



# Faculty of Public Health

of the Royal Colleges of Physicians of the United Kingdom

Working to improve the public's health

## Response from the Faculty of Public Health to the Health Select Committee's Review of Health Inequalities

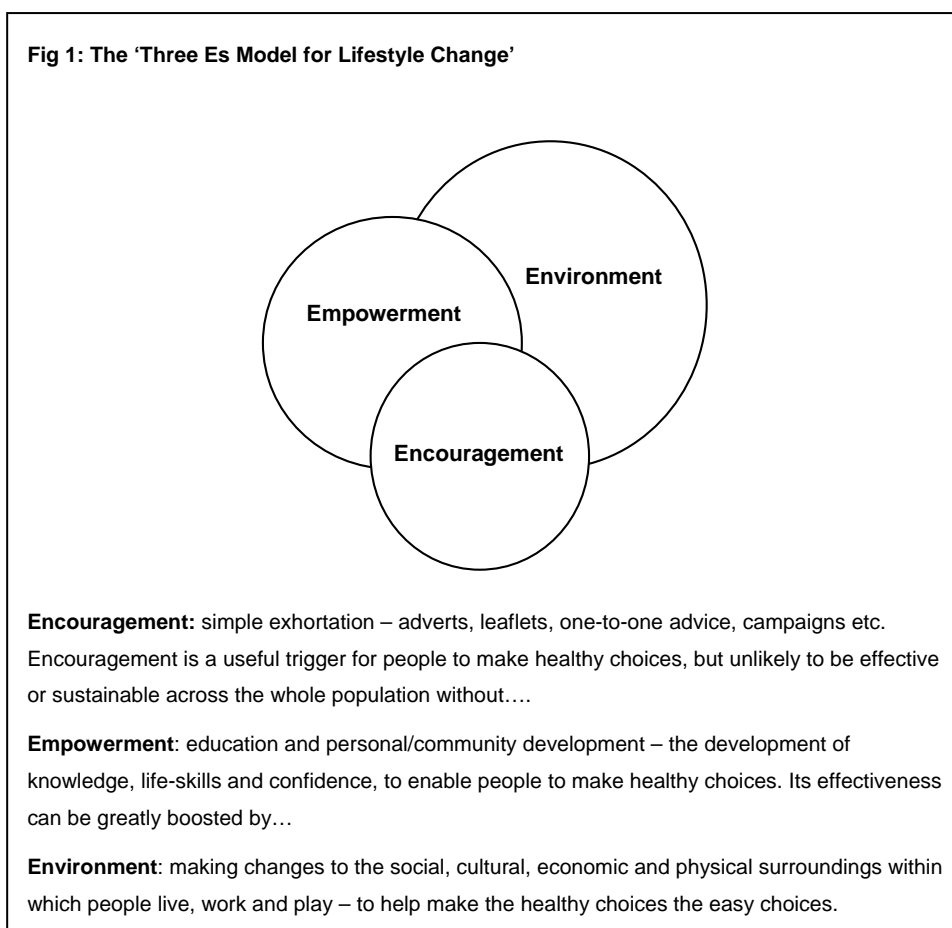
### About the Faculty of Public Health

The Faculty of Public Health (FPH) is the leading professional body for public health specialists in the UK. It aims to promote and protect the health of the population, and improve health services, by maintaining professional and educational standards, advocating on key public health issues, and providing practical information and guidance for public health professionals.

### Introduction

1. The FPH welcomes the opportunity to contribute to the Health Select Committee's review of health inequalities – an issue which is at the heart of public health and underpins its central principle of improving population health.
2. We believe this is the right time to be undertaking this enquiry. Successive Wanless reports have repeatedly pointed out the disproportionate burden of chronic disease among disadvantaged people and the need for more 'upstream' preventive approaches and improved access to these services, particularly for the more vulnerable groups and individuals in our society. Recent policy statements from government have emphasised the need to tackle health inequalities and to put the issue high on the agenda. However, we believe the reality lags a long way behind the rhetoric. There needs to be a very substantial shift of resources into upstream approaches to provide the all-embracing and specially tailored services required in the community. There also needs to be far more effective partnership-working between the NHS, local government, the voluntary sector and the public.
3. Reducing health inequalities is a fundamental driver of the public health function – some would say *the* fundamental driver. Conversely, public health skills and expertise are crucial to a proper understanding of the issues behind health inequalities, analysing the health needs of disadvantaged people, and planning and delivering services to meet those needs. We have therefore confined our comments to the public health (as opposed to the more clinical) aspects of the issue.

4. The public health function operates across three main 'domains':
  - *Health improvement* (which is about promoting healthy lifestyles and healthy environments and encompasses issues of inequalities and the wider social determinants of health such as employment, education, community etc)
  - *Service improvement* (which is about planning, commissioning and evaluation of services and interventions to ensure they are effective, of high-quality and safe. Inequalities issues of appropriateness and accessibility are crucial here).
  - *Health protection* (including immunisation and vaccination, screening, injury prevention, control of infectious diseases, emergency planning, etc. Again there are many inequalities issues in this domain, eg. with disadvantaged people missing out on vaccinations or screening opportunities, and being more susceptible to accidents and injuries).
  
5. The NHS plays a key part in all three public health domains. Planners, commissioners and providers of NHS services need to recognise that health inequalities are heavily influenced by social inequalities and that effective action to tackle inequalities must encompass insight into and understanding of each of the three domains. This requires appropriate education and training of key staff, from the frontline to the backroom, in basic public health skills, and a fully developed specialist public health workforce to support them.
  
6. Key to any strategy to reduce health inequalities is to engage and empower those who are most at risk of experiencing them. One model for achieving this is the '*Three Es Model for Lifestyle Change*' (see Fig 1).



7. What the 'Three Es Model' clearly demonstrates is that reducing inequalities is not solely the responsibility of one organisation or professional group, and that it is critical that those with a vested interest in the public's health, such as the NHS, government, local authorities and the third sector, work across professional boundaries to provide an equitable, equality-driven health service. Public health teams therefore have a critical role to play in working across and joining up these professional boundaries.
8. However, sustained reductions in health inequalities can only be achieved if there is sufficient resource to deliver and maintain programmes aimed at reducing both social and health inequalities. *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. The FPH believes that substantial funding for upstream public health programmes, whether delivered through primary care, community services, social care, the voluntary sector, mental health services or another provider, must be re-instated as a matter of urgency. This must encompass programmes to tackle inequities and inequalities across maternal and child health, young people's health and older people's health, with particular emphasis on improving nutrition, reducing smoking prevalence, preventing obesity, improving sexual and mental health, and tackling alcohol misuse.
9. *Choosing Health* set an ambitious agenda for improving public health. Yet the most recent reconfiguration of PCTs and SHAs has resulted in a shift in focus away from the health inequalities agenda and has led to a loss of valuable senior level public health expertise and a reduction in recruitment. Our latest survey of the public health workforce, conducted last autumn, shows that the number of public health consultants/specialists across the UK has declined still further to 939 – a fall of 30% since 2003. If government is committed to reducing health inequalities, then it must (in addition to protecting the expertise currently in place) support the development of a well trained and adequately resourced specialist public health workforce.
10. Whilst the FPH welcomes the recent announcement by the Prime Minister to prioritise prevention of ill health through the implementation of population screening programmes for diseases such as coronary heart disease and diabetes, it is critical that any such interventions do not exacerbate health inequalities. Government must ensure that any such screening programmes are both evidence-based and effectively targeted at those groups most at risk but which are least likely to uptake interventions or use health services.
11. The FPH is committed to supporting its members and to working with other organisations to prioritise action on reducing health inequalities, through lobbying for health protecting legislation (such as smokefree public places and workplaces) and providing practical guidance on tackling issues at local level (eg. toolkits such as *Lightening the Load: tackling overweight and obesity*).

12. The FPH is also working with the Department of Health in England to build on existing good practice. On 6 February a joint workshop is being held to bring together acknowledged leaders in reduction of health inequalities at local level to share good practice and identify gaps where more needs to be done.

## **Responses to questions raised by the Review**

### **Question 1: To what extent can the NHS 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?**

13. We welcome the Committee's recognition of the great importance of other policy areas in determining health and health inequalities. However, as outlined above, the NHS has a crucially important part to play in reducing health inequalities in all its services and settings, from health promotion at one end of the spectrum to palliative care at the other.
14. The NHS is a key partner in strategic approaches to tackle this issue at national, regional and local level. Universal services must be sufficiently flexible to accommodate the wide range of needs of their populations, including the most disadvantaged; and specialised services which cater specifically for particular subgroups of the population must be sufficiently well resourced to have a real impact. Comprehensive service reviews, such as the Next Stage Review of Lord Darzi in England, must ensure that they fully address the challenge of effectively tackling health inequalities.
15. This all-embracing comprehensive approach does not come cheap. Health promotion and preventive efforts in the community, many of which are channelled through primary care, require a massive investment to be effective. This requires a sea-change in the flow of funding so that the shift in the balance of NHS resources between primary/community-based services on the one hand and acute services on the other is significant and tangible. Too often the government rhetoric is there, but the reality fails to materialise. Despite all the promises, we have yet to see any real transfer of resources from the acute sector into community-based services, and indeed, important underpinning and support functions, such as public health specialist teams, have had to endure major cuts and disruptions, further weakening their ability to provide effective advice, analysis and leadership.
16. Reducing inequalities is a long game. It requires sustained investment in the appropriate services, aimed at the most vulnerable people and those in greatest need, tailored to their particular requirements, and made available, accessible and affordable to them. The right services, offered in the right way, to the right people, in the right places and the right times. Deciding what is 'right' in each of these parameters requires considerable expertise and analytical skill. Such expertise is embodied in public health specialists, who are comprehensively trained in all the key skills necessary to truly understand the health needs of their population and help plan and commission services in a way that can reduce inequalities. World-class commissioning will become second-

class commissioning if it does not effectively address issues of inequity and inequality. If we are to be effective in our efforts, it is crucial that specialist public health skills and expertise are brought to bear in planning and commissioning. For this to happen the recent fall in funding and staffing levels for the public health function at all levels of the NHS must be reversed as a matter of urgency.

17. The NHS can make an important contribution to reducing health inequalities through:

- ensuring provision of an equitable and equality-driving health service by improving accessibility of services, providing locally available services (ie. eliminating the postcode lottery of services), and improving care pathways to provide a seamless service – including through working with other sectors such as local authorities and the third sector. Critical to this is a thorough and comprehensive understanding of the health and wellbeing needs and aspirations of the population served. This requires in-depth analysis of the many different communities and cultures within the population with particular regard to the needs, demands and use of health services;
- fully embracing the patient-centred approach with an emphasis on understanding and serving each individual's needs and aspirations. This requires fit-for-purpose communication skills at all levels and in all settings of the service. Comprehensive equality and diversity training and support for all staff is critical;
- identifying those most at risk of health inequalities eg. those suffering/at risk of fuel poverty and acting as a link with other services to reduce risks;
- partnership working – such as the importance of joint planning and commissioning across PCTs, local authorities and the third sector, and in delivering joint strategies such as the 'Three Es Model' and other relevant programmes. In this, the specialist public health professional has a crucial role to play in spanning NHS and local government agendas;
- collating valuable data on health issues (and tapping into public health expertise in this area) such as A&E admissions for alcohol-related injuries and sharing this with other relevant organisations to provide a clear picture of the scale of an issue (public health teams have a critical role to play in data collection and synthesis);
- joint delivery of shared targets provided it is adequately resourced – and leadership and support is provided by a joined-up central government approach to support and sustain local initiatives;
- using its vast purchasing power to contribute to the development of sustainable communities and boosting the local economy by procuring only local goods and services (eg. locally produced food) – and which could also contribute to reducing carbon emissions.

**Question 2: What is 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?**

18. Despite the increased investment in primary care services, there are still far too many examples of Dr Julian Tudor Hart's infamous 'inverse care law' – the poorest quality care tends to be found in those areas most in need of the highest quality care. Increasing the availability and accessibility of high quality primary care in disadvantaged areas must underpin any serious attempt to tackle

health inequalities. This may require increased financial incentives to providers of services in such areas, including capital and revenue incentives. There tends to be a problem of high staff turnover in disadvantaged areas and difficulties in recruitment and retention. This can be tackled through improved staff training and reward schemes.

19. Specific issues to note concerning QOFs include:

- QOF is not designed to improve the distribution of GP services.
- QOF may not be supporting public health in general practice, and therefore may not help reduce health inequalities.
- QOF is not as comprehensive a source of information as its proponents suggest, as there are no breakdowns by age, sex, ethnicity, or socio-economic factors.
- As with many such systems, perverse incentives can exist and QOF data can be manipulated by altering the numerator or the denominator. For example, better figures for control of hypertension can be obtained by not including on a disease register people whose blood pressure has been measured as high but not followed up recently.
- In theory, QOF can be used to improve the quality of services but in practice this is difficult.
  - It requires targets to be met to trigger payments, but these targets need to be achievable but not so easy to achieve in many practices that no change is required, and yet not so difficult to achieve in other practices that there is no incentive to make progress because the targets will never be hit. There tends to be an assumption that practices' performance reflects the quality of the organisation and the healthcare professionals. While these are important, patient / population factors are also crucial. GPs working in an area with well-motivated middle-class patients will need to do less to achieve the same proportionate targets as those working in areas with very high patient turnover, fewer personal resources, and multiple problems to address.
  - The targets need to be beneficial in terms of improving health and reducing health inequalities. Although the 2003 GP contract focused on the health of the practice population, QOF points are geared towards biomedical measurement and delivery of risk-factor related healthcare, particularly prescribing additional medication, without acknowledgment of holistic care of individuals in primary care.
  - There sometimes needs to be an explicit trade-off between improving overall health and reducing health inequalities. QOF focuses on the former and can therefore worsen the latter.

20. However, there is some encouraging research evidence (summarised in the written submission to the Committee by Millett and Majeed) that at both practice and individual level, QOF has contributed to reductions in inequalities in management of people with chronic diseases:

- There were small differences in QOF performance between practices working in deprived and affluent areas in the first year of the contract.
- These differences appear to have narrowed in the second year of the contract.
- Studies using individual patient data suggest that there were marked age, gender and ethnic group inequalities in the quality of care being delivered before the introduction of QOF. Some of these inequalities have been partially attenuated afterwards.

**Question 3: How effective are 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?**

21. It is important to recognise that there are immediate causes of ill-health and health inequalities, such as smoking, obesity and alcohol misuse, but that there are also broader social determinants which affect these risk factors. For example, smoking prevalence has a clear social class gradient. As previously stated, it is clear that in order to reduce health inequalities, action is needed to reduce inequalities in general – which requires leadership from government, but also a joined-up approach across the various sectors.
22. Although there has been a reduction in inequalities in cancer and cardiovascular mortality, this has not been matched by reductions in infant mortality or in increases in life expectancy:
- Infant mortality: The inequality gap in the infant mortality rate has reduced for the second consecutive period, though not yet by a sufficient amount to meet the target, based on the trend since the current socio economic classifications were introduced in 2001.
  - Life expectancy at birth: The inequality gaps in male and female life expectancy at birth have both increased since the baseline. If current trends continue, the target would not be met.
23. However, much can be done by targeting immediate causes. For example, smoking accounts for at least half of all inequalities in premature mortality. Of 1,000 20-year-olds who smoke 20 a day, one will commit suicide or be murdered, six will be killed in a road traffic collision, and 500 will die prematurely because of their smoking. These deaths occur mainly from cardiovascular disease (particularly heart disease and stroke), from a range of cancers, and from respiratory diseases (particularly chronic obstructive pulmonary disease) – all of which show strong social class gradients and make substantial contributions to health inequalities. Those dying prematurely from smoking come disproportionately from more disadvantaged groups. There is a heavy social class gradient in smoking prevalence, tobacco consumption, and age of starting smoking by social class, education, or income, each of which contributes to the very large social gradient in tobacco-related death, disease, and disability.
24. Smoking can be considered both a symptom of and, paradoxically, a cause of, poverty. The latter is explained by its addictiveness, such that considerable amounts of money – and a higher proportion of lower incomes – is spent buying tobacco, and its contribution to ill-health at a much younger age than would otherwise have occurred in that individual, therefore also reducing the ability to work and earn money.
25. A comprehensive tobacco control strategy would have a large impact on health inequalities in the short, medium and longer term.
26. With reference to obesity, the Committee will no doubt read the recent Foresight Report (2007) which stresses the ‘passive obesity’ encouraged by the environment in which most people live. From the point of view of reducing health inequalities, this means that environmental change should be given a high priority. Measures which simply encourage healthy lifestyles tend to be

more widely adopted by those better able to make healthier choices, and in this way are likely to increase inequalities. Nevertheless the average population level of the relevant indicator is increased.

**Question 4: Are specific interventions designed to tackle health inequalities, such as Sure Start and Health Action Zones, effective and cost-effective?**

27. The most important policies to reduce inequalities are those which affect the social determinants of health. Sure Start and Health Action Zones can make a contribution to reducing inequalities, although in a more modest way.
28. NHS smoking cessation, which were originally piloted in Health Action Zones, have now been shown to be both effective and cost-effective, particularly the broader NHS cessation services which have been shown to be effective in more disadvantaged populations.
29. The Cornwall and Isles of Scilly HAZ included a specific strand on reducing health inequalities. It was subject to independent audit, led by Prof Sheena Asthana and Dr Joyce Halliday of Plymouth University. See eg Halliday J, Asthana S. Policy at the Margins: Developing Community Capacity in a Rural Health Action Zone. *Area*. 2005;**37**(2):180-188.
30. HAZs were introduced when the incoming Labour government was constrained by its promise to stay within the overall financial limits set by the outgoing administration. This meant that most people in health inequality were outside HAZs.
31. The overall evaluation of HAZs was carried out by Bauld and Judge - see <http://eurpub.oxfordjournals.org/cgi/content/full/16/4/341?etoc>

**Question 5: How successful are 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?**

32. As noted above, the role of public health teams – particularly public health specialists such as directors of public health (DPH) – are crucial in working across professional boundaries and in joining up agendas. However, they need to be adequately resourced to deliver on this.
33. The recent reconfiguration of the NHS resulted in a lengthy period without recruitment for new staff, such as those ending training schemes, a reduction in training placements and increased job insecurity for those already in post. Fewer public health posts now exist – particularly at the specialist level. These changes have combined to result in a substantial loss of workforce capacity. Public health delivery requires stability, not only in terms of recruitment and retention, but to ensure a sufficient knowledge-base and adequate resource for delivery of sustainable health programmes – particularly at the local level – including forming partnerships with other local sector organisations.

34. One specific example of successful cross-sectoral working is the Heart of Mersey project which is a partnership between the local NHS PCTs and Local Authorities. It was launched in 2003 to help tackle the very high levels of CVD in Greater Merseyside, where the disease kills 30% more women and 20% more men than in most other parts of the country.
35. Cardiovascular disease (heart disease and stroke, CVD) makes a major contribution to premature deaths and health inequalities. 80% of CVD is preventable, mainly through reducing the major risk factors (like smoking, poor diet and inactivity) rather than through treatments when the disease has already struck.
36. The Heart of Mersey project was modelled on the internationally successful North Karelia Project in Finland and aims to add value to local initiatives and programmes to prevent coronary heart disease, and its risk factors, through integrated, evidence-based interventions, lobbying and advocacy.

**Question 6: How effective is 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 is Government likely to meet its Public Service Agreement targets in respect of health inequalities?**

37. While the Government persists in having an individual-focus to health and inequalities, there will be difficulties in meeting targets.
38. As described above, there are immediate causes of health inequalities and social determinants of these. Until all government departments are aware of and act upon their ability to influence these determinants of health, the Department of Health will continue to be regarded as the Department of the NHS, itself a misnomer for the National Illness Service.
39. Policies focussing on individuals are important, for example for supporting individual smokers who wish to stop smoking, but these need to be complementary to and not instead of population policies and interventions. There have been recent encouraging signs, such as the focus in the New Cancer Plan of broader tobacco control strategies and an acknowledgment that however effective the Smokefree legislation is that was implemented in July 2007, tobacco control will remain important as long as significant numbers of the population continue to smoke.
40. Obesity is increasing in prevalence and will lead to increasing risk of diabetes and therefore cardiovascular disease. Because of the inequalities in obesity prevalence, the subsequent health impacts will also lead to increased health inequalities. Exhorting individuals to take more exercise is less effective – and much less cost-effective – than changing the physical and cultural environment in which individuals make their decisions. Walking is more likely in areas with clean, uncluttered, well-lit pavements and parks; where traffic is absent or slower; where more people are walking; and where perceptions of safety are greater. This is one reason why the Sustrans traffic-free walking and cycling routes have been so successful in encouraging travel by these modes, with evidence of car journeys replaced by walking and cycling, and of encouraging people

(particularly women, who are on average less physically active) to take up cycling who have not cycled before, or not since childhood.

41. One specific example where Public Service Agreement targets are important in reducing health inequalities is the HMRC PSA target for reducing smuggling. It is very important that a new PSA target is agreed as the current HMRC target ceases at the end of this year.

**General comment**

42. One critically important issue which has gained prominence and which will impact on health, and increase health inequalities, in the most fundamental way is climate change. FPH believes that climate change has become one of the most important public health challenges of this century. It threatens the basic elements of our existence – access to water, food production and land use. It could lead to exacerbated inequalities through displacement of large numbers of people, loss of entitlement and access to goods and services, and increased food and fuel insecurity. The FPH is publishing a report on the impact of climate change on health in January 2008.

43. The FPH would also like to highlight, in brief, those areas which require urgent action to reduce inequalities including:

- mental health
- alcohol
- sexual health
- fuel poverty

44. **The Faculty of Public Health would be most willing to give oral evidence to the review should this be desired.**