

02 Health inequalities in London:

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where are we now?

A personal perspective from Professor Sue Atkinson, Regional Director of Public Health to September 2006

In this section . . .

Professor Sue Atkinson CBE, Regional Director of Public Health from 1999 to 2006, reflects on how the health inequalities agenda in London developed.

I have been privileged to have been the first Regional Director of Public Health (RDPH) for London, and to have held this post at the time when the first Mayor of London was elected and the GLA started. This, with the health duties built into the GLA Act (1999), gave the opportunity both to develop the RDPH role as Health Adviser to the Mayor and GLA, and to develop the mechanisms that have been put in place to improve health and tackle inequalities, and to develop a unique strategic partnership for health in London – the London Health Commission (LHC).

I have not attempted to pick up all that has been achieved in London over the years, but have reflected on the four initial London Health Strategy priorities: inequalities; regeneration; black and minority ethnic health; and transport. These remain pertinent to London and the important role that strategic partnership, and the LHC in particular, plays in influencing, driving, supporting and co-ordinating developments in health policy and action across London. These areas offer an opportunity to learn lessons, ‘take stock’ and for London to decide on its next phase.

This is a good time for organisations in London to take stock. There are currently several important relevant changes in London: the changes to the Mayor’s powers; the single strategic health authority for London and the prospect of the LHC-led *Well London* bid to the Big Lottery Fund’s Well Being programme; the forthcoming smoke-free public places legislation; as well as the forthcoming Olympics and Paralympics in London – all giving opportunities for change in London. But more of that later.

The first *London Health Strategy* (Dawson

and Hamm, 2000) was initiated by the health sector and developed by the Coalition for Health in 1999/2000. This strategy, the first to focus on ‘wider determinants’ of health across London, identified inequalities, regeneration, black and minority ethnic health and transport as priority health issues. The LHC, the independent, strategic partnership for health in London, set up by the Mayor in 2000, grew out of the Coalition for Health. The LHC took responsibility for driving forward partnership work on the London Health Strategy priorities and for reporting annually on progress of the strategy against the high-level, *Health in London* indicators, identified in the Health Strategy. The LHC partnership focuses on health and wellbeing rather than on health services (which are the responsibility of the NHS), and has successfully engaged all the major regional organisations that are responsible for the policies that influence health, in the health inequalities agenda. (Figure 1 shows current LHC priorities.)

One of the major achievements of the LHC was to lead the work on ‘*The Big Smoke Debate*’. It was at the vanguard of assessing public opinion on smoke-free public places, the initiative being taken up by other regions afterwards, and was instrumental in assessing and changing public and politicians’ views about the benefit of legislation. We now have the Smokefree England legislation coming into place in July 2007 (Health Act 2006).

The NHS continues to have its main focus on health services and, given the current organisational changes within the NHS and its financial situation and hence the likely need to reconfigure health services across London, that will remain its major focus. Being an optimist, I am sure that

Figure 1 London Health Commission priorities



strengthening 'commissioning' in the NHS gives an opportunity for the NHS to also focus more on health improvement, by commissioning across the range of services: health improvement; prevention; treatment; rehabilitation; care.

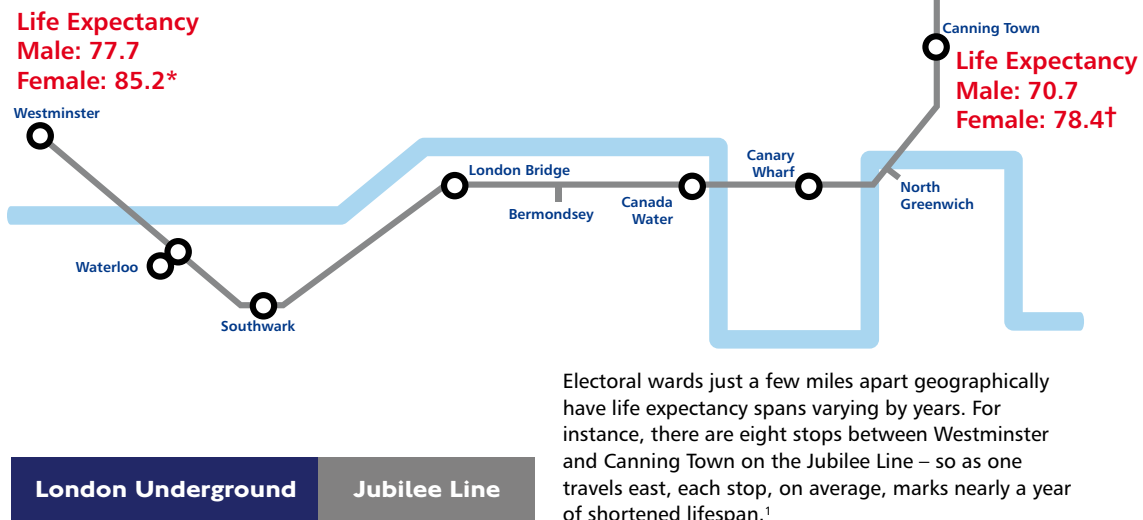
It is often easier to criticise the health services than it is to bring about changes in people's health and wellbeing, i.e. 'upstream'. But it is the latter that needs to happen. Wanless (2004), in his report about the future resources of the NHS, identified the importance of focusing on improving health. This cannot be done by the NHS alone, but can be done by the partnership of all those that are responsible for the policies that influence health – and that means the partners that form the LHC.

So, in relation to the original priorities for London – **inequalities, regeneration, black and minority ethnic health, and transport** – what has changed and what still needs to be done?

Inequalities remain a major issue in London. Reports from the LHC, GLA and LHO, including our annual *Health in London* reports, have described London's inequalities in health in many dimensions, and we have a clear view of the major discrepancies. Many more people are now aware that for every tube station along the Jubilee Line, from Westminster to the East End, Londoners living in these areas lose a almost year of expected life (Figure 2).

Figure 2 Differences in life expectancy within a small area in London

Travelling east from Westminster, each stop represents nearly one year of life expectancy lost



¹ Source: analysis by the LHO using ONS data. Diagram produced by the Department of Health.

* Life Expectancy Westminster Male: 77.7 - (CI 75.5 - 79.9), Female: 85.2 - (CI 82.2 - 88.2)

† Life Expectancy Canning Town Male: 70.7 - (CI 69.0 - 72.5), Female: 78.4 - (CI 76.7 - 80.2)

The recent most important development is that the review of the Mayor's powers identified how important health inequalities are in London, and it is agreed that the Mayor's duties on health will now include taking inequalities into account and developing, in partnership with others, a strategy for health inequalities. Over and above the health duties, the Mayor has new powers and duties in relation to housing, skills, waste, climate change and energy, culture, planning and water. All of these have major influences on health and impact on inequalities. It is important that mechanisms are in place for the relationship between these and health inequalities, as well as vice versa, to be taken into account.

Regeneration: what does it mean. How do we do it? How is it measured? All of these were still questions when the London Health Strategy was published. While some questions still remain,

especially the complex research ones in relation to measurement, there is now a much more practical approach to redevelopments and regeneration. Through the Regional Public Health Group (RPHG) and the LHC partnership, the Urban Development and Regeneration Forum (UDRF) has taken it forward. Understanding what the good outcomes for health are, for example, how to design in health improvement such as integrated transport for walking and cycling, and economic and social integration and 'design out' crime etc, is key to regenerating the more deprived parts of London. This is a key part of the Olympic and Paralympic games developments in east London, and the health components of *The London Plan* (Mayor of London, 2004a).

Capacity for the health professionals to develop skills to work with developers and urban regeneration has been increased through the Healthy Urban Development

Unit (HUDU). The London Development Agency (LDA), the RPHG and the NHS have been key to these changes. It is now clearer that sustainability, health and climate-change factors may all overlap and it may be critical to build stronger and new partnerships with those who broadly share these agendas, making use of the room for synergy. For example, the London Sustainable Development Commission (LSDC) has a remit to ensure that the Olympics and Paralympics are sustainable – much of this may overlap with ensuring it is healthy, and there may be scope for ‘doing things once’.

With 40% of the London population from black, Asian and minority ethnic (BAME) communities (Census 2001), the issues of BAME health will remain on the London agenda. Again the LHO/LHC/GLA have made a series of excellent reports, which describe various aspects of BAME health and related determinants (eg: APHO, 2005, LHO 2006a, 2006b, Aspinal & Jacobson, 2004). The evidence about the importance of skills and employment to health and mortality demonstrates that addressing BAME health issues is a long-term and an economic issue. It also emphasises the need for partnerships, working closely with partners, such as the LDA and Learning and Skills Council, and the relevance of the Mayor’s new powers in this arena, with the need for health inequalities to be taken into account.

Some of the specific health issues that are relevant to particular ethnic groups, e.g. young people’s sexual health, also highlight the importance of partnership working, e.g. what initiatives could be taken by the GLA, or the voluntary sector, and others who already have good relations with the relevant BAME communities, to open the debate.

Are there lessons from the other priorities? Yes indeed. Take transport. Transport and congestion were a major issue in London and were clearly on the agenda early on. The LHC partnership was instrumental in the Health Impact Assessment (HIA) on the draft Transport Strategy, which highlighted public transport, cycling, walking and pollution as key issues for health. We have seen the major changes to London that have already been brought about through the Mayor’s public transport strategy and through congestion charging. HIA was identified as a key tool in the *London Health Strategy*, and the LHC was involved in developing the methodology and mechanisms whereby HIA could be used as an effective tool to influence change. It helped to put London on the HIA map and HIA on the London map.

As I mentioned above, there are major changes in London, which offer opportunities, but with them come challenges, some of which I have already covered.

The unique and exciting *Well London* programme, that the LHC is co-ordinating, majors on a community development approach and focuses on food poverty, physical activity, mental health and wellbeing, children and young people, culture and tradition, and green spaces. The LHC has seized this opportunity to take a key high-profile role as strategic co-ordinator across London on issues of health improvement. In doing so, valuable new partnerships for health improvement have been forged and there will be further great potential to build on these and extend them further in the development of the *Well London* programme.

As I step down as RDPH and Health Adviser to the Mayor and GLA, I am pleased with

what has been achieved and we have some very solid foundations in place in London, but there is still much to be done if London's health issues are to be addressed.

It may be presumptuous of me to make suggestions – but in doing so I hope to offer some food for thought and debate among organisations and sectors at the local and regional levels in London. The LHC partnership is the ideal forum for this debate.

So here goes:

- Working through the LHC partnership, there is now the unique opportunity to up the ante on how health and health inequalities are taken into account in the Mayor's new powers, duties and strategies.
- This is also the ideal time to take a step back and a long hard look at what needs to be done within organisations and sectors and in partnership, and therefore where to concentrate effort.
- In identifying the big issues for the next phase it will be important to maintain a focus on wider, social determinants and health improvement and, for example, for London and the LHC to continue to be at the forefront of how to shape health in urban communities and developments:
 - to roll out and integrate HIA approaches across London, possibly being less involved in the mechanics, but in the fact that HIA should be an integral part of the process
 - potentially to ensure that integrated impact assessment is undertaken, rather than only a health or environmental or economic appraisal.
- Measuring impact to show what difference is being made is key, but it is also important to be realistic and

continue to develop the models and mechanisms, while promulgating and informing wider debates about how to address social determinants, to make populations healthier.

Maintenance and further development of strategic alliances will be key to success in this wider agenda. *Well London* is an exciting new platform to make broader strategic alliances. It will also be important to ensure that the NHS continues as a key partner, especially at this time of major change. The continued active involvement of the London NHS public health workforce in the wider health inequalities and health improvement agenda is vital to the development and action on this wider agenda in London. Important partners are, therefore, the new regional director of public health and public health team in, London NHS, the new strategic health authority, the Department of Health Regional Public Health Group and the Directors of Public Health and their teams in PCTs. The NHS changes include the strengthening of the commissioning function, and this offers an opportunity to strengthen commissioning for health improvement. Similarly, the local area agreements (LAAs) between PCTs and LAs offer an opportunity to address health improvement and the wider determinants at local level, so it is vital to keep close to these partners.

This is a major agenda but the time is ripe and the key opportunities are here, so while it may keep everyone busy it is not to be avoided!

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