Reasons for success and failure: variations in Sure Start programmes and links with NHS early years programmes
- The future: should Sure Start provide targeted or universal services

Has Sure Start worked?

124. Witnesses from individual Sure Start programmes gave us several examples of individual initiatives introduced in their areas which they felt had worked well. These included training parents to be community workers and to offer support to other parents; providing an integrated programme of support for teenagers; an initiative run jointly with the local council to increase levels of physical activity; and the establishment of a community engagement team.⁹⁷

125. The first major evaluation of Sure Start was published in June 2005, and showed evidence of benefit in the less deprived families, but little benefit in those with the greatest needs.⁹⁸ The next evaluation (2008) was more positive.⁹⁹ This showed that there were some

96 Q 369

97 Q 391

98 <http://www.ness.bbk.ac.uk/impact.asp>

benefits to living in a Sure Start Local Programme (SSLP) area. Children living in such areas exhibited more positive social behaviour and greater independence/self-regulation than children in non-Sure Start areas, whilst parents made greater use of support services, exhibited less negative parenting and provided a better home-learning environment. Families living in SSLP areas also used more child- and family-related services than those living elsewhere.

126. Unlike the 2005 study, the second study, published in 2008, showed beneficial effects for almost all children and families living in SSLP areas and provided almost no evidence of adverse effects on population sub-groups, such as workless or lone-parent families. The effects associated with SSLPs appeared to apply to all of the resident population, whereas the earlier 2005 study found positive and negative effects for different subgroups.

127. However, the evaluation was not all positive: of the 14 outcomes measured relating to health and child development, Sure Start programmes were only found to have an impact on five; they did not have a positive impact on children's immunisations, accidents, language development, mother's rating of area, father's involvement; maternal smoking, maternal body-mass index, or maternal life satisfaction.¹⁰⁰ Moreover, it is difficult as of yet to link improvements in children's behaviour and in parenting skills to long term improvements in health or narrowing of health inequalities.

128. Separate research undertaken by Hull University concluded that Sure Start, despite being targeted at deprived areas, was still not benefiting the most deprived and marginalised populations within those areas:

Too often SSLPs took a whole population approach when social and economic indicators suggested that they should be targeting specific minority communities. Although some programmes had an effective structural approach to minority groups, the majority were tending to respond in an ad-hoc, short-term way and often did not reach families who needed help. This was particularly true of groups described as 'hard-to-reach': very small populations, groups of travellers/gypsies/Roma, migrant workers, families of Bangladeshi origin.¹⁰¹

129. A local evaluation had, according Frances Rehal, Director of Millmead Sure Start, demonstrated progress in more defined, health-related outcomes:

When we started our programme in 2000, 27% of mums breastfed their babies at birth; the figure now is around 57%. In teenage births within the Sure Start area over the past nine years, and that was four prior to Sure Start and five post Sure Start, we were able to evidence 65% reduction in teenage births. When we started out, 52% of our children failed to attend speech and language therapy sessions to which they had been referred. Now, after our programme funding research into the causes of non attendance, our figure is under 5% non-attendance.¹⁰²

99 <http://www.ness.bbk.ac.uk/documents/activities/impact/41.pdf>

100 Sure Start Local programmes in England, *The Lancet*, Volume 372, Issue 9650, Pages 1610–1612, 8 November 2008

101 <http://news.bbc.co.uk/1/hi/education/6287610.stm>

102 Q 370

130. However, this is a very small scale piece of research and cannot be taken as definitive evidence of benefit. Professor Melhuish concluded that while some benefits in child development and parenting have now been demonstrated, much is still unknown about the impact of Sure Start, particularly its cost effectiveness:

We are finding the children who are born around about 2003 and 2004 are now showing some improvement in their development where they have been in Sure Start programmes and parenting practices in Sure Start programme areas seem to be better. In that sense, they are having benefits. Are they value for money? Could we have spent the money in other ways which would have produced more benefits? That is still an open question, I think.¹⁰³

Reasons for success and failure

Variation

131. In Chapter 3 we described the difficulties brought about by differences in local implementation—both for the effectiveness of the programme, and for evaluating it. Professor Melhuish drew attention to the great variation between the Sure Start programmes of different areas:

there was great variation in Sure Start programmes. Some are very effective and some are comparatively ineffective¹⁰⁴

132. In Professor Melhuish's view, the lack of guidance and direction given to those initially charged with implementing the Sure Start programme was a mistake:

Communities had almost complete control at the start about how they delivered their programmes, which led to the enormous diversity we saw across the country in the early Sure Start programmes. There should have been published some guidelines about the kinds of services to be delivered at the early set up. Apparently those guidelines were written but did not get distributed to the programmes, and so there was this enormous diversity of set up.¹⁰⁵

This made it much more difficult to evaluate Sure Start and may have led to deviations from the original, evidence-based model on which the programme was based.

Maintaining links with NHS early years services

133. Sure Start aims to integrate early years education, childcare, parenting programmes, health promotion, and early years health services. Professor Melhuish told us that his evaluation showed a general tendency for Sure Start programmes which were well integrated with local health services to have the most effective outcomes:

103 Q 377

104 Q 372

105 Q 382

There is very good reason for this. The health services give you immediate access to parents in pregnancy and children at birth, and, therefore, the Sure Start programmes can get into contact with those families very early on. Where that integration of health services with Sure Start programmes does not take place, Sure Start programmes are often at a loss to know who has had a new baby in that area, whether that new family needs help or not. Any ideal services, I would suggest, would involve very close integration of the health services with Sure Start type programmes. Currently, this is very patchy across the country. Some programmes have excellent integration of health services; for example health visitors working closely with the Sure Start programmes ... Where this does not happen, problems tend to get worse and worse as time goes on.¹⁰⁶

The future: targeted or universal children's services?

134. After providing six years of targeted support in the most deprived areas, Sure Start programmes are now being subsumed into Children's Centres, which by 2010 will be universal. Witnesses thought this development might create a number of problems. Professor Melhuish argued that putting Children's Centres under the auspices of local authorities had dislocated children's services from the NHS.¹⁰⁷

135. We also heard concerns that Sure Start programmes were being 'colonised' by the middle classes, who enjoyed the cheap, high quality childcare they offer and that extending provision universally would further dilute their focus on those who need them the most. The Secretary of State for Health did not think this was a problem:

The fact that children's centres are going into areas that are more affluent is not in any way detracting or diluting from the focus in deprived areas to get to the hardest-to-reach people.¹⁰⁸

136. However, he did not give us a clear explanation of why the policy was being extended, nor what was being done to ensure the focus on deprived families was preserved.

Conclusion

137. **The early years period was emphasised throughout our inquiry as a crucial focus for efforts to tackle health inequalities, and we commend the Government for taking positive steps to place early years at the heart of the health inequalities agenda through Sure Start. Many witnesses were very positive about the benefits of Sure Start. National evaluation shows that it has enjoyed some success, but it has yet to demonstrate significant improvements in health outcomes for either children or parents, achieving positive evaluation in only 5 out of 14 measures that were studied.**

138. **Moreover, there is concern that extending this policy, via Children's Centres, to all areas of the country, risks distracting from the original focus of deprived families who**

106 Q 372

107 Q 375

108 Q 1258

are most in need of support. We did not receive detailed evidence about the evolution of Sure Start programmes into Children's Centres, but again this is a policy change that has not been properly piloted or evaluated prior to its introduction. It is absolutely essential that early years interventions remain focused on those children living in the most deprived circumstances, and Children's Centres must be rigorously monitored on an ongoing basis.

Targets and the Cross-Cutting review

139. The NHS Plan (2000) announced the first ever national health inequalities targets for England. These were reaffirmed in the Comprehensive Spending Review as:

to reduce inequalities in health outcomes by 10% by 2010 as measured by infant mortality and life expectancy at birth.¹⁰⁹

140. In measuring progress against this target, the Government has chosen to focus on inequalities as measured by socio-economic class rather than education, ethnicity or any of the other ways in which health inequalities can be measured.

Progress towards meeting the target

141. The Department's 2008 Annual Report notes that "it will be challenging to meet all aspects of the PSA target". In fact, since the baseline period (1995–97) the gap between the 'routine and manual' groups and the population as a whole has widened. The gap in men's life expectancy in the period 2005–07 was 4% wider than the baseline period, while for women, this gap was 11% wider. From 2004–06, infant mortality in routine and manual groups was 17% higher than in the population as a whole, compared to 13% in the baseline period.¹¹⁰

142. Despite this, the Secretary of State for Health remained optimistic in his appraisal of progress, arguing that the full impact of some policies had not yet been felt, and that by 2012 progress would be better:

I do not think the full effects of smoke-free legislation, for instance, has fed through yet. There will be some effects from GP surgeries going into under-doctored areas. We will not know until 2012. That is when we will find out if we have made the 2010 target. I still think we can make it ...As I say, I do not have heroes and villains here. There is no PCT that I have been to—and I go around the country an awful lot—where I think, "They're just not interested in health inequalities." There are areas where they do not have the partnership right and there are areas where in the local strategic partnership they are not playing the active role that they should, but they all want to tackle this issue. As Hugh just quoted, the figures for people who are aware of this challenge and are aware of our targets and all the rest of it, amongst local authority chief executives is very high and very encouraging. I think we can do it.¹¹¹

109 HI 101

110 Tackling Health Inequalities: 2005–07 Policy and Data Update for the 2010 National Target, DH, 2008; http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091414

111 Q 1200

143. However, the Healthcare Commission, the body which monitors the NHS's progress against government targets, argues that it is highly unlikely that this target will be met:

Performance to date would suggest that current health inequality PSA targets will not be met.

Criticisms of the target

Should the target focus only on socio-economic inequalities?

144. As we have discussed in Chapter 2, health inequalities are evident across a number of different measures—not only socio-economic status, but ethnicity, gender, age, disability and regional area. This suggests that health inequalities should perhaps be measured and targeted in a multidimensional way. There is evidence that some PCTs are already doing this. Alwen Williams, Chief Executive of Tower Hamlets PCT, told us:

For us, given our population, issues of ethnicity are key. One of the challenges the NHS has is: how do we measure, so we can measure the impact of what we are doing in relation to the different population groups within our communities? We have implemented, for example, patient profiling in our general practices so that we are starting now to measure ethnicity in a much more comprehensive way. That will help us ensure we can then measure equity of access, equity of health outcomes in relation to some of those factors that are part and parcel of our population make-up. We are not doing that because that has been a target set for us: that is because we understand that for us to be successful in what we are trying to do around health improvement that is a key component—for us to be able to understand and measure our achievements and successes in future years.¹¹²

Should infant mortality be in the target

145. As mentioned above, we were told by the ONS that as numbers of infant deaths are now so low, it is very difficult to discriminate between areas in a statistically sound way, as only a couple of random occurrences of infant deaths are needed to invalidate this. This raises questions about whether infant mortality is a valid way in which to measure health inequalities and whether it should be included in the target.

Timeframe

146. Some witnesses told us that ten years was an insufficient timeframe to achieve this level of change; Professor Sir Michael Marmot, Professor of Epidemiology and Public Health at University College London and Chairman of the Commission on Social Determinants of Health, argued that a more realistic ambition would be 'closing the health gap in a generation'.¹¹³

¹¹² Q 211

¹¹³ Q 153

Inequalities or the health of the poorest?

147. As discussed previously, the trend of widening health inequalities does not mean that the health of those in the lowest socio-economic groups is getting worse. In fact, life expectancy amongst the lowest socio-economic groups continues to increase. Inequalities have worsened not because the health of the poor is getting worse or even staying the same, but because the rate of health gain is faster amongst more advantaged groups.

148. On visits to Norway and the Netherlands, we heard that in having a target which explicitly aims to reduce inequalities rather than simply improving the health of the poor, England has one of the toughest targets in the world. It was suggested that a better approach to improving health might be a focus on improving the health of the most disadvantaged groups rather than on narrowing differences. Professor Julian Le Grand, Chairman of Health England, agreed:

One should focus on the absolute level of ill-health of the poor. One of the pieces of advice I gave the Government a very long time ago was that setting a target in health inequalities is almost certainly a mistake, because almost certainly you will miss it—and, indeed, that is exactly what has happened.¹¹⁴

149. Professor Ken Judge, Head of the School of Health at the University of Bath, did not believe that the target has provided sufficient focus in this area:

Certainly in England the view has been, and the pressure from the public health lobby on the Government at the time was, that the adoption of targets would help to focus efforts and drive through change-agendas which deliver more progress. There is little evidence that has been the case in the last seven or eight years, I am afraid.¹¹⁵

150. Others, however, maintained that having an ‘aspirational’ target such as this was instrumental in galvanising policy makers towards targeting this area. The Healthcare Commission argue that missing the target should not be viewed as failure, arguing that:

Without these targets, the situation would have been worse. In combination with the health inequalities elements of other related targets, the target has provided a focus for commissioners and service providers and has driven improvement in several areas including teenage pregnancy, infant health, tobacco control and life expectancy. We therefore congratulate Government on setting the target and establishing a Health Inequalities Unit. These were brave decisions and gave a strong message, raising the profile of health inequalities and adding to the debate.¹¹⁶

151. The Secretary of State was firm in his defence of the adoption of such a difficult and possibly unrealistic target:

114 Q 457

115 Q 342

116 Ev 293 – Healthcare Commission

It would give us an easier life but I think it would be depressingly unambitious just to say, “Let’s target the poor and forget about the inequality gap.”¹¹⁷

Promoting short-term measures?

152. Concerns were voiced about the way in which the target is measured, skewing efforts to tackle health inequalities. Some witnesses argued that the targets, and indeed the measures recommended by Government to achieve them, focusing predominantly on treating CHD in the over-50s, might actually divert effort and funding away from more long-term and potentially more valuable interventions focused on preventing ill-health in today’s children and young people.¹¹⁸ On the other hand, it might be perverse not to treat CHD in the over-50s since it is one of the few interventions which is known to work.

Focus on the most deprived or other groups

153. The target focuses on improving the health of the most deprived section of the population relative to the population average, but inequalities occur across the whole of the population; the higher an individual’s socio-economic group, the better his or her life expectancy. A case can be made for setting a target which raises all other socio-economic groups relative to the highest. This may be more cost-effective as middling socio-economic groups might be more receptive to a range of policy instruments.

Neglecting local inequalities?

154. Efforts to meet the national target, which compares average rates for the whole PCT against national averages, may also mask inequalities that exist within deprived PCTs, as well as neglecting pockets of deprivation that exist in more affluent PCTs. Alwen Williams, Chief Executive of Tower Hamlets PCT told us:

We can do the comparison of Tower Hamlets versus other PCTs in our Spearhead group over the rest of the country, but actually if we look at men living in Bethnal Green and men living in Millwall, there is a difference of eight years in terms of life expectancy. There are some interesting statistics and we are looking a bit more at this; but looking at Spitalfields, which is predominantly a Bangladeshi community, the life expectancy there for women is higher than the national average; so we have actually got some unexpected statistics¹¹⁹

155. As the Healthcare Commission pointed out in its written evidence, focusing on improvements in only the most deprived areas would not address health inequalities fully, as there were pockets of deprivation in all areas. The HCC, in its recent review of PCTs’ efforts to improve smoking cessation, found that many PCTs, especially those in more affluent areas, were not yet successfully targeting small areas or population groups known to have high levels of smoking.¹²⁰ We were also told that in a PCT it is actually very difficult

117 Q 1189

118 Ev 293

119 Q 218

120 Ev 290

to deliver targets based on social class, as the data may not exist, often locality (eg index of multiple deprivation) and/or ethnicity are used as alternatives.

The Cross-Cutting Review

156. Since 2000, the Department has published a series of action plans and reviews aimed at bolstering progress towards the target. The Cross-Cutting review, led by the Treasury and published in 2002, aimed to co-ordinate action across Government departments. In response the Department of Health published *Tackling Health inequalities—a programme for action* in 2003, which set out a total of 82 indicators measuring factors which would contribute to reducing health inequalities, underpinned by 12 ‘headline’ indicators against which progress would be systematically reviewed.¹²¹

157. The Department of Health’s progress report, *Tackling health inequalities—2007 status report on the programme for action*, which was published in March 2008, presents a positive view, stating that of 82 departmental commitments to support the national health inequalities strategy, 72 have now been met.¹²² Unfortunately, although the most of the 82 department commitments have been met, health inequalities are widening, and of the 12 ‘headline’ indicators, only a handful have demonstrated progress in reducing inequalities between social classes. In some areas inequalities have actually widened.

121 *Tackling Health inequalities – a programme for action*, Department of Health, 2003; http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008268?IdcService=GET_FILE&dID=10311&Rendition=Web

122 *Tackling Health inequalities 2007 status report on the programme for action*, Department of Health, 2008; http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083471

Progress against 12 national headline indicators¹²³

| Indicator | Progress |
|---|--|
| Death rates from the big killers | Cancer—no significant change in relative inequalities |
| | Heart disease—widening in relative inequalities |
| Rate of under-18 conceptions | No significant change in relative inequalities |
| Road accident casualty rates in disadvantaged communities | No significant change in relative inequalities |
| Numbers of primary care professionals | No significant change in relative inequalities |
| Uptake of flu vaccinations | Slight narrowing of inequalities |
| Smoking | Manual groups—some signs of a widening in relative inequalities |
| | Pregnant women—some signs of a widening in relative inequalities |
| Educational attainment | Some signs of a narrowing in inequalities |
| Consumption of fruit and vegetables | No significant change in relative inequalities |
| Proportion in non-decent housing | Narrowing of inequalities |
| PE and school sport | In 2006/07, participation in PE and school sport in School Sport Partnership schools with a high proportion of pupils eligible for free school meals (FSM) is on average almost the same as in other schools |
| Children in poverty | The proportion of children in England living in low-income households has fallen since the baseline of 1998/99 |
| Homeless families living in temporary accommodation | Since March 2002 there has been a reduction in the number of homeless families with children in bed and breakfast (B&B) accommodation |

158. In a damning description of the status report, Hilary Graham, Professor of Health Sciences at the University of York, told us that the 2003 Cross-cutting review had simply shoehorned existing policies into the health inequalities agenda, without proper consideration of what would work:

the indicators, the 75 of the 82 successful indicators, the basket of indicators, came from the Treasury-led review of strategies—the Programme for Action strategy to

¹²³ *Tackling Health Inequalities: 2007 Status Report on the Programme for Action, DH, 2008*
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083471

tackle inequalities—and by and large it was an attempt to map existing initiatives against the targets; namely, given that this is what we are doing, how might they contribute to reducing inequalities? I think there is an opportunity to turn the question around the other way and say, “If we want to reduce inequalities in health, what should we be doing in policy terms?”¹²⁴

Conclusion

159. It is likely that the Government’s health inequalities target will be missed. This is unsurprising since it is the toughest target adopted anywhere in the world. Despite this likelihood, we agree with the HCC that aspirational targets such as this can prove a useful catalyst to improvement. We commend the Government for its adoption of this target and we recommend that the commitment be reiterated for the next ten years.

160. Health inequalities have many facets—health is unequal according not only to social class, but to gender, ethnicity, age, disability and mental health status, to name only a few. It is crucial that the Government’s focus on socio-economic inequalities alone does not lead to other aspects of health inequalities going unnoticed and ignored. We were pleased to see that some local areas already focus on health inequalities related to ethnicity as appropriate to their local populations; however there is little to suggest that health inequalities relating to either gender, age or to mental health status are even being adequately measured let alone addressed. A wider range of inequalities should be measured. Such measurements should include not just unequal outcomes in terms of length and quality of life, but should also examine unequal access which would lead to unequal outcomes. We have also heard that there are statistical problems with the infant mortality target because there are so few infant deaths in each area. We recommend that this target be reconsidered. We recommend that the best ways to measure and target health inequalities be investigated by Sir Michael Marmot’s forthcoming review.

161. In 2003, the Treasury’s Cross-Cutting review set out a seemingly ambitious plan of action across government departments to tackle health inequalities; however, we were told that this was simply an attempt to “map existing policies” on to the target, with little thought given to what would actually work. Five years on, the measures listed in the Cross-Cutting review have not delivered what they promised—although almost all the indicators have been achieved, we are still as far as ever from actually reducing health inequalities.

Support for ‘Spearhead’ areas

162. Action to meet the target has been focused on the ‘Spearhead Areas’—the 70 local authority areas with the worst health and deprivation indicators. However, according to Dr Anna Dixon, Director of Policy for the King’s Fund, giving certain PCTs/ LAs ‘spearhead’ status has not been an effective lever to galvanise people to action:

From some analysis that we have done, the identification of the spearhead local authorities has not meant a great deal on the ground. Obviously it was an important way of measuring against the target in terms of life expectancy but, particularly in those local authorities that have been designated spearheads, there has not really been a sense—and we did some interviews with directors of public health and others working in local government—that spearhead status had really made much difference in their focus on health and health inequalities, which is clearly quite disappointing.¹²⁵

163. This view was endorsed by Dr Jacky Chambers, Director of Public Health at Heart of Birmingham PCT:

I think the awareness of Spearhead and the extent to which it has got a profile in the city is probably quite low, if I am honest, in terms of it as a vehicle, and although the Spearhead local authority is a network and the conference that kick-started that, I think the reality is that in terms of the kinds of support that we have received by way of sharing good practice and networking has not really had all that much in the way of impact. We have basically got on with it. We have enjoyed having that status and we have enjoyed having the National Support Team visit but other than that I cannot say that it has really added much.¹²⁶

164. Dr Dixon also pointed out that the spearhead areas that have made the most progress in tackling health inequalities are those that were already the least deprived in that group:

those who have performed best were already the ones that were least deprived. It does seem that those spearheads which met all five of the criteria to get that status have been the really toughest ones in term of their improvement.¹²⁷

The national support team

165. Faced by the failure to reduce health inequalities, in 2006 the Department of Health created the National Support Team (NST) on health inequalities, to work with local authorities and PCTs in the spearhead areas. The NST “explores the local context and systems and promotes the success factors for delivery and shares good practice on both aspects of the target”.¹²⁸ The Secretary of State for Health described the value of the support team:

I think the major important element here are these national support teams. This is a systematic, evidence-based, scientific approach that we are developing here. We find that PCTs need some help in Spearhead areas in particular—not exclusively, but in particular. The national support teams have been very, very popular. We had only one national support team and now we have doubled that to two, which means that we can get them around to every Spearhead area by the summer of next year. What do they do? They go into these areas and they systematically look at the issues. They

125 Q 97

126 Q 260

127 Q 97

128 HI 01

concentrate attention on smoking, on cholesterol, on cardiovascular disease, and they help the PCTs.¹²⁹

166. The adoption of a specialised, unevaluated but popular, support team half way through the target's ten-year period is an implicit criticism of the failure to provide central support as soon as the targets were established. The contrast to the Teenage Pregnancy strategy is striking. In this strategy local co-ordinators received close support, guidance and management from a central unit from its launch. Spanning the same period as the health inequalities strategy, the Teenage Pregnancy Strategy has had more success; despite last year's rises, it has achieved a 6.4% reduction in under 16 conceptions and a 10.7% reduction in under 18 conceptions since its baseline period, where over the same period there has been an increase in health inequalities.¹³⁰

The Health Inequalities Intervention Tool

167. In addition to the National Support Team, the Health Inequalities Intervention Tool was introduced to identify the interventions most likely to contribute to meeting the health inequalities target in each PCT area. It also "encourages partnership work with local authorities to promote the wider, social and environmental improvements on health inequalities."¹³¹

168. For the life expectancy element of the target, the Health Inequalities Intervention Tool has meant focusing on high impact medical interventions, particularly among the over 50s, on reducing smoking among manual groups and on the prevention, effective management and treatment of other cardiovascular risk factors through primary care, particularly control of cholesterol and blood pressure.

169. Rather than identifying specific interventions, for the infant mortality aspect of the target, the Tool identifies contributory factors that may reduce infant mortality, including preventing teenage pregnancy, reducing smoking, maternal obesity and the incidence of sudden and unexpected deaths in infancy. The importance of early antenatal booking is also highlighted, although there is little evidence linking this specifically to reductions in infant mortality or any of the contributory factors identified above.

Conclusion

170. **Despite much hype and considerable expenditure we have not seen the evidence to convince us that any of the specific support given to deprived areas to tackle health inequalities has yielded positive results. Spearhead status on its own appears to have done little to galvanise areas to tackle health inequalities. Support is now being offered by the National Support Team, but although PCTs have welcomed this, there is little evidence to suggest it is or will be an effective intervention. We are also concerned that this was only introduced six years after the target was announced, and we consider that**

129 Q 1193

130 <http://www.everychildmatters.gov.uk/resources-and-practice/IG00200/>

131 HI 01

it would have been more logical and effective to have offered central support to PCTs to achieve this critical target right from the beginning.

6 The role of the NHS in tackling health inequalities

171. This chapter considers the role the NHS should play in tackling health inequalities within its day to day activities, i.e. beyond the actions we have discussed in the previous chapter. The Secretary of State was clear in his evidence to us that NHS efforts to tackle health inequalities could not be simply an ‘add-on’ to mainstream NHS services, but instead must pervade everything the NHS does—from health promotion to primary care to more specialist services. The NHS can and should provide excellent services offering evidence-based, cost-effective interventions, accessible to all on the basis of need. In common with other areas of policy, the evidence base that exists to inform decisions on how the NHS should tackle health inequalities through its clinical interventions is incomplete, and it is not always clear how these should be best targeted to the most disadvantaged groups. This is discussed in more detail in the first section of this Chapter, on clinical interventions to tackle health inequalities. The rest of the chapter then discusses the different roles that can be played by different parts of the NHS, namely:

- Strategic Health Authorities and Primary Care Trusts
- Primary care teams
- Secondary care and specialist services
- Early years NHS services—maternity and health visiting.

Clinical interventions to tackle health inequalities

172. As we have described in Chapter 2, inequalities between different socio-economic groups are evident for almost all health outcomes. The interventions that NHS service providers can provide to tackle these inequalities fall into one of three categories:

- **Treatment** – providing active management of acute and chronic conditions (such as diabetes and high blood pressure) with the aim of curing those conditions or stabilising them to prevent them worsening
- **Screening** – providing proactive screening services with a particular focus on groups at highest risk of particular conditions
- **Health promotion** – providing information, support and other incentives to promote healthier behaviour, particularly amongst those at highest risk of particular lifestyle risk factors or conditions.

Clinical effectiveness and cost effectiveness

173. More evidence exists around the specific clinical interventions discussed in this chapter than for most other policies to tackle health inequalities that we cover in this report. For example, certain clinical treatments for conditions such as high blood pressure and high cholesterol, are proven to be effective at reducing the risk of coronary heart

disease, which is the leading cause of premature death in the UK. For the first time, now, evidence exists that behavioural interventions such as smoking cessation clinics are effective in helping people quit smoking, and consequently reduce the health risks associated with it. It is because of this evidence that interventions such as these, which are discussed more fully below, are widely held up as the most effective ways of tackling health inequalities.

174. However, there is a difference between interventions being effective at improving health, and interventions being effective at improving health inequalities; an intervention which is effective at improving health will have no effect on health inequalities if all social groups benefit equally; it will actually increase them if the rich benefit more; and it will reduce them if the poor benefit more.

175. The major causes of ill-health and premature morbidity almost all reflect a social gradient, and so attempting to provide effective treatment, screening and health promotion to all those at risk of major preventable diseases such as coronary heart disease, in particular to those in lower socio-economic groups, appears sensible. However, there is limited evidence on how to ensure that those in lower socio-economic groups actually receive and benefit from these treatments.

176. Equally, debate still persists about the cost effectiveness of many of the interventions discussed below. Whilst NICE states that the behavioural interventions it recommends are cost effective, this is at a general level, rather than specifically for tackling health inequalities. The Government has argued for increased use of preventative treatments for coronary heart disease to tackle health inequalities (e.g. statins), but no evidence exists to support the cost effectiveness of this, and some academics even consider that current screening programmes, such as the breast cancer screening programme, are not cost effective at all.

Targeted vs universal

177. Linked to these points is the ongoing debate about whether interventions should be introduced on a targeted or a universal basis—that is, whether they should be offered to the whole population, or just to specific targeted groups.

178. According to Professor Edward Melhuish, who led the national evaluation of Sure Start, a major problem with targeting deprived people is that of stigmatisation: “Families who need it most see themselves as picked out, picked upon, and therefore do not co-operate with the service or avoid the service.”¹³² Some degree of universal service is also needed to identify those families who are most in need. However, Professor Melhuish pointed out that conceptions of need may not be black and white, and so some degree of flexibility is necessary:

Who is in need is then not usually either/or: there are degrees of need. Some need a lot of help, some need an extra visit now and again, and some need just very light touch. The notion of progressive universalism is quite useful, where one has a universal service potentially available to all—at least in a very light touch way

available to all—but the nature of the service becomes increasingly more intensive as the need is apparent.¹³³

Professor Melhuish told us that in his view a ‘progressively universalist’ approach would be most cost-effective; however, he acknowledged the difficulties in prioritising spending in this way:

For a hard-to-reach family, as opposed to an ordinary disadvantaged family, it costs roughly five times as many resources to deliver. You are having to devote tremendously more resources to them than to other people. There comes a point at which you have to think: “Would I be better off delivering a service to a wider range of people, which will produce benefits for that wide range of people, versus focusing on just this group and using all my resources just this group.” That is a dilemma which we have not come to terms with fully yet.¹³⁴

Treatment

179. The causes of health inequalities that can be tackled by NHS service providers are those pre-disposing people to ill health and early death. Areas of importance which have been identified in ‘causes’ chapter include smoking, diet, alcohol and exercise. There is a growing evidence base informing the best way to treat the ‘big killers’, including cancer and coronary heart disease, and applying these optimum treatments consistently is the gold standard for using treatment to tackle health inequalities. NICE guidance now exists to inform the treatment of cancer, diabetes and coronary heart disease. In addition to this, the government’s health inequalities intervention tool promotes two main treatments as effective options for tackling health inequalities.¹³⁵ These are:

- Antihypertensive prescribing in people with previously undiagnosed/uncontrolled hypertension, but who do not have existing coronary heart disease or history of stroke
- Statin prescribing in those people that are newly identified and have been treated with antihypertensive medication, but who do not have existing coronary heart disease or history of stroke

180. The main potential providers of these treatments are GPs. The impact of such treatments on health inequalities is dependent on them being effectively targeted towards those in lower socio-economic groups. Incentives for providers to do this are discussed more fully in the next section.

Screening

181. Effective treatment can only be commenced once affected individuals have been identified. Diseases, such as cancer and diabetes, and pre-disposing conditions, such as high blood pressure and cholesterol, can be latent for long periods, and therefore effective screening which reaches those most at risk can play an important role in tackling health

133 Q 403

134 Q 404

135 http://www.lho.org.uk/HEALTH_INEQUALITIES/Health_Inequalities_Tool.aspx

inequalities. However, national screening programmes, which cover the whole population, have costs as well as benefits, including the costs of administering such a large scale intervention, and the other risks that can be associated with screening, including over-treatment arising from false positives. Currently, national screening programmes exist for breast, cervical and bowel cancer.

182. The National Screening Committee, which decides which screening tests are to be introduced on a population-wide basis, has always recommended against whole population screening for coronary heart disease, diabetes, high blood pressure, and the risk factors for stroke. However, in April 2008, following the recommendation of the National Screening Committee for the development of a vascular risk management programme, the Government announced its intention to introduce regular screening for all those aged between 40–74 for vascular disease.¹³⁶

183. Vascular disease includes coronary heart disease, stroke, diabetes and kidney disease which are all linked by a common set of risk factors, including obesity, physical inactivity, smoking, high blood pressure, disordered blood fat levels (dyslipidaemia) and impaired glucose regulation (higher than normal blood glucose levels, but not as high as in diabetes). The Government estimates that it currently affects the lives of over 4 million people in England. It causes 36% of deaths (170,000 a year in England) and is responsible for a fifth of all hospital admissions. It is the largest single cause of long-term ill health and disability, impairing the quality of life for many people.

184. As the burden of these conditions falls disproportionately on people living in deprived circumstances and on particular ethnic groups, such as South Asians, and, according to Government accounts for the largest part of the health inequalities in our society, this screening test and the actions that will follow from it may have the potential to significantly affect health inequalities.

185. The screening will take the form of a single, universal, integrated check for all aged 40–74. It will measure risk of cardiovascular disease, diabetes and chronic kidney disease, and then classify people's risk as either low, moderate, high, or already having disease. For those who are at low risk, advice on how to reduce risk/maintain low risk will be given as part of a 'tailored package of prevention'. The screening will be repeated at 5 yearly intervals. For those who are at moderate risk, advice and assistance on reducing risk through lifestyle interventions will be given. These may include weight reduction class, exercise referral and smoking cessation clinics. Those at highest level of risk will be offered all of the above plus preventive statin medication, and, if necessary, blood pressure control and/ or intensive diabetes prevention.

186. The Government states that evidence confirms that this approach will be both clinically effective and cost effective, although we have not seen the evidence on which this is based. It is estimated that this programme will cost around £250 million per annum to administer.¹³⁷ It is not yet clear how the screening will be managed, administered or funded, but approaches are likely to be determined locally. The introduction of this

136 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083822

137 Putting Prevention First – a presentation, DH, 2008;
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083822

screening programme could present an ideal opportunity to plan and introduce the model in such a way that permits rigorous evaluation, as outlined in Chapter 3. However, allowing PCTs to determine the implementation of this entirely locally risks ending up with very divergent approaches which may be difficult to evaluate. A preferable approach would be a national model which could be piloted and evaluated (for example in one SHA area) instead of national introduction of this but with 152 PCTs each adopting a different, and unevaluated, approach.

187. As with the treatments described in the previous section, the impact of these and other screening programmes on health inequalities depends on sufficient incentives being introduced for providers to actively target those from lower socio-economic groups.

Health promotion

188. As most health outcomes are linked to lifestyle factors—including smoking, alcohol intake, diet, exercise and sexual behaviour, and there is evidence that changing these lifestyle factors can have a positive effect on health outcomes. Therefore educating people about appropriate lifestyle changes is crucial. This can be done both locally—by clinicians discussing health promotion opportunistically as part of consultations about other things—and nationally—through, for example, national information campaigns.

Brief interventions and referral to specialist services

189. NICE has published public health intervention guidance on:

- smoking cessation;
- smoking cessation in the workplace;
- physical activity;
- sexually transmitted infections and teenage conceptions;
- substance misuse
- school-based alcohol interventions.¹³⁸

190. With the exception of the school-based alcohol interventions guidance, which advocates a broader approach, the guidance recommends brief opportunistic health promotion advice by GPs and other health professionals, followed by referral to other specialist services (stop smoking services, exercise programmes) where appropriate.

191. NICE has assessed these behaviour change interventions to be very cost effective—where sufficient data for modelling purposes has been available, the estimated incremental costs of a QALY gained have been within a range well below the NICE acceptability threshold of £20,000–£30,000.¹³⁹

138 HI 37

139 HI 37

192. However, this does not mean that such interventions are unproblematic. Smoking cessation interventions, although cost effective in terms of QALYs, achieve up to an 8% increase in the percentage of smokers abstinent for 6 months.¹⁴⁰ Moreover, achieving success with the most heavily addicted smokers, who tend to be from deprived groups, is far harder, and a more specific approach is needed.

193. The success of the NICE approach to changing health behaviour—brief, opportunistic interventions in primary or secondary care, followed by referral to specialist services—is dependent firstly on the primary and secondary care providers providing these interventions—which may be seen as ‘add ons’ to their existing workload—and secondly, on the availability of high quality specialist services to refer them to. The RCGP were amongst many to highlight shortcomings in this area, claiming that “doctors, nurses and other health professionals are still not trained to deliver smoking cessation interventions, and some do not see it as their job to do so.”¹⁴¹

194. Beyond brief interventions, ASH argue that for smoking, the focus should not be solely on quitting, but on harm reduction—they advocate medicinal nicotine therapy as an important step on the way towards permanent smoking cessation.¹⁴²

Social marketing

195. Traditionally, the approach taken by the NHS to changing health behaviour has been large scale public information campaigns providing health promotion messages. However, research suggests that, while general public information campaigns have a strong positive effect on those in higher socio-economic groups, they are far less effective in changing the behaviour of deprived groups. They can therefore actually increase health inequalities, as detailed by Professor Sally Macintyre:

More advantaged groups in society find it easier, because of better access to resources such as time, finance, and coping skills, to avail themselves of health promotion advice (e.g. to give up smoking, improve diet, use fluoride toothpaste etc.) and preventive services (e.g. immunisation, dental check ups and cervical screening). Disadvantaged groups tend to be harder to reach, and find it harder to change behaviour. A dental health education project in Scotland widened health inequalities in dental health because it was more successful among higher SES groups. A mass media campaign intended to reduce socio-economic differences in women's use of folic acid to prevent neural defects resulted in more marked social class differences in use than before the campaign

This suggests that interventions with more disadvantaged groups may need to be much more intensive and targeted than might be appropriate for more advantaged groups: information based approaches such as food labelling, pamphlets in doctors’

140 Guidance for Commissioners on the Cost Effectiveness of Smoking Cessation Interventions, C Godfrey et al, Thorax 1998; 53; http://thorax.bmj.com/cgi/content/full/53/suppl_5/52

141 HI 96

142 HI 63

surgeries, and mass media campaigns, or those which require people to take the initiative to sign up for, may be less effective among more disadvantaged groups.¹⁴³

196. Much of our evidence argued for a new, more focused and tailored approach to providing information, under the banner of what is termed 'social marketing'. The National Consumer Council and the National Social Marketing Centre argue that:

Many of the models of public health promotion used to date are best characterised as message and information driven campaign models. Whilst raising awareness is valuable, these campaigns are often not proving effective at motivating behavioural change. Good customer focused and researched social marketing is helping to break the default position of communicating messages to people as the primary way to influence behaviour.¹⁴⁴

197. They provide the following explanation of social marketing:

Social marketing is at its core a systematic planning system driven by user or target group insight. Social marketing draws on commercial marketing techniques and principles as well as the social sciences and behavioural research to develop insight based interventions to promote positive behaviours. It is not just a health promotion strategy, as it can be applied to any behavioural challenge, nor is it a re-badging of old style campaign models of health promotion or health communication.

Incentives for people to change their health behaviour

198. We were told of the possibility of using cash incentives to encourage behaviour change as well. Professor Julian Le Grand, Chairman of Health England, was optimistic about this and reported that Health England was currently examining economic incentives for encouraging people to take up preventive care of various kinds, with vouchers for good food and so on, and the evidence tends to be that it does work.¹⁴⁵ Professor Sally Macintyre also gave such schemes a cautious welcome, although she stressed the need for upcoming evaluation.¹⁴⁶ According to Dr Anna Dixon, Director of Policy at the King's Fund, a King's Fund review suggested that the evidence on actual behaviour change was 'limited':

The evidence is pretty limited and it is fairly focused on getting people to enrol in a programme. Where a financial incentive could be, for example, to sign up for a Weight Watchers programme or to join a Quit Smoking programme it has been quite successful, but it has no bearing on the success of then changing the behaviour. Where they have been applied, they have generally been applied for some very short-term and specific behaviour but, in terms of maintaining more complex behaviour changes over time, there is at the moment a lack of evidence to suggest that financial incentives can be used in that way.¹⁴⁷

143 HI 112

144 HI 78

145 Q 414

146 Q 333

147 Q 123

199. Margaret Whitehead, Professor of Public Health at the University of Liverpool, agreed with this view; she stated that recent research from Latin America suggested that financial incentives did encourage take up of programmes, but it was not clear whether the programmes themselves were actually causing behaviour change which was then improving outcomes, or whether outcomes were improving because families have more money to spend on their children and feel less stressed and therefore the family environment improves in those ways, as research from Mexico was beginning to suggest.¹⁴⁸

Conclusion

200. Treatment, screening, and interventions to change health behaviours are the key tools available to the NHS for tackling health inequalities. Preventive prescribing of antihypertensive and cholesterol-reducing drugs have already been identified and promoted by the Government as an effective approach to tackling health inequalities, and the Government has also announced that a large-scale vascular screening programme will be introduced. However, whilst some evidence exists to support the clinical effectiveness of some of these interventions, less is known about their cost effectiveness, and in particular about how to ensure they are targeted towards those in the lowest socio-economic groups so that they actually have an impact on health inequalities. We urge the Government to plan the introduction of vascular checks with great care, and according to the steps outlined in Chapter 3, so that it does not waste another crucial opportunity to rigorously evaluate the effectiveness and cost effectiveness of this screening programme.

201. Changing health behaviour is widely acknowledged to be difficult, and evidence suggests that traditional public information campaigns are less successful with lower socio-economic or other hard-to-reach groups—in fact we were told that these interventions can actually widen health inequalities because richer groups respond to them so well. Social marketing is heralded as an approach that allows messages to be communicated in more tailored and evidence based ways. We have not seen firm evidence to support this claim, and we recommend that social marketing interventions are evaluated to ascertain their success. A sound evidence base does exist to support brief, opportunistic interventions in primary and secondary care, followed by referral to more specialist health promotion services. However, it seems that further steps are needed to ensure that the most heavily addicted smokers, who are often those from the lowest socio-economic groups, benefit fully from these interventions. This will have implications for the training of NHS staff and others.

Strategic Health Authorities and Primary Care Trusts

202. The NHS's capacity to tackle health inequalities encompasses not only those providing services—including primary and secondary care teams—but, crucially, SHAs and PCTs who are meant to provide a leadership role across local communities for health issues, both in terms of commissioning services and maintaining a focus on public health. Part of their responsibilities include planning services to meet the needs of local populations, to ensure good access. This section discusses PCTs' roles in:

- Leadership and commissioning
- Public health
- Access to services.

Leadership and commissioning

203. Primary Care Trusts have an important role in providing strategic leadership for health services at a local level, including commissioning primary and secondary care services, ensuring good access and high quality care, and retaining a responsibility for local needs assessment and public health. It is on PCTs that responsibility rests for delivering the Government's target to reduce health inequalities. Strategic Health Authorities have a role of strategic oversight at a regional level-which includes overseeing PCTs' performance in tackling health inequalities.

204. We were told by Mark Britnell, Director General for Commissioning and System Management at the Department of Health, that the Government's plans for 'World Class Commissioning' would ensure that health inequalities were at the heart of PCTs' commissioning activities, as well as developing PCTs' capacity to commission more effectively.¹⁴⁹ However, according to Dr Jacky Chambers, Director of Public Health at the Heart of Birmingham PCT, the reality of the situation is rather different from this:

Sandra Gidley: On a practical level for the PCTs, is it going to be helpful? Do you currently have the capacity to commission effectively to tackle health inequalities?

Dr Chambers: I think the answer is, no. If you really aspire to the principles that are set out in world class commissioning, there are two areas where we have not yet got the capacity: one is around partnership working across a complex system; and the other is really around public engagement as a real driver in terms of that notion of engaging with our communities to drive health and choice, and drive up the standards of service and the expectation of those services. We have got the basics in place, but if we are going to aspire to the excellence that is set out there we are going to need more capacity to do that.¹⁵⁰

Public health

205. Both PCTs and SHAs have public health functions. Their public health role differs from those providing NHS services, who bear chief responsibility for delivering public health interventions; instead their role should encompass providing leadership and strategic direction for NHS services, commissioning appropriate public health interventions, and leading in partnership working with local authorities, voluntary organisations, and other relevant local partners.

206. Public health as a specialty has struggled since the inception of the NHS, operating within a system which remains essentially focused on treatment of ill health rather than

¹⁴⁹ Q 7

¹⁵⁰ Q 222

promotion of good health. While some SHAs and PCTs may have strong teams which are recognised to play a valued role in the local health community, others are less effective. Recent years have seen a reduction in the numbers of public health specialists, especially at a senior level, attributed by the Faculty of Public Health in part to the repeated reorganisations in the NHS.¹⁵¹

207. While we have not seen any evidence specifically supporting their effectiveness, it would appear that public health specialists working in the NHS have a potentially important role to play in co-ordinating efforts to tackle health inequalities, and it seems counter-intuitive for the NHS to be reducing their numbers at the same time as committing funding and priority to tackling health inequalities, and other public health initiatives.

208. In Chapter 4 we discussed funding issues, in particular problems with PCTs not distributing sufficient funding to public health priorities, such as tackling health inequalities, even when money had been specifically earmarked for this. One solution to this proposed by Peter Smith, Professor of Health Economics at the University of York, was moving responsibility for public health from PCTs to local authorities, which in his view would allow better prioritisation and integration:

... we should shift towards prevention, and many people in public health argue that case very passionately. But we do have very limited evidence on what really works on the ground, so I think you have to be a pretty brave PCT or other NHS organisation to divert resources towards prevention and public health. I think the NHS has a special problem in diverting resources, because the rest of its business is about urgency and manifest clinical need. It is for that reason that I have argued for some time that the public health element of promoting health would be better located in different organisations. In particular, my own view would be that the best local authorities would do a better job at promoting health than the PCT.¹⁵²

Access to services

The contribution of poor access to health inequalities

209. A key responsibility of Primary Care Trusts and SHAs is to ensure good access to health services for the local populations they serve. Health services, both general practice, primary care and specialist secondary care, have not, historically, been located according to need. Many of today's NHS hospitals evolved from 19th century charitable foundations that were located in large urban centres, leading to over-provision in some areas and under-provision in others; more recent hospital development has seen hospitals relocated to brownfield sites on the edges of urban areas, which may also cause access problems. GP services have long suffered from what Julian Tudor Hart has famously described as the 'inverse care law'—deprived populations with high health needs tend to have fewer GP practices than wealthier areas, often because workload is higher and living conditions are less congenial in deprived areas, with few attendant compensations.

151 HI 21

152 Q 695

210. Several witnesses, including Dr Dixon, argued for the importance of the role of health care:

Health care has been shown in modern societies to be an important determinant of health status. Health care systems vary considerably in their performance as measured by the extent to which mortality amenable to medical care is addressed (Nolte and McKee 2003). It is therefore important that access to health services is equitably distributed if health inequalities are to be reduced (McKee 2002).¹⁵³

211. According to Dr Dixon, international analysis suggests that on the whole the UK performs well in terms of equity of access to health care with rich and poor accessing GPs equitably having adjusted for need while access to specialists is pro-rich but less so than in other countries (van Doorslaer et al 2006).

212. Notwithstanding this generally positive picture, one study found unemployed individuals and individuals with low income and educational qualifications used services less relative to need than their employed, more affluent or better educated counterparts (Dixon et al 2003). The same review found that most studies of specific services within the NHS reported that people in lower socio-economic groups use services less on average relative to need than those from higher socio-economic groups. These studies covered a range of treatments and conditions including cardiac, diagnostic and surgical care, elective procedures for hernia, gallstones, tonsillitis, hip replacements, and grommets, inpatient oral surgery, immunisation for diphtheria, pertussis, measles, mumps and rubella, and diabetes clinics and diabetes reviews. Some of the reasons identified for these inequalities in access included transport and lack of car ownership, ability to take time off to attend, communication skills and ability to navigate the system, beliefs and health seeking behaviours.

213. Age Concern argue also argue that the majority of chronic illnesses affecting the lives of older people can be either prevented or postponed, mainly through the adoption of healthy lifestyles, but that services and public health initiatives sometimes exclude older people. In their view, examples of this include the fact that the current national alcohol strategy does not mention drinking in later life, and breast and bowel cancer screening programmes are still not extended upwards to the maximum ages at which people can achieve health gains.¹⁵⁴ Age Concern also contend that some groups of older people with particularly significant health needs currently receive insufficient support from GP services, including older carers, those living in care homes, and those suffering from depression.

214. However, it is not clear how big a part access to health services plays in health inequalities, and most of those who submitted evidence to us seemed in agreement with Professor Whitehead that “inadequate access to health services is ... only one of many determinants of the observed inequalities in health, and a relatively minor one at that”.¹⁵⁵

¹⁵³ HI 108

¹⁵⁴ HI 59

¹⁵⁵ HI 106

Access to primary care services

215. Bolstering primary care services in under-served areas has been a central plank of the Government policy in recent years, with claims that this will have a positive impact on health inequalities; the Secretary of State told us that 122 new GP practices are being introduced into the 20% of areas which have the fewest GPs per capita.

216. Notwithstanding the obvious benefits of introducing new GP services into under-doctored deprived areas, there are questions about where these new GPs will come from. As Professor Martin Roland, Director of the National Primary Care Research and Development Centre explained to us, it may not be a simple matter of redistributing resources from the less needy to the more needy:

In terms of workforce planning, in some respects, the PCT is too small a unit, because experience from other countries shows that if you have a PCT which is very deprived, it puts in some sort of incentive package to get people to work in that patch. They do not actually come and work from the leafy shire over there, they move from the almost as deprived area next door, so what you get is just selective shuffling around within the deprived areas, and that does need a broader approach to workforce planning, so you do not just shuffle people around within deprived areas.¹⁵⁶

217. Alongside this initiative, another policy to improve access to primary care services is the introduction of a new, larger primary care centre, now referred to as a 'GP led health centre', into every PCT in the country. Given the Secretary of State's assertions that tackling health inequalities must be part of every health policy decision taken, this may be rather a counter-intuitive departure, as clearly health needs and health service needs are different across England. Professor Roland feared that actually the advent of such centres could make access and continuity of care worse:

I think the idea that in certain areas, you get rid of lots of small practices and move them into one big place, have outreach facilities from the hospital, well, there are some aspects of that that are quite good, but in some ways actually you are taking primary care further away from what the majority of patients want, because the majority of patients do not necessarily need access to these enhanced services, and therefore, if developing polyclinics means not investing or even worse closing down the smaller practices, you actually might make the problem of access, particularly for those who find access quite difficult, with transport and other problems, worse.

The benefits are principally that it is an opportunity to have radical improvement of the estate, which is very poor in some places; and then you have the attendant disadvantages of reducing access, reducing choice, potentially reducing continuity of care. So my view in terms of whether practices should be corralled into polyclinics is that it is an appropriate strategy where the local estate is poor, and it really is a means of improving it substantially, and probably not appropriate for many parts of the country where the local practices operate from quite good premises.¹⁵⁷

156 Q 574

157 Q 562; Q 565

Conclusion

218. PCTs and SHAs should play a central role in informing and co-ordinating efforts to tackle health inequalities. However, our evidence has not suggested that they are currently providing the leadership that might be expected of them. We have been told that numbers of senior public health specialists working in these organisations are falling; while public health specialists clearly have not demonstrated progress in tackling health inequalities to date, and we have not seen evidence specifically supporting their effectiveness in this role, it is concerning that the section of the NHS workforce probably most able to provide good leadership for tackling health inequalities is in decline, and we recommend that the government monitor this trend closely. Nor did we see any evidence to suggest that the drive towards ‘World Class Commissioning’ is likely to have a measurable impact on health inequalities in the near future.

219. Access to high quality health services is an important responsibility of PCTs and SHAs, and the Government has advertised its drive to improve access to GP services as part of its policy to tackle health inequalities. The extra GPs that are to be introduced into deprived areas which are under-doctored are welcomed, unless they are being relocated from other deprived areas, which would simply move rather than solve the problem. However, most of our evidence suggests that while access to healthcare is important, it is not high on the list of priorities for tackling health inequalities; indeed research has said that England compares well to other countries in this regard. We are also concerned that the central edict for all PCTs to introduce a GP-led health centre has not involved due consideration of either need or inequalities, and that in fact centralising GP services may make access more difficult for lower socio-economic groups. We recommend that Sir Michael Marmot’s review should examine the issue of access to healthcare closely, paying particular attention to claims of ‘institutional ageism’ and that access is worse for those suffering from mental health problems and learning disabilities.

220. We also recommend that wherever local primary care services are lost because of the introduction of GP-led health centres, the impact of this on the most needy and vulnerable groups should be carefully monitored by PCTs and steps taken, if necessary, to revert to traditional, more local patterns of service delivery.

Primary care services

221. Primary care medical services provided by general practitioners (GPs), nurses and other primary care clinicians were frequently identified in our evidence as having a crucial role to play in tackling health inequalities. GPs provide immunisation and screening services as part of national programmes (for example childhood immunisation, flu jabs and cervical screening). The 300 million plus consultations performed annually in general practice¹⁵⁸ also provide the opportunity to screen the population opportunistically, for example by measuring blood pressure or BMI, as well as to deliver face-to-face health promotion advice. Most secondary prevention—for example diagnosing and treating the

158 *The NHS Handbook 2008-09*, NHS Confederation, 2008

risk factors that can lead to Coronary Heart Disease—and much of the management of chronic diseases that can contribute to lower life expectancy also takes place in general practice. Finally, GPs can refer patients to more specialist services, and therefore have a crucial role to play in ensuring good access to secondary care.

222. Dr Julian Tudor-Hart, a former GP in a very deprived part of Wales and researcher, described to us the differences in the challenges faced by GPs delivering care to deprived populations compared with those in more affluent parts of the country:

GPs throughout the country, throughout the UK, are as if in a swimming pool, with a shallow end and a deep end. The deep end are the industrial or post-industrial areas where the GPs and their staff cannot even get their feet on the bottom of the pool, they have to swim all the time in order to avoid drowning, and they also have the task of stopping the patients drowning. They tend to save themselves first, which is understandable, because they will not save any patients if they do not. At the other end of the pool, I would not say life is easy, I think all GPs work hard, and the golf course GP is on the whole a myth, but they can put their feet on the bottom when they need to, and their patients do not drown very much. What we have called equality in the past is that all the people in the swimming pool get the same, if they are lucky, the people at the shallow end and the people at the deep end. Well, that is not equality.¹⁵⁹

223. During our visit to Glasgow, we were told by Graham Watt, Professor of General Practice at the University of Glasgow, that his initial research in Glasgow showed that GPs in deprived areas had less time to spend with each patient; however it was not yet clear whether this was having any effect on health outcomes.

The Quality and Outcomes Framework (QOF)

224. The Quality and Outcomes Framework (QOF) was introduced as part of the new GP contract in 2004, ushering in a radical new way of linking doctors' practice income to the quality of care they provided. No such scheme exists anywhere else in the NHS, although a scheme to link hospital funding to clinical outcomes has now been proposed. The first few years of the QOF's operation have seen a majority of GPs achieving continuously high scores, and the precise determination of QOF points is re-negotiated every year to ensure that the measures are sufficiently stretching and up-to-date. QOF points cannot feasibly cover the entirety of GPs' very broad area of practice, and therefore are necessarily limited in the conditions and treatments they measure. However, as with any incentive system that targets specific parts of an organisation's or individual's workload, there is the potential for unintended outcomes, through diverting resources away from other, equally valid activities.

225. Given this, it might be expected that GPs in more deprived areas would struggle to perform well under the QOF system. However, Professor Martin Roland, who has led the major research project into the impact of the new GP contract, concluded that, surprisingly, both GPs in deprived and non-deprived areas had performed very well:

My surprise in a sense is how well GPs in deprived areas have done. I was involved in advising the negotiating teams originally when QOF was developed, and I argued that the QOF points should be deprivation weighted; in other words, it was going to be harder work to achieve points in deprived areas than not. What we have actually seen is that the difference in scores between affluent and deprived areas is astonishingly small, and it has narrowed in the first three years of the QOF.¹⁶⁰

226. Professor Roland told us that despite persistent concern that practices in deprived areas under-report the true disease prevalence in their areas, and significant efforts to investigate this, they had not found evidence of widespread under-reporting. However, as Professor Roland explained, there is in fact a disincentive built in to the GP contract funding formula for GPs in deprived areas to proactively identify those people in need:

it is a technicality of the payment formula which means there is actually a disincentive for practices in deprived areas to go out and case-find, because they get relatively less additional money for doing that than practices in affluent areas with lower prevalence. So in a sense, the incentives are the wrong way round there, you need to be encouraging practices who are likely to have high prevalence to be going out and looking for people.¹⁶¹

227. The BMA reported that when the GP contract was originally being negotiated, they argued for measures which in their view would make the balance of effort and reward more equal between practices in deprived and more deprived areas:

We argued actually quite strongly [for] significantly less money in QOF and more money into funding what I would call basic services, trying to improve staffing levels in the poorer practices and suchlike, so there was more of a balance; the idea of the way you funded basic services and QOF was to have a balance between the two, so that actually practices in the more deprived, difficult areas would get bigger and better basic funding, those in the wealthier areas would get a bit less but would actually find it easier to earn the money from QOF. Now because of what I have to call political interference, that balance was never achieved, and that is why we ended up with things like the minimum practice income guarantee because there was so much more money in the Quality and Outcomes Framework, it cost a lot more.¹⁶²

228. The Secretary of State told us that the major changes that had been made this year to the GP contract that would support GPs in more deprived areas was a shift to the full prevalence adjustment and the removal of the Minimum Practice Income Guarantee.¹⁶³

229. As discussed above, the QOF does not and cannot cover the full range of conditions treated and services provided in general practice. Providing GPs with financial incentives to provide certain interventions has a cost, and therefore cannot be added to indefinitely. Research into the early years of the implementation of QOF argued that much of the QOF

160 Q 542

161 Q 548

162 Q 547

163 Q 1222

was not evidence-based,¹⁶⁴ and in recognition of the need to improve this process, determining what goes into the QOF is now the responsibility of NICE. For interventions to be included in QOF they need to have a sound evidence base for their clinical effectiveness, and data collection in a GP setting needs to be feasible.

230. According to Professor Roland, the QOF has already made good progress in focusing GPs' efforts on tackling health inequalities as it covers the major causes of health inequalities:

If you look at the difference in mortality between deprived and affluent areas, then 60% of that difference is due to conditions which are addressed in QOF. Some are addressed quite well ... for example heart disease; and some of them are addressed pretty poorly, for example cancer; but nonetheless, you have the major conditions that are the cause of health inequalities in the QOF ...¹⁶⁵

231. However, while the QOF has had some positive impact on health inequalities, in the view of Professor Roland and his team, this good outcome should not be attributed to the design of QOF, which, in their view, has never been specifically designed to take account of health inequalities:

The basic problem is that QOF was never and is still not a vehicle at heart for addressing health inequalities in the way DH thinks the money, the public reporting and the other wider revalidation and accreditation agendas etc all paved the way for practices in more deprived areas to catch up.... but not the content of the indicators themselves. The 57 point change in 09 were made on clinical grounds and not to specifically address health inequalities.

The actual impact on inequalities (deprived areas catching up) ... is really a side effect rather than a prime motivator behind QOF. Indeed, some of the literature argues that financial incentives might increase inequalities (patients in affluent areas easier to achieve targets on). The reverse of this has happened in QOF, as happened also a decade ago when financial incentives were introduced for immunization and cervical cytology. This is partly because quality indicators have been set at levels which are fairly easy to achieve in affluent areas, and partly because practices in deprived areas have worked hard to increase their levels of quality.¹⁶⁶

232. Professor Roland identified vascular disease and osteoporosis as important areas for health inequalities that could be added to the QOF. The potential of GP smoking cessation interventions were also frequently cited to us in evidence. According to ASH:

The QOF currently awards 41 of the 74 points available for smoking for simply recording smoking status. The remaining 33 points are awarded for giving smoking

¹⁶⁴ 'Do the incentive payments in the new NHS contract for primary care reflect likely population health gains?' Robert Fleetcroft and Richard Cookson *Journal of Health Service Research and Policy*, 11,1, January 2006 pages 27–31

¹⁶⁵ Q 542

¹⁶⁶ HI 121A; see also 'Effect of financial incentives on inequalities in the delivery of primary clinical care in England: analysis of clinical activity indicators for the quality and outcomes framework', Tim Doran et al, *Lancet* 2008; 372: 728–36.

cessation advice only to patients in specific disease categories by which time it may well be too late.¹⁶⁷

233. Other candidates that were mentioned to us included Chronic Obstructive Pulmonary Disease (COPD) vascular disease and osteoporosis. We are not in a position to adjudicate on the validity of these claims, but it seems essential that in future the QOF decision making process should include explicit consideration of the likely impact on health inequalities.

Beyond the QOF – other ways of tackling inequalities through GP services

234. Evidence we took from individual PCTs identified a number of improvements made to local GP services with the aim of tackling health inequalities; in Birmingham, a major screening programme for men over the age of 40 has been commissioned.¹⁶⁸ They had made specific effort to achieve high take-up rate by using a privately contracted call centre to manage appointment scheduling for circulatory screening, and all eligible patients were contacted by telephone, achieving a 70% attendance rate where up-to-date telephone numbers were available for patients.¹⁶⁹

Conclusion

235. **General Practice is at the frontline of tackling health inequalities; evidence from QOF data suggests that those practices in deprived areas are performing well in difficult circumstances. QOF has made a start in tackling inequalities, covering most of its major causes but with modest targets. However, we were told that the fact that the performance of GPs in deprived areas had caught up with that of GPs in more affluent areas was actually a fortuitous ‘side effect’ of QOF, and that the QOF had not been designed to address health inequalities. We received many suggestions for additions to the QOF points system. It is clear that the QOF needs radical revision to fully take greater account of health inequalities and to improve its general focus on the product of patient health. We therefore recommend that tackling health inequalities should be an explicit objective during annual QOF negotiations and that this objective should have measurable characteristics which can be evaluated over time. The QOF should be adjusted so that less weight is placed on identifying smokers and more weight placed on incentives to stop smoking.**

Secondary care and specialist services

236. Primary care services such as general practice and health visiting are clearly on the frontline of action necessary to reduce health inequalities. However, more specialist NHS services also have a crucial role to play, although little attention has been given to this by the Government. Specific concerns were raised about inequalities in maternity outcomes,

167 HI 63

168 Q 198

169 Q223; where telephone numbers were not available, a ‘blind mail shot’ technique was used to contact patients; only 10.7% of these attended, HI 111A

and problems with mental health services; in addition to this, witnesses also described a lack of health promotion advice in secondary care services, in particularly around smoking.

Mental health services

237. As detailed in Chapter 2, people suffering from mental ill health have starkly increased risks of many physical health problems. In certain cases, this may be ascribable to side effects of medication for their mental health problem; in others, it may be because patients are ill-equipped to negotiate NHS services for the physical care they need; it may also be because their psychiatric condition pre-disposes them to high risk behaviour, for example smoking. Paul Jenkins, Chief Executive of Rethink Mental Health, told us that in his view secondary care mental health services were failing their patients by ignoring their physical health needs:

Mental health services have taken no responsibility for people's physical health, and seen that solely as the responsibility of primary care, which people may often be poorly in touch with.¹⁷⁰

According to Rethink GPs may also be meeting the physical health needs of mental health patients inadequately.¹⁷¹

238. Mr Jenkins listed some specific areas for improvement for secondary care:

- a) Improving standards of prescribing for psychiatric medication, to give patients more choice about the side-effects of medications, their impact on physical health, and the trade-offs that exist;
- b) Ensuring routine follow up of patients' physical health when they are on particular medications that have an impact on physical health (for example, clozapine has a known link to diabetes and coronary heart disease)
- c) Integrating routine physical health care into the provision of mental health services—not only because it minimises the risk of patients not attending for physical health check ups, but also because for some patients, engaging with their own physical health can be an important part of their recovery from mental illness.
- d) Health promotion, in particular around smoking cessation; support needs to be specific to mental health because stopping smoking can alter patients' medication needs.¹⁷²

Referral to smoking cessation and other health promotion services

239. More generally, ASH presented some shocking evidence to us concerning a failure on the part of secondary care services to refer their patients to smoking cessation services, even when suffering from smoking related illnesses. Part of the problem may be with availability of smoking cessation services to secondary care:

170 Q 531

171 HI 88

172 Q 531

Only half of UK chest specialists have direct access to a Stop Smoking counsellor (despite the fact that smoking cessation is the only intervention that changes the natural history of chronic obstructive pulmonary disease (COPD) or reduces the risk of lung cancer).¹⁷³

240. However ASH also argued that even where smoking cessation services are readily available, health professionals in secondary care are not making the best use of them. A survey carried out by ASH in one hospital found that while 20% of inpatients smoked, fewer than a third of these were given smoking cessation advice, despite the hospital having a smoking cessation service. Furthermore while there were high levels of awareness amongst health professionals of the local Stop Smoking Service in a District General hospital, only one in five had referred smokers to the service.

241. According to ASH, much of the problem is that public health interventions are not prioritised in secondary care, because the Payment by Results system does not incentivise them:

We have got in this country some of the best smoking cessation services in the world, probably the best in the world, but when they were set up they very much focused in primary care, and the problem is that we know that what is happening in primary care is not replicated in what is happening in secondary care. Hospitals do what they are paid to do and what they are measured on, and currently they are not measured on smoking cessation.

It may seem strange but this is not happening, even in respiratory wards, where 80% of serious respiratory disease and death from respiratory disease is down to smoking, because doctors focus on the immediate rather than the long-term impact of what they are doing. I think there is also a danger that people think it is so difficult to give up smoking, let us not worry about that; we will put that to one side. ...The problem is that public health work tends not to get a priority in the hospital setting.¹⁷⁴

242. ASH argue that smoking cessation should be included in the Standards for Better Health assessed by the Healthcare Commission, and in particular hospitals should be required to monitor smoking rates of patients coming into hospital, and to give all smokers brief advice to quit, access to stop smoking medicines and referral to stop smoking services, and smoking rates should be monitored leaving hospital as well. ASH also mentioned anecdotal reports that PCTs were reluctant to fund smoking cessation initiatives because PCTs are concerned that smokers quitting in hospitals won't count towards their quit targets.¹⁷⁵

243. Alwen Williams, Chief Executive of Tower Hamlets PCT, told us that in her PCT efforts were already being made to ensure secondary care services played their part in tackling health inequalities through providing public health interventions:

173 HI 63

174 Q 532

175 HI 63

There are some interesting examples where patients with lung cancer have said, “Actually we went through the NHS system and nobody did talk to us about Stop Smoking”. Really getting this high on everyone’s agenda strategically at board level, but also critically in terms of the frontline delivery of services we think is very important ... the contractor requirements with acute trusts, we are now requiring what we would call brief interventions, so that we are training and putting some resource into the acute trust to train frontline staff to be able to talk to patients about maybe Stop Smoking or Lose Weight. There is the Stop Before the Op initiative, where we are encouraging people through their interface with acute clinicians.¹⁷⁶

244. In addition to smoking cessation, there are many other ways in which secondary care could potentially make a valuable contribution to tackling health inequalities through health promotion. Obvious examples include brief interventions and referrals to specialist services for those risk factors mentioned at the beginning of this report, including nutrition, activity and weight, alcohol and drug use, sexual health, and blood pressure. In addition to the evidence that brief health promotion interventions are effective, there is also evidence that illness and admission to hospital sensitises people to health issues and makes them more receptive to health promotion messages. If patients with risk factors go through the secondary care system without those being identified and addressed, this may give patients the impression that the NHS is tacitly colluding with their unhealthy lifestyle factors.

Conclusion

245. **Primary care is the chief target of most efforts to tackle health inequalities through improving NHS services; however, in solely focusing on this, there is a very real risk that inequalities in other NHS services will persist, and that the great opportunities that exist throughout the rest of the NHS to tackle inequalities will be missed. We heard evidence that the physical health needs of mental health patients are almost entirely ignored by specialist mental health services, leading to shocking health differences between mental health patients and the rest of the population. We find it scandalous that hospital patients—even those hospitalised for smoking-related illness—are not being referred to smoking cessation services—this was offered to only one third of smokers in one trust surveyed by ASH. In our view these examples are likely to represent only the tip of the iceberg in terms of missed opportunities to tackle health inequalities away from primary care. We recommend that the role of secondary care in tackling health inequalities should be specifically considered by Professor Sir Michael Marmot’s forthcoming review, and this should include consideration of including tackling health inequalities as part of the Payment by Results framework and/ or the Standards for Better Health.**

Early years NHS services—maternity and health visiting

246. As discussed in Chapter 5, witnesses to this inquiry have described the ‘early years’—and services provided to children and their families within this period—as potentially very important in tackling health inequalities.¹⁷⁷

247. Crucial factors include maternal smoking during and after pregnancy as well as alcohol and drug use; maternal diet during pregnancy; maternal obesity during pregnancy; infant and child nutrition; smoking in the family home; postnatal depression; and parenting skills. Breastfeeding was repeatedly emphasised by our witnesses—including the Secretary of State—as a top priority for reducing health inequalities, yet breastfeeding, in common with other lifestyle factors, follows a social gradient: only 67% of women in routine and manual occupations initiate breastfeeding compared with 89% of women in managerial and professional occupations. The differences are even more pronounced in terms of the duration of breastfeeding—only 32 per cent of women in the routine and manual socio-economic group breastfeeding beyond six weeks, compared with 65 per cent in managerial and professional groups. Data from the 2005 quinquennial infant feeding survey suggests that there has been a slight increase in women initiating breastfeeding across the board, and this increase has actually been slightly bigger in routine and manual occupations. However Professor Mary Renfrew, Director of the Mother and Infant Research Unit at the University of York, ascribes this to the increased age of women in the sample, and comments that duration rates (how long women manage to breastfeed for) remain ‘abysmally low’ across all social groupings, and describes exclusive breastfeeding as ‘vanishingly rare’ amongst all social groups (The Department of Health recommendation is for all women to breastfeed exclusively for the first 6 months of their child’s life).¹⁷⁸

248. Currently NHS early years services—spanning from conception to 5 years—are provided by a number of different organisations, in both primary and secondary care:

- a) Maternity services, during pregnancy, childbirth and the postnatal period, are predominantly provided by midwives either in community or secondary care services; obstetric (medical) services are also provided where necessary in secondary care, and some GPs also provide maternity care; for ten days after a new birth (check) midwives continue to provide care for mothers and infants at home, before discharging them to community GP and health visiting services.
- b) On discharge to the community, mothers and babies can access GP services in the usual way; to supplement this, additional services are provided by health visiting teams.
- c) Health visitors are specially trained health professionals drawn from a nursing background. They offer a programme of screening and developmental checks over the first years of life, as well as health promotion and parenting support services. Immunisations are provided by health visitors, GPs or community nurses.

177 See Fetal Origins of Coronary Heart Disease, Barker et al, *BMJ* 1995;311:171–174 (15 July)

178 HI 142

249. Professor Edward Melhuish, who led the national evaluation of the Sure Start programme, emphasised the importance of maternity and health visiting services in supporting early years interventions such as Sure Start:

The health services give you immediate access to parents in pregnancy and children at birth, and, therefore, the Sure Start programmes can get into contact with those families very early on ... Any ideal services would involve very close integration of the health services with Sure Start type programmes ... I would expand the midwife and health visitor services so that those services could integrate more thoroughly with Sure Start programmes; and I would also improve the training of midwives and health visitors so that they have a better understanding of the factors affecting early child development and parenting. Currently, they are not as good at that as they could be. I would have cross-agency training for people who work in Sure Start programmes and health visitors and midwives, and maybe even some doctors as well.¹⁷⁹

Maternity services

250. Maternity services are well placed to offer opportunistic health promotion advice to women, and changes made at this point have the double benefit of improving the health of both mother and baby. Maternity services are used by women when most are still at a relatively young age so lifestyle changes made at this time can have a longer effect. They also serve a large number of women (approximately 660,000 per year) spanning all sectors of society, again increasing their potential impact. Finally, unlike a single GP appointment, those using maternity services are likely to be in contact with services over a number of months, providing opportunity to both identify those mothers with particular health promotion needs, and to reinforce health promotion messages and support compliance with them.¹⁸⁰ Key health promotion interventions delivered by maternity services include nutrition, activity and weight, smoking cessation, alcohol and drug use, and breastfeeding.

251. However, according to the RCM, maternity services are severely below the capacity they need to be, largely because of funding and staffing shortages.

Staffing increases in the NHS overall have largely passed midwifery by. Both the full-time-equivalent number of midwives in England's NHS fell in the last annual staffing snapshot (down 87 between 2005 and 2006) and the headcount number fell at both of the last two counts (down 375 between 2004 and 2006).

In 1997/98, for instance, maternity services absorbed 3.1% of the NHS budget in England, but by 2006/07 this had fallen to 2.0%. Total spending on NHS maternity services in England actually fell by £55m in the last financial year for which figures are available (2006/07).

179 Q 372

180 HI 44

These cuts come despite England witnessing a rapidly rising birth rate (in the five years between 2001 and 2006 the total number of births increased by 13%).¹⁸¹

252. Declining numbers of midwives coupled with increasing numbers of births means that midwives' workloads are increasing (the number of births in England per full-time-equivalent midwife rose at the last count (September 2006) from 32 to 33. The result of this is that midwives are increasingly having to focus their limited time on labour and birth, the most 'high risk' part of maternity care, and may be devoting less time to antenatal and postnatal care, which offer the best opportunities for health promotion. The RCM also argues that Payment by Results (PbR) is having an additional, unintended effect on maternity services, drawing funding away from community services.

Health visiting

253. Sarah Cowley, Professor of Community Practice at King's College London, and Christine Bidmead, a practising health visitor at South London and the Maudesley, argued that health visitors are uniquely well placed to contribute to tackling health inequalities, as they offer health promotion support to families in the first few weeks of a new baby's life:

Universal health visiting services are a primary line of defence against social exclusion, since they reach out to all families with new born babies, providing support for parents and for parenting at the most vulnerable and significant period of an infant's life.

Early child development is a vital time for influencing life patterns that lead to health inequalities. However, health inequalities are addressed only if concerns are identified sufficiently early to prevent the infant from entering an adverse life trajectory, with established physiological and behavioural patterns, which might have been changed in the first months and years of life.¹⁸²

254. The national Sure Start evaluation found that Sure Start programmes that were led by health visiting teams rather than by any other professional group were those most likely to succeed. However, in recent years numbers of health visitors have fallen dramatically, and there is also an ageing workforce.

255. Christine Bidmead, a health visitor at South London and the Maudesley NHS Trust, ascribed this to health visiting being an 'easy target' during PCTs' recent financial difficulties:

Because the budgets of PCTs were overspent the health visiting service was an easy target to be cut and so what we have seen is a huge decline in the numbers of health visitors being employed and in the number of training places being commissioned by PCTs for health visitors.¹⁸³

181 HI 44

182 HI 130

183 Q 743

256. According to health visitors, the strength of health visiting is that, over a course of visits both antenatally and postnatally, a health visitor is able to develop a relationship with a family that firstly makes it possible to offer and help implement health promotion advice on a sustained basis; and secondly enables health visitors to form a deeper understanding of families that will help them identify hidden needs, for example, around postnatal depression. However, perhaps unsurprisingly given the decline in health visiting capacity, this type of service is becoming increasingly rare, with recent research showing that 60% of areas now deliver only a restricted service of one visit shortly after the birth of a baby, followed by drop-in baby clinics and child protection services. In the same survey, 69% of health visitors reported that they no longer had the resources to respond to the needs of the most vulnerable children, with more than half (58%) believing there was a chance that a horrific child death, such as that of Victoria Climbié, could happen where they work, a telling indictment in the wake of the case of Baby P.¹⁸⁴

257. Just before we agreed this report, the Government published a strategy for children and young people's health, which stated that its policies would include "further development of the health visitor workforce to deliver the Healthy Child Programme".¹⁸⁵

Conclusion

258. **We have been told repeatedly that the early years offer a crucial opportunity to 'nip in the bud' health inequalities that will otherwise become entrenched and last a lifetime. While there is little evidence about the cost-effectiveness of current early years services, it seems odd that numbers of health visitors and midwives, currently the main providers of early years' services, are falling, and members of both those professions report finding themselves increasingly unable to provide the health promotion services needed by the poorest families at the same time as the Government reiterates its commitments to early years services. The Department of Health must undertake research to find out the consequences of the decline in numbers of health visitors and midwives and to consider whether some aspects of the health promotion role played by midwives and health visitors could be effectively done by other types of staff to bolster early years health services.**

184 HI 130

185 See <http://publications.everychildmatters.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=285374a>

7 Tackling health inequalities across other sectors and departments

259. The main focus of this inquiry has been action which can be taken by the NHS and the Department of Health to tackle health inequalities. But, just as the causes of health inequalities lie beyond health and healthcare factors, so do many of the solutions. Although these are outside their direct control, the NHS and the Department of Health can still play a vital role in providing leadership to ensure health inequalities are taken into account in these many other areas where government policy can make a difference.

260. In this chapter we first consider the track record to date in joined up working, both in Whitehall and at a local level.

261. We then examine specific areas where we consider that joined up working is particularly important in tackling health inequalities –

- nutrition;
- health education and promotion in schools;
- the built environment; and
- tobacco control.

This involved looking at the work of departments responsible for education, border control, revenue and customs and planning.

This chapter is not intended to provide a comprehensive summary of all the possible contributory factors to health inequalities outwith the general remit of the NHS, and nor does it claim to explore every potential avenue for joined up working with other sectors and departments to further this agenda. The four specific areas were chosen as those which, from the evidence we received, appeared either particularly neglected, or with specific potential for improvement.

In common with other policy areas discussed in this report, the evidence base to support the effectiveness of action in these areas, and in particular the cost effectiveness of interventions, is thin. However, in the main the interventions we discuss are not wholly new, but are adaptations to existing policy to ensure that opportunity to exploit the symbiotic relationship between health and other aspects of policy are fully exploited: for example, reducing tobacco smuggling, as well as potentially reducing smoking-related health inequalities, would also generate significant savings for the public purse.

Joined up working in Whitehall and Government

262. The written evidence we received agreed about the need for improved co-ordination of Government policies to tackle health inequalities, providing numerous examples of other government policies which have undermined attempts to reduce inequalities such as the absence of compulsory sex and relationships education in the national curriculum

which the Healthcare Commission believed might conflict with the drive to reduce teenage conception rates.¹⁸⁶

263. We looked in some detail at the relationship between the DCSF and DH. The Secretary of State for Health told us that the relationship between his Department and the Department of Children, Schools and Families was a paragon of effective joined up working relationships at the highest level:

The DCSF, from whence I came when it was the Department for Education, works very, very closely with me. We are almost joined at the hip—we are probably the best example of working closely on this agenda that you would get between two government departments anywhere in Whitehall.¹⁸⁷

264. This did not reflect our observations: the Department for Children, Schools and Families did not respond to our initial call for written evidence for this inquiry, and when we specifically sought written and oral evidence from them, in our view they did not display a high level of knowledge about or insight into this area, and it seemed that few attempts had been made at evaluation of the health impacts of DCSF policies to date, suggesting to us that health inequalities are not a particularly high priority on this Department's agenda.

265. We were informed of other models to co-ordinate work which might be more effective. The Teenage Pregnancy Strategy was initially run and supported from the cross-departmental Social Exclusion Unit, which was part of the Cabinet Office, perhaps facilitating a more joined up approach from the outset. When it moved to a single Department, it remained a single unit spanning several government departments, and Sure Start was managed similarly.¹⁸⁸

266. The BMA argued for the appointment of a minister at cabinet level responsible for the health of the public and who would oversee work in every government department to try to facilitate this. In the BMA's view, the Department of Health has an overwhelming preoccupation with health services and has interpreted the role of the Minister for Public Health primarily as directed towards medical interventions for prevention.¹⁸⁹

267. We were told by Una O'Brien of the Department of Health that the Department of Health was very optimistic about the potential impact of cross-governmental PSA targets, progress against which we intend to follow up in a Public Expenditure Inquiry or elsewhere:

We in the Department of Health have been hugely impressed by the effort that has gone in this time on this Comprehensive Spending Review to the creation of 30 cross-government public service agreements. If you go down those agreements you can actually see how they offer a fresh and stronger platform for tackling health inequalities in a way we have not quite had before.

¹⁸⁶ HI 85

¹⁸⁷ Qq 1246–7

¹⁸⁸ Q 34

¹⁸⁹ HI 83

Conclusion

268. If, as the Secretary of State told us, joined up working between the Department of Health and the DCSF on health inequalities is truly the best in Whitehall, this must mean that elsewhere it is very poor. In our view the DCSF did not display a high level of knowledge about or insight into this area, and it seemed that few attempts had been made at evaluation of the health impacts of DCSF policies to date, suggesting to us that health inequalities are not a particularly high priority on this Department's agenda.

Joined up working at a local level

269. Underpinned by the duty to work together introduced by the Local Government and Public Involvement in Health Act (2007), much recent effort has focused on encouraging PCTs and Local Authorities to co-ordinate their work more effectively through the development of a number of new structures to encourage accountability, including

- Comprehensive Area Assessments (CAAs),
- Joint Strategic Needs Assessments (JSNAs)
- Local Area Agreements (LAAs)

270. The incentives and targets for NHS and Local Authorities partnership working have been aligned, with targets on All Age All Cause Mortality (as a proxy for life expectancy) now being mandatory for both Spearhead PCT Local Delivery Plans (LDPs) and Local Authority Local Area Agreements (LAAs) from 2007.

271. Recent restructuring of PCTs has improved co-terminosity of PCTs and local authorities, and the introduction of Local Area Agreements, through which PCTs and LAs agree shared targets, has been designed to further promote joined-up working. Shared appointments between PCTs and LAs, such as the joint appointment of a Director of Public Health, have been reported to have had a similar effect.¹⁹⁰ The Permanent Secretary of the Department of Health told us he was confident that joined-up working was now a reality:

Something like 80% [of LA Chief Executives] were saying that health inequalities were embedded in the way their local authorities approached their work and 60% were saying that they could see an impact on health in their local communities. This is work in progress obviously. Nobody is saying that it is absolutely even everywhere, but I think we have seen a step change in partnerships between local authorities and PCTs in this area over the last 12–18 months.¹⁹¹

272. However, there is little robust evidence to support this assertion. The Faculty of Public Health estimates that only one in three PCTs and LAs have joint appointments, and, as David Stout, Director of Commissioning at the NHS Confederation told us, a joint post will not per se lead to improvements:

¹⁹⁰ See for example HI 110 (Liverpool PCT and CC) and HI O1 (Department of Health)

¹⁹¹ Q 1198

It is also important that they are properly resourced. ... simply having a joint post, unless there is an underpinning capacity within the council and the PCT to actually do something and influence. A joint post on its own will not work.¹⁹²

273. While several PCTs and LAs submitted examples of good joined up working, the Heart of Birmingham PCT admitted that joined up working with its Local Authority was less successful than it could be:

The missing bit for me, certainly in Birmingham, is that the Department of Health and Government have tried to drive these targets largely through the NHS and, in a sense, I think we have only had half a system, certainly in Birmingham, in terms of the engagement and understanding of the local authority about what they can do to actually create the conditions in which people can be healthy; as opposed to doing what the NHS is good at, which is trying to deal with individual risk as it comes through the door.¹⁹³

Finally, we also heard that local organisations which need to work together may be slow to share information as they tend to defend their territories and especially their budgets. When managing joint approaches to the disadvantaged, pooling of information is essential, together with staff with appropriate analytical skills and capacity to translate data results into improved care.

Conclusion

274. Many measures are now in place to align the objectives of PCTs and LAs towards tackling health inequalities and to promote joined-up working. The introduction in some areas of jointly appointed Directors of Public Health is to be welcomed. However, the evidence we received suggested that there is a great deal of work still needed to translate these objectives into a reality of effective joined-up working between every PCT and its LA, and there are currently no incentives to share data and pool budgets.

Nutrition

275. Nutrition is a key determinant of health and health inequalities. England's obesity epidemic has attracted considerable policy attention in recent years, with the Foresight report leading to the government's Change for Life strategy. The adverse health effects of obesity are well known. However, independently of a person's Body Mass Index (BMI) nutrition influences health in many other ways—high intakes of salt and saturated fat heighten the risk of CHD, while diets that are high in red meat, low in fibre and low in fruit and vegetables can increase the chances of certain types of cancer. At the earliest stage of life, maternal nutrition during pregnancy can have an impact on an unborn child's future weight and predisposition to certain illnesses, and breastfeeding for the first six months of a child's life has significant health benefits for both mother and child.

192 Q 205

193 Q 199

276. As the graphs in Chapter 2 show, poor nutrition and obesity have a particularly marked impact on the most deprived groups. Jamie Oliver, a well known chef and broadcaster, eloquently described to us the problems with the nation's nutrition as 'a new kind of poverty':

There is a new poverty that I have never seen before ... The poverty in this fifth richest country of the world, that looks different from any poverty ... This is not about flash trainers or mobile phones or Sky dishes and plasma TV screens—because that is there, they have got that. It is the poverty of being able to nourish their family, in any class, and directly runs with the outrageous obesity that is factually happening now.¹⁹⁴

277. Poor nutrition amongst the most deprived parts of society is nothing new—Joseph Rowntree as far back as 1901, documented inadequate nutrition in poor households. But now, rather than the problem being one of insufficient calories, it is that of too many calories coming from the wrong sorts of foods.

278. We were disappointed with the Secretary of State's responses to our questions in the area of nutrition. He emphasised the importance of breastfeeding, which we support, but the detail of his reply revealed a degree of complacency which we find surprising, given the decline in postnatal health visiting and midwifery services, two key channels for promoting breastfeeding:

It is very difficult to think of what is not being done. It is a huge campaign which Sure Start are doing, health visitors are doing, community nurses are doing, schools are doing. Everyone is combining to say that breastfeeding is best ... I do not think there are many places where this is not the subject of a huge amount of focus and any more ideas would all be very welcome in terms of what I think is one of the most important health issues.¹⁹⁵

279. He told us he was confident that the government's obesity strategy, 'Change for Life', would work, but that he had no evidence yet to support this; and beyond this he thought one of the most important interventions for tackling problems with nutrition was central promotion of healthy foods:

I think the healthy food promotion guidance that we give is very important because it gives solid information from a body that people trust, ie the NHS.¹⁹⁶

280. However we have heard repeatedly that simply advising people to choose healthier lifestyles is unlikely to have a positive effect on lower socio-economic groups, and many witnesses explained to us that there are many factors that make adopting a healthier diet very difficult, particularly for those in lower socio-economic groups.

194 Q 812

195 Q 1255

196 Q 1256

School meals

281. Laying the foundations of good nutrition at an early age is crucial for promoting healthier eating throughout people's lives, and the school environment offers an ideal opportunity to ensure children of all socio-economic groups eat at least one healthy, nutritious meal a day. Since we last examined this issue, in our 2003–04 inquiry into Obesity, considerable progress has been made, with the Government committing £650m between 2005–2011 to improve school meals. However, in the view of Jamie Oliver, who has been one of the chief campaigners for these reforms, much more still remains to be done, and more investment is needed. According to Mr Oliver, the most crucial people delivering nutritious school meals, are, however, those who actually produce school meals, who need good training, and need to be supported with adequate equipment, and sufficient facilities to seat children comfortably:

The most important thing in school dinners is the training of the dinner ladies. Then it is equipment. Then it is facilities to sit these young people down. A lot of our secondary schools were designed for 600 kids 30 years ago, 40 years ago, and now they have 1800. We cannot physically get them all through anyway. But the training is the big deal breaker and, unfortunately, that has been incredibly slow. If you look at the statistics of how many people have been trained versus the amount out there, it is pathetic. Really the good practice that you have seen amplified over the last five years is just due to individuals who already were quite bright and on it and quite empowered. The ones that are not empowered, still are not empowered. We have 125,000 dinner ladies and probably not over 4,000 or 5,000 have been trained in five years.¹⁹⁷

282. Baroness Morgan told us that by 2011 33,000 members of the school food workforce will have been trained—but it is not clear whether these will all be front line dinner ladies; even if so, it represents just over a quarter of the total.

283. However, McCain Foods pointed out that since healthier menus were introduced for school meals, uptake of school meals has fallen. The School Food Trust has set up an annual survey to measure uptake of school meals. The first couple of years saw a drop as schools started to introduce new meals but primary numbers are increasing again (43% in 2008) and secondary numbers are stabilising (37%). Take-up of school meals has now been included in the government's new obesity strategy as a key performance indicator. The latest 2008 figures show an increase of 1.7% in primary schools to 43% (from 41.3%) and a levelling off in the decline in secondary at 37.6%, virtually the same as in 2007 (37.7%) whereas the previous year had seen a 5% drop.¹⁹⁸ Analysis from the School Food Trust suggests that schools which have played a leadership role in improving food have done much better in sustaining and increasing uptake of healthy school meals.

284. McCain also claimed that take up of free school meals had fallen, suggesting further impacts on inequalities as the most disadvantaged children no longer eat school meals. When we asked the Minister for Children whether it was possible to look at takeup of

¹⁹⁷ Q 828

¹⁹⁸ HI 08

school meals by socio-economic class, to see whether healthier school meals were reaching those who need them most, we were surprised to be told that such data was not collected, even though take-up of school meals has now been included in the government's new obesity strategy as a key performance indicator. A scheme offering free school meals to all primary school children is now being piloted in three local authority areas, and a key outcome indicator of this research will be its impact on uptake of school meals.¹⁹⁹ However, again it is not known whether the research will gather information on socio-economic deprivation.

Teaching people to cook healthily at home

285. Jamie Oliver told the Committee that “this is the first time in British history where we do not have most of the population able to cook”.²⁰⁰ He told us that this needed to be addressed both in schools, and in workplaces. The Government has recently announced that practical cooking training will become compulsory for 11–14 year olds from 2011. Practical cookery is already compulsory for primary school children. The Government's recent announcement is supported by extra funding (£150 million ringfenced capital investment to build food technology teaching areas, and £750,000 to recruit and train 800 new food technology teachers).

286. However, Mr Oliver cast doubt on whether there would be sufficient numbers of properly trained teachers to deliver lessons in secondary schools effectively, and finally, he argued that the proposed requirement for children to fund and bring their own ingredients risked jeopardising the scheme:

If you talk to five home economics teachers in Great Britain you would have a very, very sad, depressed, demoralised workforce with very little facilities, who struggle even to have the budgets to have anything other than flour, butter and jam. Getting fresh food in there is very hard for them. Is there going to be enough money? I see that in secondary school education kids are going to have to bring their own food in, which means the parents are going to have to pay for it. I think that is a drag, a pain. Also, it is going to be erratic. It will be, “Oh, I've forgotten this, I've forgotten that,” so you will have half the class doing it properly and half the class not. I do not think that the young people or parents should have to pay for the ingredients. If you went to chemistry and were asked to bring in your own magnesium and phosphate, it would be a liability. What a liberty! I would urge you to make sure that is stopped. In my job, in the jobs I do, I try to make as much non vulnerable to not working as possible. I think that by having them do that it is vulnerable.²⁰¹

287. Cooking skills are clearly also necessary for adults; in a recent television series, Jamie Oliver established a centre offering free cooking lessons to adults on a drop-in basis, together with a work-based scheme to promote cookery skills. While these initiatives proved popular in the town in which they were introduced, there do not seem to be any moves from Government towards tackling this difficult problem.

199 See http://www.dcsf.gov.uk/pns/DisplayPN.cgi?pn_id=2008_0212

200 Q 815

201 Q 835

Food labelling

288. Food labelling provides vital information about the nutritional content of food to enable people to make healthy choices, but according to Jamie Oliver the current Guideline Daily Amounts system is virtually incomprehensible, even to those like himself working in the food business.

Mr Oliver: I am confused is the truth.... I think clarity is really important. Having one united answer, whichever way it goes, is really important. I do think that a traffic light system is clearer

Dr Stoate: If you are a mother of three young kids and you are trying to do your best nutritionally for those kids and you are looking at the back of the packet and it says, "13% saturated fat GDA", what the hell does that mean? How does that help me to feed my kids?

Mr Oliver: I totally agree, what does it mean? Do you know what, I do not even know.²⁰²

289. Professor Alan Maryon-Davies, President of the Faculty of Public Health, went one step further and argued that a lack of clear labelling in fact contributes to health inequalities:

The GDA labelling system is discriminatory: it actively disadvantages people who are less able to interpret it. It is very complex.²⁰³

290. Research by the Food Standards Agency to compare different schemes showed very clearly that, although, on average, both schemes currently in use improve understanding, the benefits for people in the less advantaged groups was significantly greater with use of the colour-coded multiple traffic light scheme. The FSA made recommendation to this effect, but fewer than half of manufacturers and supermarkets have adopted this voluntary scheme. However the Government's national obesity strategy commits it to establishing a single, effective food labelling scheme, and as a result of this the FSA is now funding an independent study to evaluate the impact of the three main FoP nutrition signpost labelling approaches used in the UK on purchasing behaviour and consumer knowledge.²⁰⁴

Dr Susan Jebb, Scientific Adviser to the Government's Foresight obesity review, told us that she was strongly in favour of the traffic light approach:

Research done by the Food Standards Agency to compare different schemes showed very clearly that, although, on average, both schemes currently in use improve understanding, the benefits for people in the less advantaged groups was significantly greater if we used the colour-coded multiple traffic light scheme. It seems to me that is a specific example where we could have a much clearer emphasis on a specific

202 Q 863–866

203 Q 412

204 The three approaches are: monochrome GDA schemes; traffic light colour coded schemes indicating the nutrient level; and hybrid schemes which provide both a traffic light colour code and percentage of GDA

policy that did not disadvantage anybody but particularly offered benefits for people who suffered the greatest inequalities.²⁰⁵

291. The Secretary of State, however, told us that despite the failure so far of a large section of the food retailing industry to adopt traffic light labelling voluntarily, he remained committed to a voluntary scheme:

I do not think it will be quick or easy. We will try to form a consensus behind that and continue down the voluntary route. I am very reluctant to rush to legislation and regulation in this area. I would like to do it through a voluntary route which means you take a bit more time.²⁰⁶

292. Finally, although one in five meals are now eaten outside the home, information on portion size and nutrition is still virtually non-existent in the majority of the restaurant and catering sector. In June, a poll of 2,000 people carried out by the FSA revealed that 85% were in favour of catering outlets displaying nutritional data. The FSA have recently announced that several of the biggest food chains (whom they have not named) are now signed up to a new scheme providing calorie information on menus together with information on salt, sugar and fat content. However, whilst this is a welcome step, there is clearly a great deal still to be done.²⁰⁷

Conclusion

293. Jamie Oliver argued that this country is suffering from ‘a new kind of poverty’, because many people are now unable to give nutritious meals to our families. We were disappointed that the Secretary of State’s responses to this—advocating simple health promotion messages—underestimated the challenges of removing the barriers to healthy eating, particularly for more disadvantaged groups. In reality, those people need cheap and convenient access to healthy food, rather than a multiplicity of takeaways on their high street; they need easily comprehensible nutrition labels on the food they buy; and they need the skills to cook healthy meals. Children need a guarantee of at least one healthy meal a day at school.

294. We welcome recent improvements in school meals, but we remain concerned about their low rates of take-up, and also about the lack of any data about whether the poorest children are benefiting from a healthy meal. We recommend that the DCSF closely monitors take-up of school meals and analyses this by socio-economic group.

295. Cooking lessons are to be made compulsory, but, unlike in other practical lessons such as science where equipment is provided, pupils will need to buy and bring in their own ingredients. We think it likely that many pupils will fail to do this. The Government’s approach seems to confirm that the proposed cooking lessons are still seen as an ‘added extra’ rather than a government priority. We recommend that free ingredients be provided for all school cookery lessons.

205 Q 412

206 Q 1253

207 See <http://www.food.gov.uk/news/newsarchive/2008/jun/eatout>

296. We are appalled that, four years after we first recommended it, the Government and FSA are continuing to procrastinate about the introduction of traffic-light labelling to make the nutritional content of food clearly comprehensible to all. In the light of resistance by industry, and given the urgency of this problem, we recommend that the Government legislate to introduce a statutory traffic light labelling system. This should apply to food sold in takeaway food outlets and restaurants as well; currently food purchased from such outlets, despite often being very high calorie, does not have any nutritional labelling at all.

Health education and promotion in schools

Personal, social and health education

297. In 2003, a predecessor Health Committee, as part of its inquiry into sexual health, recommended that Personal Social and Health Education (PSHE), and in particular the sex and relationships elements of it, should become a statutory part of the national curriculum. With a 2005 OFSTED report highlighting many shortcomings in PSHE, in particular a lack of assessment of pupils' progress,²⁰⁸ in its follow up inquiry in 2005 the Health Committee again reiterated its call for statutory PSHE.

298. On 23 October 2008, the Government announced that following the recommendations of reviews into sex and relationships education and drug and alcohol education, PSHE will become a compulsory part of the national curriculum from key stages 1 to 4 (ages 5–16 years).²⁰⁹

299. PSHE will cover issues including:

- drugs, alcohol and tobacco
- emotional health and wellbeing
- sex and relationships education (SRE)
- nutrition and physical activity
- personal finance
- safety.

300. Baroness Delyth Morgan, Parliamentary Under Secretary of State for Children, Young People and Families, told us that PSHE is ultimately “about creating in children and young people an understanding of risk and encouraging them to have the health literacy to make healthy choices, whether it is about drinking at a young age or about choosing a healthier diet or about taking up opportunities for vaccination.”²¹⁰

208 OFSTED, *Personal, Social and Health Education in Secondary Schools*, January 2005, pp1–2

209 See http://www.dcsf.gov.uk/pns/DisplayPN.cgi?pn_id=2008_0235

210 Q 1075

301. A major concern of the Health Committee in its reports into sexual health was that SRE, and PSHE in general, should be taught by specialist teachers rather than form tutors with no specific expertise, training or interest in this area. In 2005 the Committee was told that the majority of PSHE was delivered by form tutors rather than specialist teachers. It is also unclear how pupils' progress in PSHE will be assessed.

Dr Taylor: Do you think we have got suitably trained and qualified teachers to be able to pass this on?

Professor Wellings: I would like to be able to say yes, but all the evidence is that we have not and that we need a lot more training. Now that it is mandatory it will be much easier to put in place that training. When it was not mandatory it was much more difficult to put it into teacher training colleges and colleges of education.²¹¹

302. Baroness Morgan told us that a budget of £3m had been set aside to promote the training of PSHE teachers, and in particular the government was keen to encourage more specialist teachers to go into this as a field, but admitted that it was “early days”.²¹² Nor, according to the DCSF is it possible to estimate the total number of trained PSHE teachers. The job of teaching PSHE need not be confined to teachers; health visitors, school nurses, and even young people themselves in the role of peer educators, may prove equally if not more effective than teachers in this area, provided they have received sufficient training.

303. There is also uncertainty about how statutory PSHE will interact with the rights of school governing bodies particularly around sensitive areas. We were shocked to hear of one school that has already opted out of providing the cervical cancer vaccine to its students.²¹³ The DCSF has commissioned Sir Alasdair McDonald to carry out a review into how best to make PSHE compulsory, which will address this issue.

The wider role of schools in reducing health inequalities

304. Schools clearly have a broader role in tackling health inequalities than solely PSHE, including providing healthy nutrition, promoting physical activity, and of course providing children with educational opportunities that may help them close the health gap themselves, as Baroness Morgan described:

one of the most important things for a young person or child from a disadvantaged background is that they have a good quality school that they can attend and that is there and that they get there and that it is warm and welcoming and that they have access to an education that will give them greater opportunities in the future.²¹⁴

305. As with health services, some degree of additional funding is provided to schools serving particularly deprived populations, in recognition of the additional needs they face:

211 Q 791

212 Q 1058

213 Catholic school bans girls from having cervical cancer jab, Telegraph, 30 September 2008

214 Q 1071

Core funding through the dedicated schools grant is £29 billion this year, includes £3 billion specifically for deprivation and to make sure this gets to the schools and pupils which need it most local authorities are reviewing their local funding formulae to make sure it is properly targeted at schools and pupils who need it most. I am also advised that the school funding settlement for 2008–09 to 2010–11 includes £40 million in each of the next three years for particular pockets of deprivation, specifically to support children from deprived backgrounds who attend school in less deprived local authorities²¹⁵

306. The DCSF will shortly be publishing baseline data showing how local authorities target the funding they receive to deprived pupils, with those who are not targeting sufficient funding being expected to make changes to address this.

307. Schools have a long history of aspiring to promote health more broadly, and, more recently, to engage more proactively with the communities they serve. We were told about two specific national programmes, the healthy schools initiative, and the extended schools initiative.

308. The Healthy Schools initiative is a joint Department of Health and DCSF programme, launched in 1999, supporting a whole school approach to health promotion, with schools assessing themselves against quality criteria supporting health themes. Schools need to satisfy criteria in the four core themes within the programme:

- Healthy eating
- Physical activity
- PSHE
- Emotional health and well-being.

309. Over 95% of schools are actively participating in the programme with 68% of schools accredited, and 75% expected to have achieved accreditation by 2009. The healthy schools programme has now been in operation for nearly ten years, and Noreen Graham, Deputy Director for the Pupil Well-being Health and Safety Unit at the Department for Children, Schools and Families, told us that schools were generally positive about the programme:

One of the things we do know about Healthy Schools is that schools themselves say that they find it tremendously helpful in helping them raise health awareness. It is a very positive programme which lots of schools do want to get involved in ...²¹⁶

310. This is corroborated by an evaluation of the Healthy Schools programme in Birmingham, which asked schools whether they felt PSHE, emotional health and well being, physical activity and healthy eating had improved as a result of the programme.

311. However, we were disappointed to find that no evidence of the actual impact of this programme on children's health yet exists.

215 Q 1072

216 Q 1079

It is really hard actually to get really clear outcome evidence there is an enormous amount of statistical information in the Department and huge volumes of information but how that looks in terms of evidence is quite difficult ... that level of evidence is very difficult to achieve because everything gets compounded.²¹⁷

312. A national evaluation of the Healthy Schools programme has now been commissioned, with an interim report due to be published in the spring of 2009. In common with the Birmingham evaluation, this evaluation will be largely based on qualitative data (including surveys and focus groups with pupils). Again, we were told by the MRC Social and Public Health Sciences Unit that problems with the design of the healthy schools programme meant serious problems for evaluating its efficacy:

To be blunt—this evaluation, as it is unfolding, won't even produce the outcomes etc [that it is aiming to] ... However this is entirely the fault of how the programme was rolled out without prior thought to evaluation.

The DCSF also highlight the role their extended schools programme may have in addressing health inequalities. Extended schools work with other professionals so that pupils get access to any specialist support they need including specialist health support such as speech therapy or mental health support.

313. An evaluation of the extended schools programme in 2007 found that they have had a positive impact on the educational attainment of pupils attending them, but health outcomes do not appear to have been included in this evaluation.²¹⁸

Physical activity in schools

314. According to the DCSF, the last few years have seen a big increase in the level of PE and sport in schools. The target of having 85% of children engaged in two hours' physical activity per week has now been met and exceeded (the figure is now 95%) and the Government is working on extending the number of children who have the opportunity to engage in 5 hours' physical activity per week, with 3 of those hours being delivered outside school time. However in our 2004 report into obesity we expressed serious doubts about whether these targets went far enough:

While we very much welcome the DCMS/DfES target to have 75% of school children thus active by 2006 we do not believe that this goes far enough. We have reservations about the quality of much of the activity undertaken, since little work has been done to establish what the two hours involves, and whether it includes, for example, time taken in travelling to and from facilities. Moreover, even the two hour target puts England below the EU average in terms of physical activity in school, despite the fact that childhood obesity is accelerating more quickly here than elsewhere.²¹⁹

217 Q 1078

218 See <http://www.everychildmatters.gov.uk/ete/extendedschools/>

219 *Obesity*, Third Report, Health Committee, 2004, House of Commons, HC 23-I; <http://www.publications.parliament.uk/pa/cm200304/cmselect/cmhealth/23/2302.htm>

315. When we questioned the DCSF minister and her department again about whether the two hours included travel time to playing fields, they were not able to answer this question, and nor were they able to give us any indication of the number of schools where pupils have to travel long distances for their PE and sport.

316. Travel to school offers further opportunity for children to increase their physical activity, if safe options exist for walking or cycling to school. Latest figures show that 49% of 5–15 year olds walk to school, 48% use motorised transport, and 2.1% cycle. Interestingly, children from lower socio-economic groups are more likely to walk and less likely to use motorised transport than those from higher groups (58% of most deprived walk and 40.2 used motorised transport compared with 44% of least deprived walking and 52% using motorised transport.) However these trends are reversed for cycling, where only 1.1% of the most deprived children cycle to school compared with 2.8% of the least deprived.²²⁰

Conclusion

317. We are pleased that, five years after we first recommended it, Personal Social and Health Education (PSHE) is finally being made a statutory part of the national curriculum. However, we still have the same concerns we had five years ago about the lack of specialist teachers and assessment in this area; pupils should have PSHE taught by someone who has received a appropriate training, whether this be a teacher, health visitor, school nurse, or even a peer educator. In our view OFSTED should carry out an early review of implementation of PSHE, which should include who it is being taught by. We are also very concerned that elements of PSHE may remain at the mercy of ‘local discretion’ and that schools will be given the option to opt out of certain elements, much as one school, shockingly, has already opted out of providing its pupils with the HPV vaccine.

318. We were told by the DCSF of apparently successful initiatives to provided wider health and social support in schools, such as the Extended Schools and Healthy Schools initiatives. However, we were deeply concerned that no evaluation has yet been published of the Healthy Schools initiative, despite it now being in its tenth year of operation, and that claims of success are based on the whether or not schools report finding the programme ‘positive’, while levels of childhood obesity, teenage pregnancy and smoking are persistently high. If the Government wishes to claim that the DCSF is actively engaged in the health inequalities agenda, it must be prepared to back this up with hard evidence of whether its policies are actually influencing health outcomes, together with information on their costs and cost effectiveness. We recommend that the DCSF and the Department of Health collaborate to produce quantitative indicators and to set targets for the Healthy Schools programme at the earliest opportunity.

The built environment

319. The built environment can have a significant impact on health and on health inequalities, as the WHO Commission on Social Determinants of Health has recently recognised:

“Communities and neighbourhoods that ensure access to basic goods, that are socially cohesive, that are designed to promote good physical and psychological wellbeing, and that are protective of the natural environment are essential for health equity”.²²¹

320. In fact, public health and town planning have shared roots in the late nineteenth century, and some environmental factors first documented then are still causing ill health today. Some aspects of the built environment can have a direct causal link with ill health; these include:

- Issues such as indoor and outdoor air quality, noise exposure, water quality, flooding, road safety and crime;
- The quality of housing, including temperature, ventilation, fire safety, damp and vermin; and
- Wider influences, including community cohesion, access to facilities and jobs and an environment which encourages physical activity.

321. Those in lower socio-economic groups are more likely to suffer from a poorer built environment: many 1960s–70s tower block developments suffered from problems within this category; the Department of Transport estimated that in 2007 there were 2500 ‘excess’ pedestrian casualties in deprived areas.²²²

322. During the inquiry witnesses raised concerns and recommendations for improvements about several aspects of the built environment which we consider below. Just as significant are wider influences on health that the built environment can have.

A sense of identity and community

323. A sense of identity and community promotes health and wellbeing. Design and planning cannot alone create these, but they do influence the environments within which these occur. The relationship between social capital, neighbourhood and health is complex and still being studied. Rob Ballantyne, an independent planning consultant, told us of a small study of a heat wave in Chicago in 1995. In one week there were 465 heat-related deaths. The study found that the risk factors were living alone, not leaving home daily, lacking access to transportation, being sick or bedridden, and not having social contacts nearby. The people at risk were fearful of going out and getting help. Areas with an active street life, where neighbours saw each other and there were trusting neighbour relations, were more successful at protecting the vulnerable.²²³ Closer to home, an analysis of the

221 HI 128

222 HI 127

223 E. Klinenberg 'Heat Wave: a social autopsy of disaster in Chicago. Chicago University Press 2002

Health Survey for England 2003 concluded that “low stocks of social capital across the domains of trust and reciprocity, perceived social support and civic participation are significantly associated with poor measures of health status”.²²⁴

Green space

324. Research on green space published recently in *The Lancet* argued that “health inequalities related to income deprivation in all-cause mortality and mortality from circulatory diseases were lower in populations living in the greenest areas.”²²⁵

Access to health and other essential services

325. Witnesses stressed the importance of access to health and other essential facilities, particularly for deprived groups. There was therefore disappointment that the location of new GP-led health centres, one of the centrepieces of the Government’s strategy to ensure availability of primary care services for those that need them most, had not been planned at all:

Has any work been done on the exact location of these new premises in relation to health inequalities and health impacts in general, or are they being placed pretty much at random?

Mr Blackshaw: You may know that there have been five polyclinics approved in London this year, and those, essentially, are facilities that are already almost built or planned ... I will say that health inequalities is not an issue that is being systematically taken into account in the location of those health facilities.²²⁶

Mr Blackshaw went on to explain to us that many of the decisions on the location of the first round of polyclinics in London did not seem to have taken into account a full assessment of the location of supply and demand but had rather been determined largely by pragmatic factors, including the location of existing and already proposed new facilities. While a degree of pragmatism may be essential in these decisions, for the sake of both timing and value for money, it is worrying that no systematic approach has been taken to locating these facilities, the central aim of which, of course, is to improve access to services by placing them in the heart of the communities that need them. We were told:

HUDU (The NHS London Urban Development Unit) has recently completed a review of a sample (10) of the 31 London PCT Strategic Plans For 2009 onwards for the SHA. Amongst many other things these plans must show what steps the PCT is proposing to make to implement the ‘Darzi Plan’ in so far as ‘polyclinics’ are concerned.

A minority of the plans make reference to accessibility but set varying and unsubstantiated standards (‘20 minutes’ for instance) but none adopt a systematic

224 Social capital and its relationship with measures of health status: evidence from the Health Survey for England 2003. S Petrou *E Kupek Health Econ.* 17: 127–143 (2008)

225 R Mitchell & F Popham. Effect of exposure to natural environment on health inequalities: an observational population study’. *The Lancet*, Volume 372, Issue 9650, Pages 1655–1660, 8 November 2008]

approach. One makes reference to the greater health needs in part of the area (although the proposed 'polyclinic' will not be delivered there for some time) but none adopt a systematic approach to the spatial planning of new facilities in the context of a needs assessment.

London, it must be said is something of a special case not least because of the obvious fact that the population is, at least in large parts very dense, and, again for the most part, public transport is relatively easily accessible. The implication of this fact is that wherever facilities are located they will be accessible by some reasonable standard. Nevertheless this, to the extent that it can be said to hold true for all parts of all PCTs, still does not obviate the need to carry out a systematic assessment in order to demonstrate that a given level of accessibility is being achieved—if that indeed is one of the criteria.²²⁷

326. London PCTs have recently announced that they will evaluate the first of their polyclinics to see whether they are making a difference to healthcare and access, and this would seem to be an ideal opportunity to evaluate their impact on health inequalities.²²⁸

Physical activity and the built environment

327. Recent publications such as NICE's guidance on physical activity and the environment and the Government's National Obesity Strategy have highlighted importance of the built environment to health in promoting physical activity. Increasing physical activity can have a positive impact not only on weight, which is a predisposing factor for many conditions, but is directly associated with cancer, CHD and diabetes.

328. The amount of physical activity varies by socio-economic group. The Sport England' 2007–08 survey showed that activity rates were 14.7% in Newham and 16.2% in Easington, two highly deprived boroughs, but 28% in Chichester. Nationally the participation rates (defined as moderate intensity recreational activity for 30 minutes 3 times per week) were 16.4% for lower socio-economic groups and 28.8% for the highest socio-economic groups.

329. Governments' policies have too often discouraged physical activity, for example through permitting the development of out-of-town supermarkets, hospitals and other facilities. The Government was also criticised for adopting the wrong priorities. Dr Susan Jebb, a scientific advisor to the Foresight obesity programme, told us that to promote physical activity the Government's focus on gym membership—typically taken up amongst the higher social classes—was wrong, and that for impacts to be felt amongst the lower socio-economic groups, efforts would be far better directed towards ensuring a safe environment for healthy travel.

On the physical activity side of things, building on my environmental determinants theme, we do need to do more to develop active transport policies. Too often on physical activity in relation to obesity there has been an emphasis on sport, gym memberships, and all these sorts of things which we know are taken up by people with higher incomes, from a higher social class. If we turned our attention more

227 HI 127B

228 London will review polyclinics, *Health Service Journal*, 11 February 2009

firmly to the active transport issues we would perhaps see some contribution to reducing inequalities.²²⁹

Planning

330. There are, theoretically, many ways in which health needs can and should be taken into account in planning the built environment. King's Cross in London was cited by witnesses as an example of the system working well:

Kings Cross...a massive mixed use development for offices, retail and housing, one of the largest in Europe at the time, by the developers Argent... has recently received planning permission. The Health Impact Assessment was carried out under the guidance of the PCT in 2003 onwards. It resulted in changes to the methods of construction, following participation of local residents in the Health Impact Assessment. The process also ensured that the PCT were fully engaged in the planning process whereas they might not otherwise have been. The subsequent s106 agreement that made significant provision for health was one positive outcome of this engagement.²³⁰

331. However despite the existence of an enabling framework, and some examples of good practice, town planners who gave evidence to us were in agreement that "the spatial planning system is a key area of influence that could be better exploited by the NHS". According to Neil Blackshaw, Head of the NHS London Healthy Urban Development Unit (HUDU), this is because of poor understanding of how health and planning need to link together; this poor understanding is evidenced across both the planning sector and the health sector, and at all levels:

The level of mutual understanding of health and planning is highly variable and in places almost non existent. The NHS is not organised to engage in the planning process and the planning sector finds it difficult to get the NHS to engage.

The generally poor understanding of the potential of the spatial planning system that I have described in the NHS is reflected in the Department of Health and other national bodies active in the health field.

The lack of understanding in the health community of the spatial planning system is ... reflected in the field of spatial planning. I have met an Inspector in the planning system, examining an LDF, who was genuinely puzzled as to why I was promoting the health agenda.²³¹

332. The Secretary of State told us that it was his understanding that PCTs were consulted in the 'rare' event that a planning decision concerned them.²³² However, in the view of the planners who gave evidence to the inquiry, health should be factored into every planning decision, and opportunities are being missed at every turn:

229 Q 412

230 HI 127A

231 HI 127

232 Q 1280

- Whilst there are some 25 national planning policy statements none address health in anything like an explicit and holistic way...the effect of this is for health to be given lower priority in plan making.
- The HUDU Unit has examined many plans, up to and including regional spatial strategies, that do not explicitly address health, and many planning decisions that ignore it completely.
- In London last year the vast majority of decisions dealing with over 40,000 houses failed to scrutinise the health implications.

333. To improve the situation, our witnesses recommended:

- A Planning Policy Statement (PPS) on health;
- Making PCTs statutory consultees in planning decisions

Transport expenditure

334. We received a joint memorandum from the Association of Directors of Public Health, Sustrans, the National Heart Forum and the Commission for Architecture and the Built Environment on behalf of a group called 'Take action on active travel'.²³³ The memorandum claimed that an analysis undertaken in 2008 had showed that of total UK investment on transport of £19.6 billion, in England 0.3% of this and in Wales 0.4% went on cycling (about £1 per capita per annum) and spending on walking could not be identified; in London 0.75% went to walking and cycling together. Thus the most inclusive and equitable forms of transport, and those most health promoting, were almost totally neglected. In the Netherlands, by comparison, Amsterdam spent €27 per capita per annum on cycling alone, and the budget just for improving cycle parking at railway stations, at €350 million, was more than the entire UK budget for walking and cycling for a year.

335. The group's main recommendation was that 10% of transport budgets should be spent on cycling and walking initiatives. In addition, it proposed:

- "a 20mph speed limit to be made the norm in residential areas;
- a coherent high quality network of walking and cycle routes that link everyday destinations;
- improved driver training and better enforced traffic laws; and
- ambitious official targets to be set for increases in walking and cycling.

²³³ The Take action on active travel policy call was published in April 2008, initially signed by 57 organisations from the public health, transport, architecture and social sectors. By December 2008, over 90 organisations from these sectors had become signatories in support of the policy call

Prevalence of fast food outlets

336. Making healthy choices easier and more attractive and unhealthy choices more difficult and less attractive is seen as central to supporting efforts to tackle health inequalities.

337. We were told that a growing concern is the proliferation of fast-food outlets that are coming to dominate high streets, while increasingly fresh produce can only be purchased cheaply in large supermarkets which are often out of reach of those without access to cars. We were told by Jamie Oliver, chef and broadcaster, that the temptation may be too great:

If [the high street] is riddled with fast food options on every corner and hardly any fresh food options, then, essentially that is like having more off licences and pubs in place of high alcoholism²³⁴

338. Pertinently, Mr Oliver went on to question why planning processes continue to permit this proliferation:

If I go to get an extension on my house, that goes through rigorous thought from Listed Buildings or the council ... There is none of that for businesses in the areas—do you know what I mean? In California, at the moment, a new law is being passed to cap the amount of fast food outlets within an area, and I totally agree with that.²³⁵

339. Support for restrictions on fast-food outlets is provided by research which suggests that high-level, environmental interventions, which are essentially compulsory and impact on everyone, for example bans on smoking in public places, have a better impact on lower socio-economic groups than other types of intervention.

Conclusion

340. **The built environment has a crucial impact on health and on health inequalities and affects every aspect of our lives. We are concerned that it does not encourage good health. Particular problems raised with us were;**

- **The built environment often discourages walking and cycling;**
- **High streets are awash with fast food outlets but have too little access to fresh food;**
- **Flagship health centres have been located at random, with little systematic consideration of access or need; London PCTs have recently announced that they will evaluate the first of their polyclinics to see whether they are making a difference to healthcare and access, and this would seem to be an ideal opportunity to evaluate their impact on health inequalities.**

341. We are disappointed by Government priorities which, according to its own Foresight Obesity team, seem more concerned with promoting gym membership than

234 Q 818

235 Q 819

promoting active travel through redesign of the built environment which would have been far more effective for all socio-economic groups.

342. In our view, health must be a primary consideration in every planning decision that is taken, and to ensure that this happens, we recommend that

- in collaboration with the Department of Health, DCLG should publish a Planning Policy Statement on health; this Statement should require the planning system to create a built environment that encourages a healthy lifestyle, including giving local authorities the powers to control the numbers of fast food outlets.
- PCTs should be made statutory consultees for local planning decisions; PCTs, for their part, need to ensure they have the knowledge of cost effectiveness of alternative policies and resources to make an informed contribution to such decisions.

343. We recommend that the Government increase the proportion of the transport budget currently spent on walking and cycling.

Tobacco control

344. Smoking is a major determinant of health inequalities, as ASH describe

There is an iron chain linking deprivation and smoking. Smoking accounts for half the difference in life expectancy between social class 1 and 5. Death rates from tobacco are two to three times higher among disadvantaged social groups than among the better off.²³⁶

Tobacco legislation

345. Much of the evidence we received was highly optimistic about the likely impact of legislation banning smoking in public places, introduced in 2007. As this policy is so new, it is too early to see demonstrable effects in England, but studies in other countries suggest a positive impact, including a 19% decrease in smoking prevalence in New York City residents between 2002 and 2006.²³⁷

346. In the view of many academics, policies which act at a whole population level rather than an individual level, such as legislation and regulation, are likely to enjoy a greater degree of success in tackling health inequalities, as their impact is universal, and, unlike health promotion advice, their impact does not depend on individual circumstances or motivation. The Government has recently announced a ban on point of sale tobacco advertising, a move which, in the view of ASH, is likely to have a particularly strong effect on the young.²³⁸ This move is to be welcomed. However, our evidence suggests that there is more still to be done in the area of tobacco control.

236 HI 63

237 See: <http://www.cdc.gov/MMWR/preview/mmwrhtml/mm5624a4.htm>

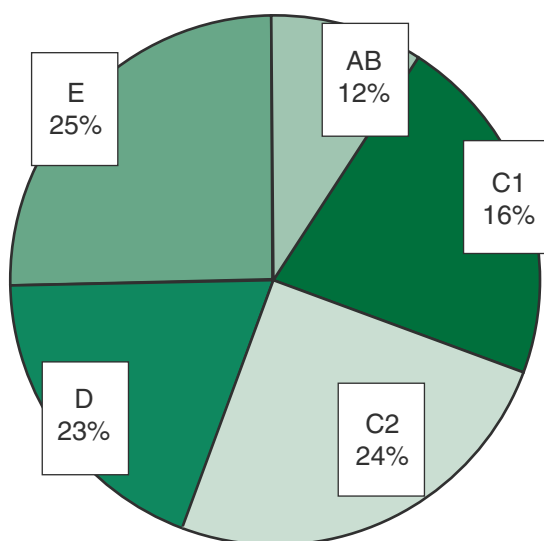
238 Q 515

Tobacco smuggling

347. Recent research published in the BMJ estimates from government statistics that 21% of tobacco consumed in the UK is smuggled, including 8.5 billion manufactured cigarettes and the equivalent of 7.27 billion own roll cigarettes per annum.²³⁹ (This estimate excludes legal cross border shopping.) This compares to 5 million manufactured cigarettes brought in legally which have been bought abroad. The price of smuggled products is about half of the duty paid equivalent.²⁴⁰ According to West et al, eliminating tobacco smuggling could potentially save between 4000 and 6500 deaths per year. This compares with about 1000 deaths per year from all smuggled illicit drugs. In addition to its health costs, according to ASH tobacco smuggling costs the Government over £2bn a year in lost revenue.²⁴¹

348. A recent survey carried out by ASH suggests that the least well off smokers are twice as likely to use illicit sources of tobacco as the most affluent smokers, exacerbating health inequalities. One in four of the least affluent smokers buys smuggled cigarettes, including handrolled tobacco, compared to one in eight of the most affluent. Nearly half of those who buy illicit cigarettes in the England are from the socio-economic Groups D and E and SEG C2, D and E combined constitute almost 3 out of 4 of the customers in the smuggled market (72%).

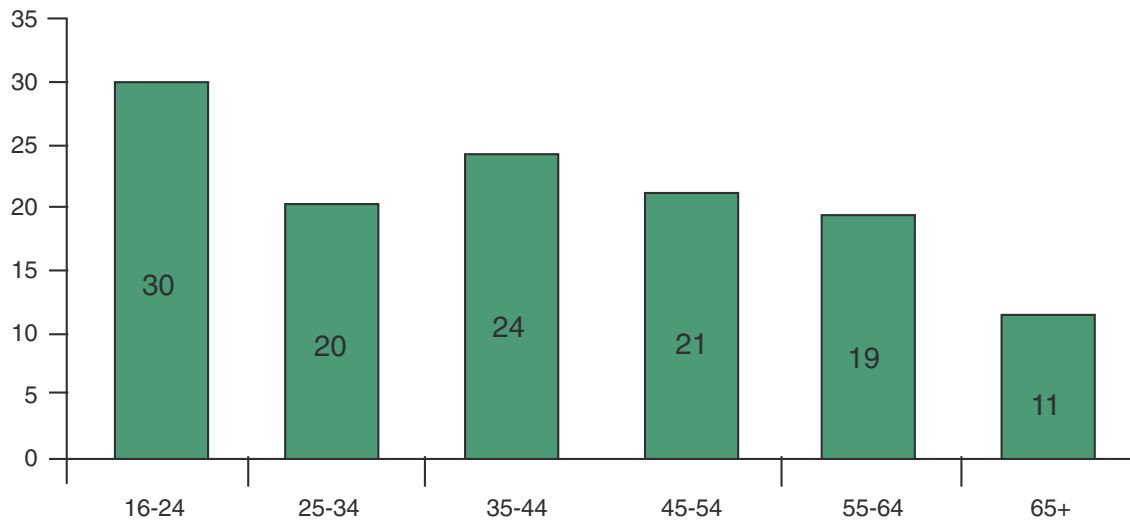
Bought illicit tobacco (by SEG)



239 2005–06 figures

240 BMJ, West et. Al, 9 October 2008

241 HI 63



Bought illicit tobacco (by age)

349. As shown in the figure above, young people are also more likely to buy smuggled tobacco, with one in three of the youngest smokers in the sample (16–24 year olds) reported buying cigarettes from illicit sources.

350. ASH also argue that inequalities in smoking are also exacerbated by the particularly strong trade in smuggled handrolled tobacco, as this disproportionately affects those in lower income groups who are far more likely to smoke handrolled tobacco:

A much higher proportion of handrolled tobacco is smuggled compared to cigarettes, 56% in 2005/6. (3) This is of particular concern for health inequalities as there are significant gender and class differences. One in four smokers primarily smoke handrolled cigarettes. However, this rises to 42% of male routine and manual smokers, compared to only 25% of male professional and managerial smokers. Fewer women smoke handrolled tobacco, although the numbers have increased significantly in the last decade, but again significantly more women smokers in routine and manual occupations smoke handrolled tobacco.²⁴²

351. Good progress has been made in tackling tobacco smuggling in recent years, with the market share for smuggled cigarettes reducing from 21% in 2000 to 13% today. Previously, HMRC's performance in this area has been monitored against stringent targets, which may have been a factor in their success. Efforts to tackle the smuggling of handrolled tobacco have not been as successful as those to tackle cigarette smuggling, with rates remaining static, and high, for many years.

352. However, concerns were raised to us in oral evidence about the transfer of responsibility for tackling smuggling from HMRC to the newly formed UK Borders Agency, and the loss of PSA targets in this area. ASH argue that targets are crucial to ensure that tobacco smuggling remains a priority, particularly in the light of the transfer of operational responsibility for this area to the Borders Agency who have other high-profile, high priority areas to balance with this one. The outcomes UKBA commit to in Annex 1 of

the strategy (p.23) are only to restrict the cigarette market to no more than 13% implying no further reduction on current levels. The target for Hand Rolled Tobacco is for a reduction of 1200 tonnes against 2003/4 levels by 2007-08, which again is implying no further reduction after the current targets are met.

353. ASH recommends that the HSC urge government to adopt the new targets set out in our response to the Department of Health consultation and in “Beyond Smoking Kills” of 8% for cigarettes by 2010 and 3% by 2015 (latest figures 2005–6 13%); and for targets for Hand Rolled Tobacco to be expressed in the same way as for cigarettes as a market share which should be 45% by 2010 and 33% by 2015 (latest figures around 56%).

354. We were also told that a potential impediment to the fight against tobacco smuggling was the UK’s failure to sign up to agreements to control supply with the tobacco companies Philip Morris International and Japan Tobacco International. These agreements are legally enforceable and include a requirement for the tobacco companies to tightly control and regulate the distribution system and to stop supplying contractors if they are found to be complicit in smuggling; marking systems allowing customs to independently identify smuggled cigarettes so that they can be traced back to the contractor who originally bought them from the company; and seizure payments. We were pleased to be told by Mike Eland, title, that good progress is now being made in resolving any legal issues over signing up to the EU agreements.

Conclusion

355. Smoking remains one of the biggest causes of health inequalities; we welcome both the Government’s ban on smoking in public places, and its intention to ban point of sale tobacco advertising, as evidence suggests that both of these measures may have a positive impact on health inequalities. However, tobacco smuggling, by offering smokers half price cigarettes, negates the positive impact of pricing and taxation policies. Tobacco smuggling has a disproportionate impact on the poor, particularly young smokers. Some progress has been made in this area but not enough; there has been no progress at all in reducing the market-share of smuggled hand-rolled tobacco, which is smoked almost exclusively by those in lower socio-economic groups. We recommend the reinstatement of tough targets and careful monitoring now this crucial job has passed to UKBA, to ensure that it remains a sufficiently high priority. We also recommend that the UK signs up to the agreements to control supply with the tobacco companies Philip Morris International and Japan Tobacco International as a matter of urgency.

8 A new approach to tackling health inequalities

356. In 2000 the Government set itself the extremely tough target of reducing health inequalities. We commend it for doing so, for setting out so clearly its desire to tackle a notoriously trenchant problem and for establishing an explicit policy framework for doing so.

357. However, the target is unlikely to be met and limited progress has been made to date, even bearing in mind that we would not expect to see quick results. During our inquiry the Government commissioned Professor Sir Michael Marmot to review the evidence and policy in this area with a view to setting a strategic framework for tackling health inequalities for the future, which we welcome.

358. Options for change include abandoning the goal of reducing inequalities as an unachievable goal, recasting the policy framework, or making changes to existing policy and policy-making to increase their chances of success. We do not support the first option; the second option, recasting the entire policy framework, risks further destabilising an area where there have already been too many disruptive changes to policy; so we offer some recommendations for improving existing policy and policy making in this area.

359. This chapter draws together recommendations made previously in this report which aim to improve existing policy and policy making in this area. We first make recommendations about the need to collect evidence about policies and, most importantly, to ensure policies are introduced in ways which permit rigorous evaluation. We then go on to look at a few practical measures the Government should take to improve policy.

Designing and evaluating policy effectively

360. One of the major difficulties, which has beset this inquiry, and indeed is holding back all those involved in trying to tackle health inequalities, is that it is nearly impossible to know what to do given the scarcity of good evidence and good evaluation of current policy. Policy cannot be evidence-based if there is no evidence and evidence cannot be obtained without proper evaluation. As we stated in chapter three, time and again we have heard that policies to tackle health inequalities have been introduced without sufficient thought being given to designing them in a way which enables them to be properly evaluated. While the Government has made attempts at evaluation, these have often been descriptive studies of processes which are not good enough. As a result of these failings, very large sums of money have been spent on initiatives to tackle health inequalities, but we do not know whether they have been effective.

361. Evaluation is an ethical imperative. It is essential to ensure that more public funds are not wasted on imposing ineffective and possibly damaging interventions on already disadvantaged populations. Such waste deprives the community of potentially more productive investments in health and social care which might advantage the poor. Some very simple changes in this area should be adopted. Policies must be designed and implemented in a manner that means they can be evaluated and need to be given sufficient

time to yield results before the next set of changes is imposed. Firstly it is essential that all policy innovations are designed with clear definition of their goals and how success will be evaluated. Secondly piloting is essential to determine whether the intervention is sufficiently cost effective to deserve nationwide implementation. We recommend that all future Department of Health policies must, prior to their introduction, demonstrate adherence to the basic set of research guidelines we have detailed in Chapter three, which include:

- piloting
- randomisation and pairing of controls (except where this is impossible);
- collection of adequate baseline data; and
- monitoring and measurement of pre-determined health-related outcomes within a set period of time.

362. It is very disappointing that the Department's latest initiative, *Healthy Towns*, has failed to follow these principles.

Resource allocation and health inequalities

363. The Department of Health is responsible for allocating resources to the NHS. As we showed in chapter four, the resource allocation model used by the Government seeks to equalise the funding available to PCTs in relation to proxies for need, and has had a major effect on the funding PCTs receive; in 2009–10, the neediest PCTs are to receive almost 70% more money per head than the least needy. However, many PCTs have not yet received their full needs-based allocations. The Government must move more quickly to ensure PCTs receive their real target allocations.

364. Trade offs exist between redistribution of health resources to tackle health inequalities, and the NICE model of distribution, based on investing in the most cost-effective treatment for the whole populations. These trade offs have never been explicitly articulated and examined and we recommend that they should be. There needs to be a wide debate about the public willingness to shift resources to those socio-economic groups with the poorest health.

365. In addition, as we have recommended previously, more needs to be known about the treatments and services which are displaced to fund the new treatments recommended by NICE. A first step in this process would be to assess the added cost of NICE guidance on each PCT in England—research which we recommend the Government should fund immediately.

366. The Government must also track the money which is spent to tackle health inequalities and what it is spent on, both funds specifically allocated for health inequalities initiatives, and mainstream funding that is directed towards this. As a useful first step the Department of Health should commission an in-depth study in a small sample of PCTs.

Specific health inequalities initiatives

367. The Government has introduced specific policies to tackle health inequalities. As we saw in chapter five, two of particular importance were establishing:

- Health inequalities targets; and
- Surestart.

Targets

368. In aiming to reduce health inequalities by 10% in ten years, the Government has introduced a target which is arguably the toughest anywhere in the world, and which has received international plaudits. Despite the likelihood that the target will be missed, we believe that aspirational targets such as this can prove a useful catalyst to improvement, and we therefore recommend that the commitment be reiterated for the next ten years.

369. However, there remain significant problems with the data used to monitor progress against this target. The infant mortality aspect of the target does present difficulties. There are now so few infant deaths in each spearhead area that comparing infant mortality between these areas has severe limitations. We recommend that the Government review the infant mortality component of the health inequalities target and replace it with a more meaningful measure.

370. Health inequalities have many facets—health is unequal according not only to social class, but to gender, ethnicity, disability and mental health status, to name only a few. There is concern that the elderly receive worse treatment. It is crucial that the Government's focus on socio-economic inequalities alone does not lead to other aspects of health inequalities going unnoticed and ignored. We were pleased to see that some local areas already focus on health inequalities related to ethnicity as appropriate to their local populations; however there is little to suggest that health inequalities relating to age, gender, disability or mental health status are even being adequately measured let alone addressed, and we recommend that the Government rectify this.

Sure Start, Children's Centres and the early years

371. We commend the Government for taking positive steps to place early years at the heart of policy to address health inequalities through Sure Start. As we have already discussed, many witnesses were very positive about the benefits of Sure Start. National evaluation shows that it has enjoyed some success, however, we must sound a note of caution that Sure Start has still not demonstrated significant improvements in health outcomes or health inequalities for either children or parents. This policy, originally introduced to specifically target those in deprived areas, is now being extended, without any prior piloting, to all areas of the country regardless of level of deprivation. It is absolutely essential that early years interventions remain focused on those children living in the most deprived circumstances, and the impact of Children's Centres must be rigorously monitored.

The role of the NHS in tackling health inequalities

372. The NHS has the capacity to tackle health inequalities by providing excellent services targeted at, and accessible to those that need them. Chapter X considered a number of ways this might best be done.

Effective interventions

373. Treatment, screening, and interventions to change health behaviours are the key tools available to the NHS for tackling health inequalities. Whilst evidence exists to support the clinical effectiveness of some interventions, such as prescribing of antihypertensive and cholesterol-reducing drugs, less is known about their cost effectiveness, and in particular about how to ensure they are targeted towards those in the lowest socio-economic groups so that they actually have an impact on health inequalities. The Government is to introduce vascular checks; we urge it to do so with great care, and according to the steps outlined in chapter three, so that it does not waste another crucial opportunity to rigorously evaluate the effectiveness and cost effectiveness of this screening programme.

374. Getting people to adopt a healthy lifestyle is widely acknowledged to be difficult, and evidence suggests that traditional public information campaigns are not successful with lower socio-economic or other hard-to-reach groups—in fact we were told that these interventions can actually widen health inequalities because richer groups respond better to health promotion messages. Social marketing is heralded as an approach that allows messages to be communicated in more tailored and evidence based ways. We have not seen firm evidence to support this claim, and we recommend that social marketing interventions are evaluated to ascertain their success. There is sound evidence to support brief, opportunistic interventions in primary and secondary care, such as advice from GPs to give up smoking, followed by referral to more specialist health promotion services. However further steps are needed to ensure that the most heavily addicted smokers, who are often those from the lowest socio-economic groups, benefit fully from these interventions.

Primary care services

375. Primary care services are at the frontline of tackling health inequalities; we received many suggestions for additions to the QOF points system. It is clear that the QOF needs radical revision to fully take account of health inequalities, and we therefore recommend that tackling health inequalities should be an explicit objective during annual QOF negotiations. In particular, the QOF needs to provide more incentives to stop smoking. However, additions to the QOF may be costly and this can only be done if other things are removed.

Secondary and specialist services

376. Primary care is the chief target of most efforts to tackle health inequalities through improving NHS services; however, in solely focusing on this, there is a real risk that inequalities in other NHS services will persist, and that the great opportunities which exist throughout in secondary care and specialised services to tackle inequalities will be missed. We recommend that the role of secondary care in tackling health inequalities should be

specifically considered by Professor Sir Michael Marmot's forthcoming review, and this should include consideration of including tackling health inequalities as part of the Payment by Results framework and/ or the Standards for Better Health.

NHS Early years services—health visiting and midwifery

377. We have been told repeatedly that the early years offer a crucial opportunity to 'nip in the bud' health inequalities that will otherwise become entrenched and last a lifetime. While there is little evidence about the cost-effectiveness of current early years services, it seems odd that numbers of health visitors and midwives are falling, and members of both those professions report finding themselves increasingly unable to provide the health promotion services needed by the poorest families, at the same time as the Government reiterates its commitments to early-years' services. The Department must undertake research to find out the consequences of the decline in numbers of health visitors and midwives and to consider whether some aspects of the health promotion role played by midwives and health visitors could be effectively done by other types of staff.

PCTs and SHAs

378. PCTs and SHAs should play a central role in informing and co-ordinating efforts to tackle health inequalities. However, our evidence has not suggested that they are currently providing the leadership that might be expected of them.

Tackling health inequalities across other sectors and departments

379. Many of the causes of health inequalities are outside the direct areas of health and health policy, the NHS and the Department of Health still have a valuable role to play in providing leadership across all sectors and government departments to promote joined up working to tackle health inequalities. As we set out in chapter seven, criteria need to be established by which their success in doing this is systematically and explicitly evaluated, possibly by adding this to the Cabinet Office reviews of the performance of Whitehall Departments.

Cookery and nutrition in schools

380. We welcome recent improvements in school meals and the introduction of compulsory cookery lessons, but we remain concerned about low rates of school meal take-up, and also about the lack of any data about whether the poorest children are benefiting from a healthy meal. We recommend that the Government closely monitors take-up of school meals and analyses this by socio-economic group. We also recommend that free ingredients should be provided for all school cookery lessons; it is unlikely that all children will bring the ingredients with them.

Food labelling

381. We are appalled that, four years after we first recommended it, the Government and FSA are continuing to procrastinate about the introduction of traffic-light labelling to make the nutritional content of food clearly comprehensible to all. In the light of resistance

by industry, and given the urgency of this problem, we recommend that the Government legislate to introduce a statutory traffic light labelling system. A traffic light labelling system should also be introduced for all food sold in takeaway food outlets as well; currently food purchased from such outlets, despite often being very high calorie, does not have any nutritional labelling at all. The Government should consider the best ways of providing information about the nutritional content of food bought from restaurants.

Health promotion in schools

382. We were told by the DCSF of several apparently ‘successful’ initiatives to provide wider health and social support in schools, such as the Extended Schools and Healthy Schools initiatives. However to date there has been no evaluation of the impact of these programmes on health or health inequalities. If the Government wishes to claim that it is actively engaged in the health inequalities agenda, it must be prepared to back this up with hard evidence of whether its policies are actually influencing health outcomes, together with information on their costs and cost effectiveness. We recommend that the Department of Health and DCSF collaborate to produce quantitative indicators and to set targets for the Healthy Schools programme.

The built environment

383. The built environment affects every aspect of our lives. During the inquiry we heard many concerns: high streets awash with fast food outlets, flagship health centres located ‘at random’ and planning policies which have created towns and cities dominated by the car, with out-of-town supermarkets and hospitals, which have discouraged walking and cycling. In our view, health must be a primary consideration in planning decisions. To ensure that this happens, we recommend

- The publication of a Planning Policy Statement on health, which should encourage walking and cycling and enable local planning authorities to restrict the number of fast food outlets
- that PCTs should be made statutory consultees for local planning procedures;

We recommend that the Government increase the proportion of the transport budget currently spent on walking and cycling.

Tobacco control

384. Smoking remains one of the biggest causes of health inequalities; we welcome both the Government’s ban on smoking in public places, and its intention to ban point of sale tobacco advertising, as evidence indicates that both of these measures may have a positive impact on health inequalities. Unfortunately, tobacco smuggling, by offering smokers half price cigarettes, negates the positive impact of pricing and taxation policies. Tobacco smuggling has a disproportionate impact on the poor, particularly young smokers. Some progress has been made in this area but not enough; there has been no progress at all in reducing the market-share of smuggled hand-rolled tobacco, which is smoked almost exclusively by those in lower socio-economic groups. We recommend the reinstatement of tough targets and careful monitoring of them following the transfer of this crucial job has

passed to UKBA, to ensure that it remains a sufficiently high priority. We also recommend that the UK signs up to the agreements to control supply with the tobacco companies Philip Morris International and Japan Tobacco International as a matter of urgency.

Conclusions and recommendations

Extent and causes of health inequalities

1. Health in the UK is improving, but over the last ten years health inequalities between the social classes have widened—the gap has increased by 4% amongst men, and by 11% amongst women. Health inequalities are not only apparent between people of different socio-economic groups—they exist between different genders, different ethnic groups, and the elderly and people suffering from mental health problems or learning disabilities also have worse health than the rest of the population. The causes of health inequalities are complex, and include lifestyle factors—smoking, nutrition, exercise to name only a few—and also wider determinants such as poverty, housing and education. Access to healthcare may play a role, but this appears to be less significant than other determinants. (Paragraph 49)

Designing and evaluating policy effectively

2. The most damning criticisms of Government policies we have heard in this inquiry have not been of the policies themselves, but rather of the Government's approach to designing and introducing new policies which make meaningful evaluation impossible. As one witness described, "there is a continual procession of area-based initiatives and that in itself is quite disruptive. Nothing is given time to really bed in and function" Even where evaluation is carried out, it is usually "soft", amounting to little more than examining processes and asking those involved what they thought about them. All too often Governments rush in with insufficient thought, do not collect adequate data at the beginning about the health of the population which will be affected by the policies, do not have clear objectives, make numerous changes to the policies and its objectives and do not maintain the policy long enough to know whether it has worked. As a result, in the words of one witness, 'we have wasted huge opportunities to learn'. (Paragraph 75)
3. Governments have spent large sums of money on social experiments to reduce health inequalities, but we do not know whether these experiments have worked or whether the money has been well spent. The latest initiative on Healthy Towns has all the failings of previous policies, indicating that the Government has learnt nothing from past mistakes. (Paragraph 76)
4. There is an ethical imperative to develop and use evidence-based policy. All the reforms we have discussed are experiments on the public and can be as damaging (in terms of unintended effects and opportunity cost) as unevaluated new drugs or surgical procedures. Such wanton large-scale experimentation is unethical, and needs to be superseded by a more rigorous culture of piloting, evaluating and using the results to inform policy. (Paragraph 77)
5. Simple changes to the design of policies and how they are introduced could make all the difference. We recommend that all future initiatives to tackle health inequalities initiatives must, prior to their introduction, demonstrate adherence to the basic set of research guidelines we have detailed in this chapter, which include:

- Piloting;
 - randomisation and pairing of controls;
 - use of quasi-experimental methods with controls where randomisation would be too costly;
 - collection of adequate baseline data; and
 - monitoring and measurement of pre-determined health-related outcomes within a set period of time, and in relation to cost. (Paragraph 78)
6. Professor Sir Michael Marmot's forthcoming review on health inequalities offers the ideal opportunity for the Government to demonstrate its commitment to rigorous methods for introducing and evaluating new initiatives in this area which are ethically sound and safeguard public funds. (Paragraph 79)

Funding for health inequalities

7. Trade offs exist between redistribution of health resources to tackle health inequalities—as happens through the formula which the Department of Health uses to distribute funds to PCTs, and the NICE model, which influences PCTs' spending by recommending certain treatments and interventions on the grounds of cost-effectiveness on a population basis. These trade offs have never been explicitly articulated and examined and we recommend that they should be. Professor John Harris said “if rationing is inevitable, let us ration in some fair way ... you have to look at the whole range of health care”. How far the majority of the population is willing to forgo health care to switch resources to the most needy is a moral question which requires a wide debate. (Paragraph 105)
8. As we have stated in previous reports, more needs to be known about the relative cost effectiveness of treatments and services that are displaced to fund the new treatments recommended by NICE. A first step in this process would be to research the cost of implementing NICE guidance in each PCT in England—which we recommend the Government should fund immediately. (Paragraph 106)
9. The resource allocation model used by the Government seeks to equalise the funding available to PCTs in relation to proxies for need. It has had a major effect on the funding PCTs receive; the neediest PCTs receive almost 70% more money per head than the least needy. However, many PCTs have not yet received their full needs-based allocations. The Government must move more quickly to ensure PCTs receive their real target allocations. (Paragraph 107)
10. Furthermore, money that was intended to be spent on preventive health promotion programmes which may have reduced health inequalities has instead been spent by PCTs on the acute sector in times of financial difficulty. (Paragraph 108)
11. Suggestions for protecting the NHS public health budget included a return to ring fencing, or relocation of public health budgets in local authorities rather than PCTs. We also heard that PCTs' current funding constraints, including one-year financial cycles and inability to retain and invest surpluses, should be removed in the interests

of enabling more long-term investment in health inequalities. We did not receive enough evidence on these specific points to be able to recommend them. (Paragraph 109)

12. The Government has not made even basic calculations about how much has been spent on tackling health inequalities. We recommend that the Department of Health find out both how far PCTs spend the funds they received under the resource allocation formula on tackling health inequalities and what funds specifically allocated for health inequalities initiatives are spent on, and the health outcomes achieved. As a first step the Department should commission an in-depth study of health inequalities funding in a small sample of PCTs. (Paragraph 110)
13. PCTs do not have adequate knowledge about how money should be spent to best tackle health inequalities, and we recommend investment in the systematic evaluation of policy initiatives with a focus on relative cost effectiveness, following the principles set out in chapter three, to inform these difficult choices. (Paragraph 111)

Specific health inequalities initiatives

14. During the course of this inquiry we heard widespread praise and support, both in this country and abroad, for the explicit commitment this Government has made to tackling health inequalities. This commitment has involved a framework of specific policies, underpinned by a challenging and ambitious target. We would like to emphasise our support and commendation for the Government for taking specific actions to tackle health inequalities, although, as we have written, we are critical of aspects of planning and evaluation (Paragraph 113)
15. Health Action Zones were an ambitious initiative that could not achieve the extremely challenging targets that were set for them in the short time they were in existence. We have heard that they were a victim of many of the problems with policy design and implementation documented previously—they were both under funded in relation to their objectives, and ill-thought through. (Paragraph 119)
16. The early years period was emphasised throughout our inquiry as a crucial focus for efforts to tackle health inequalities, and we commend the Government for taking positive steps to place early years at the heart of the health inequalities agenda through Sure Start. Many witnesses were very positive about the benefits of Sure Start. National evaluation shows that it has enjoyed some success, but it has yet to demonstrate significant improvements in health outcomes for either children or parents, achieving positive evaluation in only 5 out of 14 measures that were studied. (Paragraph 137)
17. Moreover, there is concern that extending this policy, via Children's Centres, to all areas of the country, risks distracting from the original focus of deprived families who are most in need of support. We did not receive detailed evidence about the evolution of Sure Start programmes into Children's Centres, but again this is a policy change that has not been properly piloted or evaluated prior to its introduction. It is absolutely essential that early years interventions remain focused on those children

living in the most deprived circumstances, and Children's Centres must be rigorously monitored on an ongoing basis. (Paragraph 138)

18. It is likely that the Government's health inequalities target will be missed. This is unsurprising since it is the toughest target adopted anywhere in the world. Despite this likelihood, we agree with the HCC that aspirational targets such as this can prove a useful catalyst to improvement. We commend the Government for its adoption of this target and we recommend that the commitment be reiterated for the next ten years. (Paragraph 159)
19. Health inequalities have many facets—health is unequal according not only to social class, but to gender, ethnicity, age, disability and mental health status, to name only a few. It is crucial that the Government's focus on socio-economic inequalities alone does not lead to other aspects of health inequalities going unnoticed and ignored. We were pleased to see that some local areas already focus on health inequalities related to ethnicity as appropriate to their local populations; however there is little to suggest that health inequalities relating to either gender, age or to mental health status are even being adequately measured let alone addressed. A wider range of inequalities should be measured. Such measurements should include not just unequal outcomes in terms of length and quality of life, but should also examine unequal access which would lead to unequal outcomes. We have also heard that there are statistical problems with the infant mortality target because there are so few infant deaths in each area. We recommend that this target be reconsidered. We recommend that the best ways to measure and target health inequalities be investigated by Sir Michael Marmot's forthcoming review. (Paragraph 160)
20. In 2003, the Treasury's Cross-Cutting review set out a seemingly ambitious plan of action across government departments to tackle health inequalities; however, we were told that this was simply an attempt to "map existing policies" on to the target, with little thought given to what would actually work. Five years on, the measures listed in the Cross-Cutting review have not delivered what they promised—although almost all the indicators have been achieved, we are still as far as ever from actually reducing health inequalities. (Paragraph 161)
21. Despite much hype and considerable expenditure we have not seen the evidence to convince us that any of the specific support given to deprived areas to tackle health inequalities has yielded positive results. Spearhead status on its own appears to have done little to galvanise areas to tackle health inequalities. Support is now being offered by the National Support Team, but although PCTs have welcomed this, there is little evidence to suggest it is or will be an effective intervention. We are also concerned that this was only introduced six years after the target was announced, and we consider that it would have been more logical and effective to have offered central support to PCTs to achieve this critical target right from the beginning. (Paragraph 170)

The role of the NHS in tackling health inequalities

22. Treatment, screening, and interventions to change health behaviours are the key tools available to the NHS for tackling health inequalities. Preventive prescribing of

antihypertensive and cholesterol-reducing drugs have already been identified and promoted by the Government as an effective approach to tackling health inequalities, and the Government has also announced that a large-scale vascular screening programme will be introduced. However, whilst some evidence exists to support the clinical effectiveness of some of these interventions, less is known about their cost effectiveness, and in particular about how to ensure they are targeted towards those in the lowest socio-economic groups so that they actually have an impact on health inequalities. We urge the Government to plan the introduction of vascular checks with great care, and according to the steps outlined in Chapter 3, so that it does not waste another crucial opportunity to rigorously evaluate the effectiveness and cost effectiveness of this screening programme. (Paragraph 200)

23. Changing health behaviour is widely acknowledged to be difficult, and evidence suggests that traditional public information campaigns are less successful with lower socio-economic or other hard-to-reach groups—in fact we were told that these interventions can actually widen health inequalities because richer groups respond to them so well. Social marketing is heralded as an approach that allows messages to be communicated in more tailored and evidence based ways. We have not seen firm evidence to support this claim, and we recommend that social marketing interventions are evaluated to ascertain their success. A sound evidence base does exist to support brief, opportunistic interventions in primary and secondary care, followed by referral to more specialist health promotion services. However, it seems that further steps are needed to ensure that the most heavily addicted smokers, who are often those from the lowest socio-economic groups, benefit fully from these interventions. This will have implications for the training of NHS staff and others. (Paragraph 201)
24. PCTs and SHAs should play a central role in informing and co-ordinating efforts to tackle health inequalities. However, our evidence has not suggested that they are currently providing the leadership that might be expected of them. We have been told that numbers of senior public health specialists working in these organisations are falling; while public health specialists clearly have not demonstrated progress in tackling health inequalities to date, and we have not seen evidence specifically supporting their effectiveness in this role, it is concerning that the section of the NHS workforce probably most able to provide good leadership for tackling health inequalities is in decline, and we recommend that the government monitor this trend closely. Nor did we see any evidence to suggest that the drive towards ‘World Class Commissioning’ is likely to have a measurable impact on health inequalities in the near future. (Paragraph 218)
25. Access to high quality health services is an important responsibility of PCTs and SHAs, and the Government has advertised its drive to improve access to GP services as part of its policy to tackle health inequalities. The extra GPs that are to be introduced into deprived areas which are under-doctored are welcomed, unless they are being relocated from other deprived areas, which would simply move rather than solve the problem. However, most of our evidence suggests that while access to healthcare is important, it is not high on the list of priorities for tackling health inequalities; indeed research has said that England compares well to other countries in this regard. We are also concerned that the central edict for all PCTs to introduce

a GP-led health centre has not involved due consideration of either need or inequalities, and that in fact centralising GP services may make access more difficult for lower socio-economic groups. We recommend that Sir Michael Marmot's review should examine the issue of access to healthcare closely, paying particular attention to claims of 'institutional ageism' and that access is worse for those suffering from mental health problems and learning disabilities. (Paragraph 219)

26. We also recommend that wherever local primary care services are lost because of the introduction of GP-led health centres, the impact of this on the most needy and vulnerable groups should be carefully monitored by PCTs and steps taken, if necessary, to revert to traditional, more local patterns of service delivery. (Paragraph 220)
27. General Practice is at the frontline of tackling health inequalities; evidence from QOF data suggests that those practices in deprived areas are performing well in difficult circumstances. QOF has made a start in tackling inequalities, covering most of its major causes but with modest targets. However, we were told that the fact that the performance of GPs in deprived areas had caught up with that of GPs in more affluent areas was actually a fortuitous 'side effect' of QOF, and that the QOF had not been designed to address health inequalities. We received many suggestions for additions to the QOF points system. It is clear that the QOF needs radical revision to fully take greater account of health inequalities and to improve its general focus on the product of patient health. We therefore recommend that tackling health inequalities should be an explicit objective during annual QOF negotiations and that this objective should have measurable characteristics which can be evaluated over time. The QOF should be adjusted so that less weight is placed on identifying smokers and more weight placed on incentives to stop smoking. (Paragraph 235)
28. Primary care is the chief target of most efforts to tackle health inequalities through improving NHS services; however, in solely focusing on this, there is a very real risk that inequalities in other NHS services will persist, and that the great opportunities that exist throughout the rest of the NHS to tackle inequalities will be missed. We heard evidence that the physical health needs of mental health patients are almost entirely ignored by specialist mental health services, leading to shocking health differences between mental health patients and the rest of the population. We find it scandalous that hospital patients—even those hospitalised for smoking-related illness—are not being referred to smoking cessation services—this was offered to only one third of smokers in one trust surveyed by ASH. In our view these examples are likely to represent only the tip of the iceberg in terms of missed opportunities to tackle health inequalities away from primary care. We recommend that the role of secondary care in tackling health inequalities should be specifically considered by Professor Sir Michael Marmot's forthcoming review, and this should include consideration of including tackling health inequalities as part of the Payment by Results framework and/ or the Standards for Better Health. (Paragraph 245)
29. We have been told repeatedly that the early years offer a crucial opportunity to 'nip in the bud' health inequalities that will otherwise become entrenched and last a lifetime. While there is little evidence about the cost-effectiveness of current early years services, it seems odd that numbers of health visitors and midwives, currently

the main providers of early years' services, are falling, and members of both those professions report finding themselves increasingly unable to provide the health promotion services needed by the poorest families at the same time as the Government reiterates its commitments to early years services. The Department of Health must undertake research to find out the consequences of the decline in numbers of health visitors and midwives and to consider whether some aspects of the health promotion role played by midwives and health visitors could be effectively done by other types of staff to bolster early years health services. (Paragraph 258)

Tackling health inequalities across other sectors and departments

30. If, as the Secretary of State told us, joined up working between the Department of Health and the DCSF on health inequalities is truly the best in Whitehall, this must mean that elsewhere it is very poor. In our view the DCSF did not display a high level of knowledge about or insight into this area, and it seemed that few attempts had been made at evaluation of the health impacts of DCSF policies to date, suggesting to us that health inequalities are not a particularly high priority on this Department's agenda. (Paragraph 268)
31. Many measures are now in place to align the objectives of PCTs and LAs towards tackling health inequalities and to promote joined-up working. The introduction in some areas of jointly appointed Directors of Public Health is to be welcomed. However, the evidence we received suggested that there is a great deal of work still needed to translate these objectives into a reality of effective joined-up working between every PCT and its LA, and there are currently no incentives to share data and pool budgets. (Paragraph 274)
32. Jamie Oliver argued that this country is suffering from 'a new kind of poverty', because many people are now unable to give nutritious meals to our families. We were disappointed that the Secretary of State's responses to this—advocating simple health promotion messages—underestimated the challenges of removing the barriers to healthy eating, particularly for more disadvantaged groups. In reality, those people need cheap and convenient access to healthy food, rather than a multiplicity of takeaways on their high street; they need easily comprehensible nutrition labels on the food they buy; and they need the skills to cook healthy meals. Children need a guarantee of at least one healthy meal a day at school. (Paragraph 293)
33. We welcome recent improvements in school meals, but we remain concerned about their low rates of take-up, and also about the lack of any data about whether the poorest children are benefiting from a healthy meal. We recommend that the DCSF closely monitors take-up of school meals and analyses this by socio-economic group. (Paragraph 294)
34. Cooking lessons are to be made compulsory, but, unlike in other practical lessons such as science where equipment is provided, pupils will need to buy and bring in their own ingredients. We think it likely that many pupils will fail to do this. The Government's approach seems to confirm that the proposed cooking lessons are still seen as an 'added extra' rather than a government priority. We recommend that free ingredients be provided for all school cookery lessons. (Paragraph 295)

35. We are appalled that, four years after we first recommended it, the Government and FSA are continuing to procrastinate about the introduction of traffic-light labelling to make the nutritional content of food clearly comprehensible to all. In the light of resistance by industry, and given the urgency of this problem, we recommend that the Government legislate to introduce a statutory traffic light labelling system. This should apply to food sold in takeaway food outlets and restaurants as well; currently food purchased from such outlets, despite often being very high calorie, does not have any nutritional labelling at all. (Paragraph 296)
36. We are pleased that, five years after we first recommended it, Personal Social and Health Education (PSHE) is finally being made a statutory part of the national curriculum. However, we still have the same concerns we had five years ago about the lack of specialist teachers and assessment in this area; pupils should have PSHE taught by someone who has received a appropriate training, whether this be a teacher, health visitor, school nurse, or even a peer educator. In our view OFSTED should carry out an early review of implementation of PSHE, which should include who it is being taught by. We are also very concerned that elements of PSHE may remain at the mercy of 'local discretion' and that schools will be given the option to opt out of certain elements, much as one school, shockingly, has already opted out of providing its pupils with the HPV vaccine. (Paragraph 317)
37. We were told by the DCSF of apparently successful initiatives to provided wider health and social support in schools, such as the Extended Schools and Healthy Schools initiatives. However, we were deeply concerned that no evaluation has yet been published of the Healthy Schools initiative, despite it now being in its tenth year of operation, and that claims of success are based on the whether or not schools report finding the programme 'positive', while levels of childhood obesity, teenage pregnancy and smoking are persistently high. If the Government wishes to claim that the DCSF is actively engaged in the health inequalities agenda, it must be prepared to back this up with hard evidence of whether its policies are actually influencing health outcomes, together with information on their costs and cost effectiveness. We recommend that the DCSF and the Department of Health collaborate to produce quantitative indicators and to set targets for the Healthy Schools programme at the earliest opportunity. (Paragraph 318)
38. The built environment has a crucial impact on health and on health inequalities and affects every aspect of our lives. We are concerned that it does not encourage good health. Particular problems raised with us were;
 - The built environment often discourages walking and cycling;
 - High streets are awash with fast food outlets but have too little access to fresh food;
 - Flagship health centres have been located at random, with little systematic consideration of access or need; London PCTs have recently announced that they will evaluate the first of their polyclinics to see whether they are making a difference to healthcare and access, and this would seem to be an

ideal opportunity to evaluate their impact on health inequalities. (Paragraph 340)

39. We are disappointed by Government priorities which, according to its own Foresight Obesity team, seem more concerned with promoting gym membership than promoting active travel through redesign of the built environment which would have been far more effective for all socio-economic groups. (Paragraph 341)
40. In our view, health must be a primary consideration in every planning decision that is taken, and to ensure that this happens, we recommend that
 - in collaboration with the Department of Health, DCLG should publish a Planning Policy Statement on health; this Statement should require the planning system to create a built environment that encourages a healthy lifestyle, including giving local authorities the powers to control the numbers of fast food outlets.
 - PCTs should be made statutory consultees for local planning decisions; PCTs, for their part, need to ensure they have the knowledge of cost effectiveness of alternative policies and resources to make an informed contribution to such decisions. (Paragraph 342)
41. We recommend that the Government increase the proportion of the transport budget currently spent on walking and cycling. (Paragraph 343)
42. Smoking remains one of the biggest causes of health inequalities; we welcome both the Government's ban on smoking in public places, and its intention to ban point of sale tobacco advertising, as evidence suggests that both of these measures may have a positive impact on health inequalities. However, tobacco smuggling, by offering smokers half price cigarettes, negates the positive impact of pricing and taxation policies. Tobacco smuggling has a disproportionate impact on the poor, particularly young smokers. Some progress has been made in this area but not enough; there has been no progress at all in reducing the market-share of smuggled hand-rolled tobacco, which is smoked almost exclusively by those in lower socio-economic groups. We recommend the reinstatement of tough targets and careful monitoring now this crucial job has passed to UKBA, to ensure that it remains a sufficiently high priority. We also recommend that the UK signs up to the agreements to control supply with the tobacco companies Philip Morris International and Japan Tobacco International as a matter of urgency. (Paragraph 355)

Formal Minutes

Thursday 26 February 2009

Members present:

Mr Kevin Barron, in the Chair

Charlotte Atkins
Mr Peter Bone
Sandra Gidley
Dr Doug Naysmith

Dr Howard Storate
Mr Robert Syms
Dr Richard Taylor

Draft Report (Health Inequalities), proposed by the Chairman, brought up and read.

Ordered, That the Chairman's draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 384 read and agreed to.

Summary agreed to.

Resolved, That the Report be the Third Report of the Committee to the House.

Ordered, That the Chairman make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be reported to the House for printing with the Report.

Written evidence was ordered to be reported to the House for placing in the Library and Parliamentary Archives.

[Adjourned till Thursday 5 March at 9.30 am]

Witnesses

Thursday 13 March 2008

Dr Fiona Adshead, Deputy Chief Medical Officer and Chief Government Advisor on Health Inequalities, **Mr Mark Britnell**, Director General, Commissioning and System Management, and **Ms Una O'Brien**, Director of Policy and Strategy, Department of Health

Thursday 27 March 2008

Dr Anna Dixon, Acting Director of Policy, The King's Fund, **Professor Hilary Graham**, Professor of Health Sciences, University of York, and **Professor Margaret Whitehead**, Professor of Public Health, University of Liverpool

Professor Kay-Tee Khaw, Professor of Clinical Gerontology, University of Cambridge, **Professor Richard Wilkinson**, Professor of Social Epidemiology, University of Nottingham, and **Professor Sir Michael Marmot**, Professor of Epidemiology and Public Health, University College London, and Chairman, Commission on Social Determinants of Health

Thursday 3 April 2008

Dr Jacky Chambers, Director of Public Health, Heart of Birmingham Teaching PCT, **Ms Alwen Williams**, Chief Executive, Tower Hamlets PCT, and **Mr David Stout**, Director of PCT Network, NHS Confederation

Dr Paula Grey, Joint Director of Public Health, Liverpool PCT/Liverpool City Council, **Mr Andy Hull**, Divisional Manager, Public Protection and Regeneration, Liverpool City Council, and **Mr Jamie Rentoul**, Head of Strategy, Healthcare Commission

Wednesday 30 April 2008

Professor Ken Judge, University of Bath, **Professor Mike Kelly**, Director, Centre for Public Health Excellence, National Institute for Health and Clinical Excellence, and **Professor Sally Macintyre**, Director, MRC Social and Public Health Sciences Unit

Professor Edward Melhuish, Birkbeck, University of London, Director, National Evaluation of Sure Start, **Ms Pauline Naylor**, Programme Manager, Sure Start Barkerend Children's Centre, **Mr Richard Sharp**, West Ham and Plaistow, New Deal for Communities, and **Ms Frances Rehal**, Director/Chief Executive Officer, Sure Start Millmead Children's Centre

Thursday 22 May 2008

Professor Alan Maryon-Davis, President, Faculty of Public Health, **Professor Julian Le Grand**, Chair, Health England, and **Dr Susan Jebb**, Foresight Obesity Project

Mr Paul Jenkins, Chief Executive, Rethink, **Ms Saranjit Sihota**, Head of Public Policy, Diabetes UK, and **Ms Deborah Arnott**, Director, ASH

Thursday 5 June 2008

Dr Hamish Meldrum, Chairman of Council, British Medical Association, **Professor Martin Roland**, Director, National Primary Care Research and Development Centre, and **Dr Julian Tudor Hart**, retired GP and Research Fellow, University of Wales

Professor James Nazroo, Professor of Sociology, University of Manchester, **Ms Margit Physant**, Health Policy Adviser, Age Concern, and **Mr Peter Baker**, Chief Executive, Men's Health Forum

Thursday 23 October 2008

Professor Peter C Smith, Professor of Health Economics, **Professor Mark Sculpher**, Professor of Health Economics, University of York, and **Professor John Harris**, Professor of Bioethics, University of Manchester

Ms Christine Bidmead, Health Visitor, South London and Maudsley NHS Foundation Trust, **Professor Kaye Wellings**, Professor of Sexual and Reproductive Health, London School of Hygiene and Tropical Medicine, and **Professor Jane Sandall**, Professor of Midwifery and Women's Health, King's College London

Wednesday 5 November 2008

Mr Jamie Oliver, Chef and Broadcaster

Thursday 6 November 2008

Mr Mike Eland, Director General of Enforcement and Compliance, HM Revenue and Customs, and **Brodie Clark**, Head of the Border Force, UK Border Agency

Mr Rob Ballantyne, Independent Planning and Health Consultant, and **Mr Neil Blackshaw**, Head, NHS London Healthy Urban Development Unit

Thursday 13 November 2008

Baroness Morgan of Drefelin, a Member of the House of Lords, Parliamentary Under Secretary of State, and **Noreen Graham**, Deputy Director for the Pupil Well-being Health and Safety Unit, Department for Children, Schools and Families

Ms Gill Fine, Director of Consumer Choice and Dietary Health, and **Mrs Rosemary Hignett**, Head of Nutrition Division, Food Standards Agency

Wednesday 19 November 2008

Rt Hon Alan Johnson MP, Secretary of State, and **Mr Hugh Taylor CB**, Permanent Secretary, Department of Health

List of written evidence

The following memoranda were published as *Health Inequalities: Written evidence*, HC 422–II, Session 2007–08

HI

- 1 Department of Health
- 2 Imperial College Faculty of Medicine
- 3 Adam Oliver
- 4 GlaxoSmithKline
- 5 Dr Richard Cookson
- 6 Diana Moss
- 7 Thames Ditton Women's Institute
- 8 McCain Foods (GB) Ltd
- 9 North West ASH
- 10 Dr Gilles de Wildt
- 11 Dr Sebastian Kraemer
- 12 Public Management Associates
- 13 fpa
- 14 Nuffield Council on Bioethics
- 15 The British Thoracic Society
- 16 Infants and Dietetic Foods Association
- 17 Dr Jonathan Orrell
- 18 South Asian Health Foundation
- 19 Royal College of Physicians' Clinical Standards Department
- 20 Weight Watchers (UK) Ltd
- 21 Faculty of Public Health
- 22 Roche Diagnostics
- 23 Men's Health Forum
- 24 Smokefree North West
- 25 Royal College of Paediatrics and Child Health (RCPCH)
- 26 Cancer Research UK
- 27 Medact
- 28 British Fluoridation Society
- 29 Socialist Health Association
- 30 Ophthalmic Public Health Group at the Royal College of Ophthalmologists and
The VISION2020UK Primary Care Group
- 31 Joint Epilepsy Council of the UK and Ireland
- 32 British Heart Foundation
- 34 Professor Ken Judge, Dean of the School for Health, University of Bath
- 35 Clinical Solutions
- 36 ADASS
- 37 National Institute for Health and Clinical Excellence
- 38 Bowel Cancer UK
- 39 Global Health Advocacy Project (GhAP)

- 40 Diabetes UK
- 41 Professor Jill JF Belch, Professor Gerry Stansby, Mr Michael Gough, Mr Jonothan Earnshaw, Professor Cliff Shearman, and Professor Gerry Fowkes
- 42 Children's Heart Federation
- 43 Philip Morris Limited
- 44 Royal College of Midwives
- 45 Heart of Mersey
- 46 Roche Products Limited
- 47 Bristol Myers Squibb and sanofi-aventis
- 48 Unite the Union (Amicus Section)
- 49 Foyer Federation
- 50 British Lung Foundation
- 51 Mencap
- 52 Football Foundation
- 53 Improvement Foundation Limited
- 54 Professor Hilary Graham, University of York
- 55 National AIDS Trust
- 56 Royal College of Nursing
- 57 The Royal Society of Health, The Royal Institute of Public Health and the National NGO Forum
- 58 Prostate Cancer Charter for Action
- 59 Age Concern
- 60 Lloydspharmacy
- 61 Chronic Pain Policy Coalition
- 62 The Assura Group
- 63 Action on Smoking and Health (ASH)
- 64 Royal Pharmaceutical Society of Great Britain
- 65 Alliance Boots
- 66 Asthma UK
- 67 Royal College of Physicians
- 68 British Dental Association
- 69 Association of Directors of Public Health
- 70 Slimming World
- 71 Arthritis Care
- 72 Terrence Higgins Trust
- 73 H E A R T UK
- 74 Every Disabled Child Matters
- 75 Oxford Health Alliance
- 76 Professor Sarah Cowley
- 77 UK Public Health Association
- 78 National Consumer Council and National Social Marketing Centre
- 79 Whizz-Kidz
- 80 National Infertility Awareness Campaign
- 81 Help the Aged
- 82 Sickle Cell and Young Stroke Survivors (SCYSS)
- 83 British Medical Association

- 84 Dr Ramesh Bhatt
- 85 Healthcare Commission
- 86 NHS Sickle Cell and Thalassaemia Screening Programme
- 87 Association of Public Health Observatories (APHO)
- 88 Rethink
- 89 National Heart Forum
- 90 CBI
- 91 The NHS Confederation
- 92 Pfizer Limited
- 93 The Association of the British Pharmaceutical Industry
- 94 The MODEL (Management of Diabetes for Excellence) Group
- 95 Mayor of London
- 96 Royal College of General Practitioners
- 97 Allen Carr's Easyway to Stop Smoking
- 98 Breakthrough Breast Cancer
- 99 West Midlands Perinatal Institute
- 100 Nick Seddon

List of further written evidence

The following written submissions were received after the publication of *Health Inequalities: Written evidence*, HC 422–II, Session 2007–08. They are reproduced with the Oral evidence in Volume II of this Report.

- 1 Department of Health (HI 01A and 01C)
- 2 Men's Health Forum (HI 23A)
- 3 Unite / CPHVA (HI 48A)
- 4 Mencap (HI 51A)
- 5 Action on Smoking and Health (ASH) (HI 63A)
- 6 Action on Smoking and Health (ASH) (HI 63B)
- 7 Action on Smoking and Health (ASH) (HI 63C)
- 8 Kay-Tee Khaw, Professor of Clinical Gerontology, University of Cambridge School of Clinical Medicine (HI 101)
- 9 National Obesity Forum (HI 102)
- 10 Dignity in Dying (HI 103)
- 11 Professor Sir Michael Marmot, UCL (HI 104)
- 12 Dr Julian Tudor Hart (HI 105)
- 13 Professor Margaret Whitehead (HI 106)
- 14 Professor Richard Wilkinson (HI 107)
- 15 The King's Fund (HI 108)
- 16 Tower Hamlets Primary Care Trust (HI 109)
- 17 Liverpool Primary Care Trust and Liverpool City Council (HI 110)
- 18 Heart of Birmingham Teaching Primary Care Trust (HI 111)
- 19 Sally Macintyre, MRS Social and Public Health Sciences Unit (HI 112, HI 112A and HI 112B)
- 20 Professor Maria Goddard, University of York (HI 113)
- 21 Sure Start Barkerend Children's Centre (HI 114)
- 22 Sure Start Children's Centres, District of Bradford (HI 115)
- 23 National Evaluation of Sure Start (HI 116)
- 24 Millmead Children's Centre Partnership Limited (HI 117)
- 25 Millmead Children's Centre Partnership Limited (HI 117A)
- 26 West Ham and Plaistow New Deal Partnership Limited (HI 118)
- 27 Professor Julian Le Grand, Health England (HI 119)
- 28 Professor James Nazroo, University of Manchester (HI 120)
- 29 Professor Martin Roland, National Primary Care Research and Development Centre (HI 121 and HI 121A)
- 30 Citizens Advice Bureau (HI 122)
- 31 BLISS (HI 123)
- 32 EarlyBird Diabetes Trust (HI 124)
- 33 PROSTaid (HI 125)
- 34 Professor Tony Culyer (HI 126)
- 35 NHS London Healthy Urban Development Unit (HI 127, HI 127A and HI 127B))
- 36 Rob Ballantyne (HI 128 and HI 128A)

- 37 Professor Peter C Smith (HI 129 and HI 129A)
- 38 Professor Sarah Cowley and Christine Bidmead (HI 130)
- 39 Professor Sarah Cowley and Christine Bidmead (HI 130A and HI 130B)
- 40 Professor Jane Sandall (HI 131)
- 41 Professor Mark Sculpher (HI 132)
- 42 Professor Kaye Wellings (HI 133)
- 43 Dr Brian Fisher (HI 134)
- 44 Department for Children, Schools and Families (HI 135)
- 45 Department for Children, Schools and Families (HI 135A)
- 46 Food Standards Agency (HI 136)
- 47 Food Standards Agency (HI 136A)
- 48 School Food Trust (HI 137)
- 49 Which? (HI 138)
- 50 HM Revenue & Customs and UK Border Agency, Home Office (HI 139)
- 51 Take Action on Active Travel (HI 140)
- 52 Schering Plough Pharmaceuticals (HI 141)
- 53 Professor Mary Renfrew, University of York (HI 142)
- 54 Myer Glickman (HI 143)

List of unprinted evidence

The following memoranda have been reported to the House, but to save printing costs they have not been printed and copies have been placed in the House of Commons Library, where they may be inspected by Members. Other copies are in the Parliamentary Archives, and are available to the public for inspection. Requests for inspection should be addressed to The Parliamentary Archives, Houses of Parliament, London SW1A 0PW (tel. 020 7219 3074). Opening hours are from 9.30 am to 5.00 pm on Mondays to Fridays.

Department of Health (HI 01B)

List of Reports from the Health Committee

The following reports have been produced by the Committee in this Parliament. The reference number of the Government's response to the Report is printed in brackets after the HC printing number.

Session 2008–09

| | | |
|---------------|-------------------------------|--------|
| First Report | NHS Next Stage Review | HC 53 |
| Second Report | Work of the Committee 2007–08 | HC 193 |

Session 2007–08

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| First Report | National Institute for Health and Clinical Excellence | HC 27 (Cm 7331) |
| Second Report | Work of the Committee 2007 | HC 337 |
| Third Report | Modernising Medical Careers | HC 25 (Cm 7338) |
| Fourth Report | Appointment of the Chair of the Care Quality Commission | HC 545 |
| Fifth Report | Dental Services | HC 289 (Cm 7470) |
| Sixth Report | Foundation trusts and Monitor | HC 833 (Cm 7528) |
| First Special Report | National Institute for Health and Clinical Excellence: NICE Response to the Committee's First Report | HC 550 |

Session 2006–07

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|---------------|---|------------------|
| First Report | NHS Deficits | HC 73 (Cm 7028) |
| Second Report | Work of the Committee 2005–06 | HC 297 |
| Third Report | Patient and Public Involvement in the NHS | HC 278 (Cm 7128) |
| Fourth Report | Workforce Planning | HC 171 (Cm 7085) |
| Fifth Report | Audiology Services | HC 392 (Cm 7140) |
| Sixth Report | The Electronic Patient Record | HC 422 (Cm 7264) |

Session 2005–06

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|---------------|--------------------------------------|------------------|
| First Report | Smoking in Public Places | HC 436 (Cm 6769) |
| Second Report | Changes to Primary Care Trusts | HC 646 (Cm 6760) |
| Third Report | NHS Charges | HC 815 (Cm 6922) |
| Fourth Report | Independent Sector Treatment Centres | HC 934 (Cm 6930) |