

Place Based Approach on Health Inequalities

Definition of Health Inequalities

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. Health inequalities arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health and wellbeing.

Health inequalities have been documented between population groups across at least four dimensions, as illustrated in figure 1 below. It is important to note that these are overlapping dimensions with people often falling into various combinations of these categories.

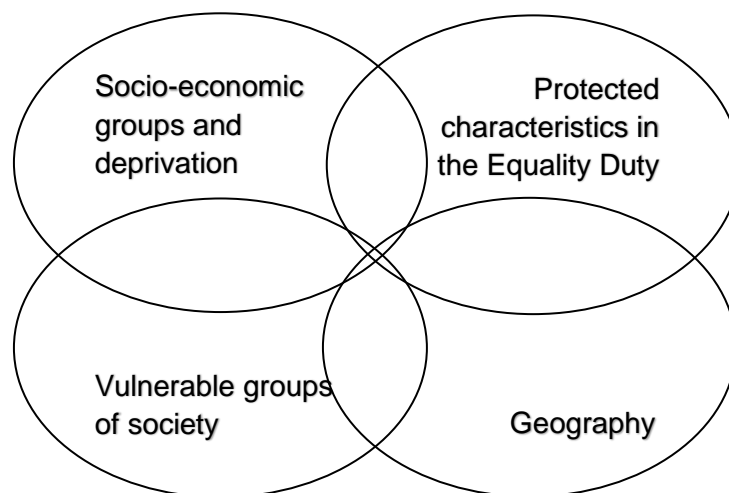


Figure 1 Groups usually considered for health inequalities

Examples of the characteristics of people/communities in each of these groups are below (this is not an exhaustive list):

- Socio-economic status and deprivation: e.g. unemployed, low income, people living in deprived areas (e.g. poor housing, poor education and/or unemployment).
- Protected characteristics: e.g. age, sex, race, sexual orientation, disability (including those with learning disabilities).
- Vulnerable groups of society, or 'inclusion health' groups: e.g. vulnerable. migrants; Gypsy, Roma and Travellers; homeless people; and sex workers.
- Geography: e.g. urban, rural.

Action on health inequalities requires improving the lives of those with the worst health outcomes, fastest.

Context

After decades of progress, since 2011 the improvement in age-standardised mortality rates and life expectancy has slowed down considerably, for both males and females.

The gap in life expectancy between the most and least deprived areas is 9.4 years for males and 7.4 years for females¹. However this gap has recently widened since 2010-12 and the improvement in life expectancy has been slower in more deprived areas than less deprived areas of England². In addition, female life expectancy in the most deprived decile areas has actually decreased. Therefore, the causes of the slowdown in improvement are having the greatest impact in the more deprived areas.

Health is not just about the length of life we live, but also the quality of life. The gap in healthy life expectancy (years lived in good health) between the most and least deprived areas of England was around 19 years for both males and females from 2015-2017³.

These stats provide a strong moral case for action. However organisations also face legal requirements to act on this agenda (as described in annex 1), as well as an economic case for action (set out in annex 2).

Principles for action by NHS on inequalities

- Urgent targeted action is needed on access, experience, and outcomes, as well as joint working with system partners
- Action needs to be place based and link all partners who can influence the wider determinants of health
- We must learn from where places have reduced health inequalities and past places that have made progress

What does success look like on this agenda

- Delivery of all commitments set out in the LT Plan
- A joint system wide approach to addressing health inequalities, developed in conjunction with voluntary sector and communities based on the Place Based Approaches for Reducing Health Inequalities (PBA)
- Local NHS bodies adopt a suite of indicators for inequalities which incentivises action towards the most deprived and vulnerable groups, on conditions management, behaviours and the wider determinants
- Joint and prioritised plans are agreed between LA and NHS bodies that create shared priorities and points of action based on JSNA's or other local data and look at prevention and wider determinants of health
- CCGs in the most deprived areas use their adjusted allocation to reduce inequalities in line with the 'Menu of Interventions' and other evidence
- Local communities are actively involved in the scoping, delivering and evaluation of activities

¹ Public Health England. Health Profile for England. 2018

² Office for National Statistics, 'Health state life expectancies by national deprivation deciles, England and Wales: 2015 to 2017

³ Office for National Statistics, 'Health state life expectancies by national deprivation deciles, England and Wales: 2015 to 2017

- Health and Wellbeing Boards are used to report and govern action on inequalities across place

The sum of all these actions sum up to a place based system that works together to act on the key drivers of health inequalities bespoke their local area which results in sustained population level impacts.

Support available from national teams in NHS E/I and PHE

- Supply intelligence at national level on general approaches (PBA), evidence of what works (Menu) and data sets (e.g. EHI RightCare Packs and PHE's Local Health tool)
- Run workshops at regional and local level to support development of plans and delivery
- Development and roll out of peer-led support offer to local areas
- Share best practise from across the country

Support at regional level

- Support ICSs in developing their LTPs and offer help locally where requested
- This help should be for the whole local system backed by leadership from the NHS, Local Government, Voluntary and Community Sector and business sectors
- Enable shared learning
- Facilitate national policy development

NHS England/Improvement Equality Objectives

Monitor (part of NHS I) set 4 main equality objectives in 2015:

- attract, retain and develop high performing people from the widest talent pool, with the right skills, experiences and competencies from a diverse range of backgrounds
- demonstrate clear leadership with senior commitment and accountability for further embedding diversity and inclusion into our organisation
- create an inclusive workplace where our people feel valued, respected, are treated fairly and have a sense of belonging, free from bullying, harassment and discrimination
- ensure our people receive targeted fairness and inclusion awareness training through a structured programme of initiatives to enhance our reputation as an employer of choice

NHS England's current Equality Objectives (until 2020) are:

- To improve the capability of NHS England's commissioners, policy staff and others to understand and address the legal obligations under the public sector Equality Duty and duties to reduce health inequalities introduced by the Health and Social Care Act 2012.
- To improve disabled staff representation, treatment and experience in the NHS and their employment opportunities within the NHS.
- To improve the experience of LGBT patients and improve LGBT staff representation.
- To reduce language barriers experienced by individuals and specific groups of people who engage with the NHS with specific reference to identifying how to address issues in relation to health inequalities and patient safety.

- To improve the mapping, quality and extent of equality information in order to better facilitate compliance with the public sector Equality Duty in relation to patients, service-users and service delivery.
- To improve the recruitment, retention, progression, development and experience of the people employed by NHS England to enable the organisation to become an inclusive employer of choice.

We will be reviewing these objectives in 2020.

Annex 1 – Suggested roles and responsibilities on health inequalities at a local level from the PBA

<https://www.gov.uk/government/publications/health-inequalities-place-based-approaches-to-reduce-inequalities/place-based-approaches-for-reducing-health-inequalities-annexes>

Health and Wellbeing Boards:

Health and Wellbeing Boards (HWB) have a duty to encourage integrated working between health and social care commissioners, the HWB, and commissioners of health-related services such as housing, and local government services ¹⁶.

Examples of good practice by HWBs to address health inequalities include:

- working with Directors of Public Health to undertake analysis of the main drivers of inequalities in health outcomes and access in an area
- developing integrated 'SMART' (specific, measurable, achievable, realistic and time-bound) plans to reduce health inequalities
- developing plans which incorporate the principles of system, scale and sustainability - and specific actions from all partners to address the wider determinants of health
- ensuring plans include locally agreed short, medium and longer-term targets to reduce health inequalities
- engaging with Voluntary, Community and Social Enterprise (VCSE) sector and local residents to ensure actions build connected and empowered communities
- ensuring local communities, community and voluntary sector organisations and statutory services work together to plan, design, develop, deliver and evaluate health and wellbeing initiatives

Local authorities:

Local authorities have a responsibility to meet their duties in The Health and Social Care Act ¹⁷, the Care Act ¹⁸, and the Social Value Act ¹⁹.

The Health and Social Care Act ²⁰ requires local authorities to take such steps as they consider appropriate for improving the health of the people in their areas.

The terms of the Public Health Grant to local authorities indicate that a local authority must, in using the grant have regard to the need to reduce inequalities between the people in its area, with respect to the benefits that they can obtain from that part of the health service provided in exercise of the functions referred to in paragraph 3 (public health functions as specified in Section 73B(2) of the National Health Service Act 2006 ("the 2006 Act") ²¹.

The [Care Act 2014](#) ²² indicates that local authorities must provide or arrange services that help prevent people developing needs for care and support, or delay people deteriorating such that they would need ongoing care and support.

Care and support planning considers a number of different things, such as what needs the person has, what they want to achieve, what they can do by themselves or with the support they already have, and what types of care and support might be available to help them in the local area.

In addition the [Social Value Act 2012](#) ²³ requires public sector commissioners – including local authorities and health sector bodies – to consider economic, social and environmental wellbeing in the procurement of services or contracts.

Creating social value has clear connections with efforts to reduce health inequalities through action on the social determinants of health – for example, by improving employment and housing.

Examples of the kind of actions that local authorities could consider to address health inequalities include:

- working with other system leaders to develop integrated SMART plans at neighbourhood and place-level, underpinned by analysis of local drivers of, and protective factors for addressing, health inequalities, including individual and community assets
- ensuring plans capture all council functions and local authorities' place-based function in addressing health inequalities
- engaging community members and voice in planning and delivery, especially from the most marginalised communities
- identifying measurable cross-council targets for addressing health inequalities
- identifying and prioritising action with a specific focus on addressing health inequalities as part of delivering Care Act wellbeing duties
- considering how regulatory and other functions can contribute to place-based plans to better address health inequalities (for example planning, licensing, environment, transport, environmental health, leisure)
- utilising community-centred approaches to improve health and wellbeing, and building social capital to help communities to reduce inequalities
- working with employers, including the NHS, to improve access to employment and the health and wellbeing of employees
- considering addressing inequality by devolution of power and resources from the local to community level, through integrating communities into local decision making in line with findings from the [Due North inquiry report](#) ²⁴.

Clinical commissioning groups

CCGs have duties regarding health inequalities under the [NHS Act 2006](#) as amended by the [Health and Social Care Act 2012](#) and Social Value Act 2012 (see details in local authority duties).

Examples of the kind of actions that public-sector commissioners, including CCGs, could consider to address health inequalities include:

- ensuring commissioning plans have a specific focus on improving the health of people with the poorest health outcomes fastest
- identifying and closing the gaps in care which have the most impact on health inequalities
- ensuring that all screening and vaccination programmes are designed to support a narrowing of health inequalities in access, uptake and outcomes
- ensuring procurement processes formally assess impact on health inequalities
- considering the potential of service models to inadvertently increase health inequalities (for example are psychosocial factors likely to impact on accessing services for some groups)
- undertaking and acting upon Health Equity Impact Assessment of plans and services
- using formal mechanisms to proactively identify people who are most likely to benefit from earlier intervention – based on the identification of risk, and early diagnosis
- targeting resources to support them and transforming care models and pathways to improve access, experience and outcomes
- employing targeted use of personal budgets and personalisation, to empower individuals and communities including those in positions of disadvantage

Sustainability Transformation Partnerships/ Integrated Care Systems

The [NHS Long Term Plan](#) indicates that ICSs provide stronger foundations for working with local government and voluntary sector partners on the broader agendas of prevention and health inequalities.

Examples of the kind of action that STPs or ICSs could consider to address health inequalities include:

- setting out specific measurable goals for narrowing inequalities, in line with the NHS Long Term Plan requirement. During 2019 they will set out how they will specifically reduce health inequalities by 2023 to 2024 and 2028 to 2029
- working with other system leaders, ICSs develop integrated SMART plans underpinned by analysis of local drivers and protective factors, to reduce health inequalities systematically at the different local levels of place-based organisation
- ensuring plans include co-ordinated action on the wider determinants of health including employment and poverty
- undertaking Health Equity Audit (HEA) plans, and completing audit change cycles
- ensuring plans include locally agreed short, medium and longer-term targets to address health inequalities at system, place and neighbourhood level
- ensuring plans engage the most marginalised communities in setting, delivering and monitoring priorities
- engagement with VCSE organisations, and inclusion of civil society organisations in strategic approaches

Health and social care (HSC) service providers

Examples of the kind of action that HSC service providers could take to support delivery of the NHS Long Term Plan, and the Care Act ambitions on Health Inequalities, include:

- targeting services to the needs of individuals, families and communities most likely to experience health inequalities (including through utilising available data, for example demographic, equality and diversity or wider determinants data)
- the use of evidence-based risk stratification tools, for example, the Patient Activation Measure (PAM) offers different levels of wellbeing support depending on individuals' health literacy as part of targeted self-care
- implementing structures that engage community members, especially the most marginalised groups, in decision-making about service needs, priorities and appropriate delivery methods with demonstrable resulting changes
- implementing an enhanced and targeted continuity of carer models, in particular, to help improve outcomes for the most vulnerable mothers and babies
- ensuring that by 2023 and 2024, all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services
- using their role as a system anchor to improve health outcomes through co-ordinated action on the wider determinants of health, including air pollution and employment. For example, through 'green' transport provision and targeted recruitment of people from deprived communities
- influencing supply chain to address health inequalities, for example through use of the Social Value Act
- utilising community-centred approaches to improving health and wellbeing
- continuing to take action on healthy NHS premises

Primary care networks

Primary care networks (PCNs) are expected to play a pivotal role, with local authority and community partners, in improving population health and reducing inequalities. They play a full part in co-producing and implementing ICS plans to reduce inequalities by 2023 to 2024 and 2028 to 2029.

PCNs from 2020 to 2021 will assess their local population at risk of unwarranted health outcomes and, working with local community services, make support available to those who need it most. The [Five Year Framework for GP Contract reform](#) ²⁵ sets out ambitions on social prescribing including its role in addressing health inequalities, making social prescribing more widely available and accessible.

Examples of the kind of action that Primary Care Networks could take to contribute to addressing health inequalities include:

- recognising the impact of health literacy and psychosocial factors on demand, need and uptake of primary care services

- systematically targeting and adapting services to the needs of people most likely to experience health inequalities
- working closely and systematically with other front-line delivery partners to co-ordinate person and family-based approaches to addressing complex needs
- embedding community-centred approaches in their work with communities as part of developing social prescribing systems
- utilising community-centred approaches to improve health and wellbeing, building social capital to help communities to reduce inequalities

Voluntary and community sector

The [Health Foundation](#) ²⁶ and [All Party Parliamentary Committee on Arts and Wellbeing](#) ²⁷ have identified the contribution that specific elements of civil society make to improving health.

Examples of the kind of action that civil society organisations could take to further contribute to addressing health inequalities include:

- continuing to contribute knowledge of the strengths of local communities to inform cross-system plans to ‘grow’ the protective factors, and to better link communities with services
- further helping to create social capital to support communities to reduce inequalities
- aligning civil society resources with those of statutory partners to support the delivery of place-based plans (where appropriate)
- providing advocacy and voice for people and groups who face most barriers

Business

The Confederation of British Industry has identified the [business benefits of good workplace](#) ²⁸ health. The [Industrial Strategy](#) ²⁹ includes an ambition to narrow the gap between the experience (in relation to healthy independent years of life) of the richest and poorest.

Examples of the kind of action that the business sector could take to address health inequalities include:

- recognising their role as a system anchor through maximising social, environmental and economic impacts for the local communities’ benefit
- business organisations, for example, Chambers of Commerce, encouraging their members to understand the business case for addressing health inequalities, and work with others to identify opportunities for business to participate in place-based health inequalities activity

Public Health England

The Health and Social Care Act 2012 [30](#) placed a legal duty on PHE to have due regard to the need to reduce health inequalities. PHE does this by:

- providing data and evidence of health inequalities trends and drivers
- supporting monitoring of local, regional and national outcomes in reducing health inequalities
- sharing good practice from across the country
- providing practical tools and resources to implement joined-up place-based approaches to health inequalities outlined in this in this framework

At a local level, PHE centres and regions support local areas through place-based approaches to:

- share learning and good practice
- build capacity and co-produce work
- support local action on reducing inequalities in health through evidence, information, guidance, partnerships and advice

Supporting areas to use the tools within this work is a key means of achieving of these objectives, and there is dedicated support available at both a national and local level to do this. If you are interested in drawing on this support, please contact

health.equity@phe.gov.uk

Annex – Economic case for acting on health inequalities

There are many reasons to come together to find solutions at a national and local level to break the cycle of entrenched health inequalities in England. As many of these inequalities are avoidable, the moral case cannot be overstated. There are also economic reasons for action. The high burden of disease in deprived areas generates higher use of health and social care services, higher unemployment and lower productivity: The Marmot Review estimated that health inequalities cost society £31 billion in lost production, in 2010 prices⁴. Whilst this is a national figure, it is in local jobs and economies where this impact is borne out.

The higher burden of disease experienced by women living in the most deprived neighbourhoods costs the NHS 22% more per person than women living in the least deprived neighbourhoods, despite having shorter life expectancy (or £400 per person per year in secondary care costs). For men this figure is 16% per person (or an additional £300 per person per year in secondary care costs). This results in an additional spend of £4.8 billion per year, almost 20% of the total hospital budget⁵, without taking into account additional costs, including social care provision.

⁴ Marmot M. Fair society, healthy lives: the Marmot Review: strategic review of health inequalities in England post-2010. 2010

⁵ Asaria M, Doran T, Cookson R. The costs of inequality: whole-population modelling study of lifetime inpatient hospital costs in the English National Health Service by level of neighbourhood deprivation. *Journal of Epidemiology and Community Health*. 2016;70(10):990