

# Mapping for the Health Inequalities Strategy

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## ***National, regional and local context, strategies and activities***

Overview report/Discussion paper

# 1 Introduction

## 1.1 Background

The Government's Draft Greater London Authority (GLA) Bill, announced in July 2006, proposed new health duties for the Mayor including a duty to develop and lead a statutory pan-London Health Inequalities Strategy (HIS). As part of the development of the draft Health Inequalities Strategy a mapping of the existing policy context and current and planned activities relating to the determinants of health and their capacity to reduce health inequalities was undertaken. In late April 2007 the GLA commissioned Marsaili Cameron and Liza Cragg to undertake a mapping of the existing regional context and activities in London. At the same time the Regional Public Health Group (RPHG) undertook a mapping of national and local context and activities.

The brief for the regional mapping was to look at all the statutory and non-statutory Mayoral strategies, the corporate or business plans of the GLA group (GLA, TfL, MPA/MPS, LDA and LFEPA), emerging areas of GLA work and other regional strategies and programmes only where they go beyond straightforward regional delivery of national programmes. The detailed regional mapping is contained in a report, 'The mapping tables'. This is accompanied by a regional mapping overview report/discussion paper. Both documents are available from the GLA.

The national mapping summarised the evolution of current government policy on health inequalities and analysed recent white papers, actions and reviews undertaken by the Department of Health and other government departments. The local mapping looked at activities at the level of local authority and ward area. Detailed information on the national and local mapping is available from the RPHG.

At each of the three levels the mapping is structured around 29 themes provided by the GLA. The themes are grouped into *the wider determinants of health*, *health related policies* and *particular health challenges*. The key questions considered during the mapping are:

- What is the legislative context?
- What roles are assigned by this context?
- What strategies have been developed to fulfil these roles?
- How are these strategies being implemented through action?
- What are the gaps and opportunities at each of these levels?

## 1.2 Purpose and structure of this report

This report/discussion paper brings together the key findings from the national, regional and local level mapping of the policy context and current and planned activities relating to the determinants of health and their capacity to reduce health inequalities. It has three main purposes:

- 1 To present the main messages emerging from the analysis of the mapping to the HIS working and steering groups.
- 2 To stimulate discussion about the scope of the HIS and challenges and opportunities that could be further worked up further through the 'Issues and Options' paper and subsequent work to develop the strategy.
- 3 To provide a resource to inform the development of the draft HIS and the final HIS.

The report contains the following sections:

### **1 Introduction**

### **2 A summary of the context for action to reduce health inequalities**

Brings together some of the key background information needed to understand the nature and scale of the multi-level challenges presented by health inequalities in London.

### **3 Recent improvements in the determinants of health and health outcomes**

Summarises policies, programmes and other activities or interventions that appear to have gone some way to reducing health inequalities in London.

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**4 *Current and planned action to reduce health inequalities***

Describes existing initiatives at national, regional and local level in the capital, and indicates the kind of outcomes looked for.

**5 *Risks that could threaten the effectiveness of existing action to reduce health inequalities***

Identifies potential areas of risk for existing initiatives – what factors might prevent them from being successful in reducing health inequalities in London?

**6 *Opportunities for London-wide action to reduce health inequalities***

Outlines potential areas of opportunity for the Mayor to build on and challenge nationally, and to lead, support and influence at regional and local levels.

**7 *Challenging assumptions about health inequalities – and moving towards policy options***

Identifies some of the key issues raised by the experience of reviewing a mass of wide-ranging measures relating to health inequalities, and suggests some ways of moving forward on addressing complex challenges with meaningful policy options and action.

## 2 A summary of the context for action to reduce health inequalities

This section brings together some of the key background information needed to understand the nature and scale of the multi-level challenges presented by health inequalities in London.

### 2.1 Health inequalities and wider determinants of health – definitions and scope

Concern about health inequalities centres on a paradox, first explored in the 1980 Black Report, that although health overall was improving after many years of the welfare state, factors such as poverty were contributing to widening inequalities in health.

In current national policy terms, health inequalities are often defined by the targets set out to reduce those inequalities. A national public service agreement (PSA) target aims to reduce inequalities in health outcomes by 10 per cent as measured by life expectancy and infant mortality. The government recognises that action to achieve this target needs to encompass both health interventions, such as reducing smoking in manual groups, and action on the wider determinants of health, such as poverty, worklessness, poor housing and low educational attainment.

This approach is supported by the 1998 Independent Inquiry into Inequalities in Health led by Acheson, which concluded that, 'the weight of scientific evidence supports a socio-economic explanation of health inequalities. This traces the roots of ill health to such determinants as income, education and employment as well as material environment and lifestyle.'

All three strands of policy mapping summarised in this report – national, regional and local – examined both policies explicitly directed at health improvement and also policies on the 'wider determinants', given their potential to impact on health. A basic shared assumption was that any policy that has the potential to impact on health has the ability to create inequalities.

#### Responding to complexity may involve using a range of indicators

The issues involved, however, are complex, and there is no simple satisfactory answer to the question, 'What is meant by health inequalities?' National government action and targets have focused on the gap in infant mortality across social groups and the difference in life expectancy between those living in the most disadvantaged areas and those living elsewhere as key indicators of health inequalities. However, as recognised by the Government's Cross-Cutting Review and subsequent Public Service Agreements (PSA), there are many other possible definitions and indicators of health inequalities. Some of them relate to changes across the whole distribution of health outcomes, whereas others focus on the position of the lowest group relative to the average or to the group at the top. These may also be relevant to the challenges involved in developing the Mayor's Health Inequalities Strategy.

These definitions and indicators include the *groups to be compared* in order to measure health inequalities. The difference between geographical areas where populations have the worst health outcomes and the best could be used. However, it is also important to recognise that some people experiencing deprivation do not live in geographical pockets of deprivation so a geographical focus alone will not be effective. Socio-economic groups, usually defined by income and/or occupation, are sometimes used to measure health inequalities. The difference in health outcomes between ethnic groups, between men and women, between gay men and lesbians and heterosexual people and between other groups can also be significant.

Different types of indicators can also cover the *outcomes to be compared*. These include life expectancy, morbidity such as incidence of CVD and cancer, excess morbidity and mortality. Self assessed health – how well people feel themselves to be – may also be an important factor in health inequalities.

Focusing on a single type of indicator may miss the complexity of the interaction of factors that contribute to health inequalities as well as the individual's experience of health and well-being.

## How the Draft GLA Bill defines health inequalities

The Mayor's responsibility for producing a statutory health inequalities strategy originates from the Draft GLA Bill currently passing through parliament. The Draft Bill defines health inequalities as 'inequalities in respect of life expectancy or general state of health which are wholly or partly a result of differences in respect of general health determinants.' The Bill then defines general health determinants as:

- (a) standards of housing, transport services or public safety,
- (b) employment prospects, earning capacity and any other matters that affect levels of prosperity,
- (c) the degree of ease or difficulty with which persons have access to public services,
- (d) the use, or level of use, of tobacco, alcohol or other substances, and any other matters of personal behaviour or lifestyle that are or may be harmful to health, and any other matters that are determinants of life expectancy or the state of health of persons generally, other than genetic or biological factors.

## 2.2 London's key characteristics

London's characteristics present some unique challenges and opportunities in addressing health inequalities. The nature of these may affect the implementation of national policies in the capital.

London's characteristics include:

- The *size* of London's population. The estimated total population of London is 7.52 million. This is by far the largest population of any city in the UK – more than seven times bigger than Birmingham and more than 10 times bigger than Glasgow.
- The *ethnic diversity* of London's population. Half of the UK's black, Asian and ethnic minority communities live in the capital. London's ethnic minority population stands at 42 per cent, with nonwhite groups making up 30 per cent of residents. The 2001 Census indicates that there were 42 communities of over 10,000 people born in countries outside Britain living in the capital.
- The *age* of London's population. London is home to nearly 1.63 million children and young people under the age of 18, accounting for almost 22 per cent of London's total population. Almost 16 per cent of London's population – 1.165 million people – are aged 60 or over.
- The *mobility* of London's population. London has many immigrants, some of whom stay for a short time. It has high numbers of refugees and asylum seekers. It also has a mobile population, with people often moving in when they are younger and looking for work and moving out when they have families. London also receives around 30 million tourists every year.
- The *economic disparities* that exist within London. London is one of the world's wealthiest and most vibrant economies, but includes some of the country's poorest communities - 43 per cent of London's children live in households below the poverty line.
- The opportunities presented by hosting the *2012 Olympic and Paralympic Games*.
- The *transport difficulties* in travelling around London, with heavy traffic and a public transport system in need of huge investment – although alleviated in central London through the introduction of the congestion charge and major expansion in bus capacity.
- The *higher cost of living in London*, partly due to the chronic housing shortage and very high cost of housing.
- *Pockets of deprivation* existing close to areas of extreme wealth.

## 2.3 The strategic context...

### ...national and local

A key point in the development of the Government's approach to tackling health inequalities, was when the then Office for Deputy Prime Minister (now the Department for Communities & Local Government) set out the National Strategy for Neighbourhood Renewal in 2001. This strategy set out the work with other departments needed to meet Public Service Agreement (PSA) floor targets and narrow the gap in health, education, crime, worklessness, housing

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and liveability outcomes for the most deprived areas and the rest of England by 2010. It included area-based initiatives such as New Deal for Communities and Neighbourhood Renewal led by Local Strategic Partnerships (LSPs). It followed targeted action for specific groups of workless people outlined in a raft of 'New Deals' and picked up the Government's specific concern about these neighbourhoods.

In London, 20 boroughs were identified as being within the bottom quintile of deprived authorities in England and as such became Neighbourhood Renewal boroughs with requirements to work in partnership across all public services locally to progress delivery against the PSA floor targets.

In response to the Comprehensive Spending Review round in 2004, the extra emphasis on inequalities in health led to the introduction of the Spearhead programme led by the Department of Health. Like Neighbourhood Renewal, this programme was intended to be delivered through local partnership arrangements including LSPs. In London, eleven authorities have Spearhead status and all are also Neighbourhood Renewal areas. These areas in London are expected to reduce the gap in health inequalities between the borough and the England average at faster rate than other non-Spearhead areas. (However as discussed later, a good borough level position might mask inequalities at a neighbourhood or ward level.)

Both programmes are designed to tackle the wider determinants of health as well as actual health and health service related inequalities; and both programmes focus to some degree on the geographical dimension of health inequalities.

### **Roles and responsibilities**

While the Department of Health has a lead role in tackling health inequalities at the *national* level, the contribution of other departments has been recognised in the setting of PSA targets aimed at narrowing the gap in a range of wider determinants such as employment and road traffic accidents.

In addition to this, the Social Exclusion Task Force within the Cabinet Office is responsible for co-ordinating the government drive against social exclusion and the Neighbourhood Renewal Unit within the Department for Communities and Local Government is responsible for delivering the Government's National Strategy for Neighbourhood Renewal which aims to ensure that no-one is seriously disadvantaged by where they live.

The roles and responsibilities for *local* organisations are undergoing a whole systems review by Government.

Currently, in London, every borough has a Local Strategic Partnership supported and convened by the Local Authority. Each LSP also has involvement from other local statutory and non-statutory partners including the NHS (usually led by the PCT), the Police service, local skills agencies, the VCS, and the local business sector.

The role of the LSP is to bring together public services, business and third sector organisations to develop local sustainable community strategies. The new Local Government White Paper (LGWP) (discussed in more detail below) describes the role of the LSP as being central to developing a Sustainable Community Strategy as the long term vision and agreeing a Local Area Agreement with central Government as the delivery framework of key priorities for the local area.

LSPs work through a series of themed groups such as a Health and Well-being Partnership, or Crime & Drugs Reduction Partnership (CDPR). Some of these themed groups have a statutory role such as the CDRP or deal with statutory delivery priorities such as Children & Young People's Partnerships.

The LGWP sets out the role of Local Authorities as leading local public services and having responsibility for delivery of outcomes agreed within the LAA. The roles of key partners at the local level are also clearly defined and discussed further on in this paper under *Current & Planned activity*.

### **...regional**

The GLA was established in 2000. It covers the 32 London boroughs and the City of London. It is made up of a directly elected Mayor (the Executive) and a separately elected Assembly (to scrutinise the Mayor). The GLA is designed to provide citywide, strategic government for London. Its principal purposes are to promote the economic and social development and the environmental improvement of Greater London. The GLA is also required to take account of

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three crosscutting themes: the health of Londoners; equality of opportunity and sustainable development.

Under the GLA Act 1999 the Mayor of London is responsible for the development of eight statutory strategies covering spatial development, the economy, culture, transport, ambient noise, biodiversity, waste and air quality. In addition to these, many more strategies and actions have been developed under the Mayor's general power to do anything that will promote economic and social development, and environmental improvement in London.

The Mayor is also responsible for setting the budgets of the London Development Agency (LDA), the London Fire and Emergency Planning Authority (LFEPA), the Metropolitan Police Authority (MPA) and Transport for London (TfL), and these organisations take forward the delivery of the Mayoral strategies. Together the GLA, LDA, LFEPA, TfL and the MPA are known as the 'GLA group'.

The Department of Communities and Local Government announced the Government's intention to give additional powers to the Mayor in July 2006. These new powers will give the Mayor new lead roles on housing and adult skills in London; a strengthened role over planning in the capital; and additional strategic powers in a wide range of policy areas including waste, culture and sport, health, climate change and appointments to the boards of the functional bodies. The necessary legislation to introduce these new powers is currently making its way through Parliament. In the meantime, the Mayor is undertaking preparation work in readiness for his new responsibilities. The London Assembly is also to be given stronger powers on scrutiny and statutory appointments.

As all the Mayoral Strategies involve action on the determinants of health, there is very little included that could be said to be outside the scope of this work. Therefore, the challenge of the regional mapping has been to focus on those areas of existing strategic and planned activity that are most relevant.

In addition to the context provided by the GLA, there are a number of other organisations and partnerships operating at the London regional level that were considered as part of this mapping work. These include:

- *NHS London* is the new strategic health authority for London, is responsible for developing and implementing a strategy for health and healthcare in London and for managing the performance of healthcare providers in the capital.
- *The Government Office for London (GOL)* represents central government across the capital, delivering policies and programmes for eleven central government departments in a joined up way, and making London's case in Whitehall.
- *The Regional Public Health Group* acts as the Department of Health's presence London and carries out a wide range of public health responsibilities.
- *The London Health Observatory* is one of a network of nine Regional Public Health Observatories that were created in England following the publication of the White Paper Saving Lives: Our Healthier Nation. Its role includes monitoring health, healthcare and disease trends and highlight areas for action, identifying gaps in health information carrying out projects to highlight particular health issues and evaluating progress by local agencies in improving health and reducing inequality.
- *The London Health Commission* works in partnership with agencies across the capital to reduce health inequalities and improve the health and well being of all Londoners through co-ordinated action to improve the determinants of health across London. Members of the Commission are drawn from across London and all sectors and represent a wide range of interests. The Commission itself has no statutory powers, functions or funding. Instead, its work programme is delivered through resources and expertise provided by its members and key partner agencies
- *London Councils* (formerly the Association of London Government) represents the 32 London boroughs, the City of London, the Metropolitan Police Authority and the London Fire and Emergency Planning Authority. It lobbies for more resources for London, works to help member councils deliver better services, and to promote better cross-borough and pan-London working. develops policy and runs a range of services.

### 3 Recent progress in the determinants of health and health outcomes

This section summarises policies, programmes and other activities or interventions that appear to have gone some way to reducing health inequalities in London.

It is rarely possible to attribute changes in health outcomes and health inequalities to particular interventions. Health outcomes, and therefore health inequalities, are influenced by the wider determinants of health, health care interventions and individual influences such as genetic make-up and behaviour – and these factors interact in complex ways.

Because of difficulties in attribution (discussed further in section 7), this section does not attempt to attribute changes in health outcomes and health inequalities to particular national, regional or local activity. Rather, it seeks to provide recent examples of progress in the determinants of health in London that can be expected to impact positively on health in the long term. It also provides details of improvements in health outcomes using several measures.

A key message from the mapping exercise is that concerted effort on even very complex health challenges can make a real and lasting difference to the present and future well-being of Londoners. Partnership working is key to successful effort of this kind, as is evidenced by the review of progress by London Health Commission partner organisations contained in *Health in London 2006/07*.

#### 3.1 Progress in the determinants of health

- Major *improvements in public transport* including a significant increase in bus services with London buses operating their highest mileage since 1963 - 397 million kilometres in 2002/03.
- An *increase in bus use* so London buses are carrying the highest number of passengers since 1969 with the fastest rate of passenger growth since 1945. Buses now carry 5.4 million passengers a day, up 19% since 1999/2000.
- The introduction of *free travel* for all under-18s in full time education on buses and trams and free travel for under 11 on the tube.
- The introduction of *congestion charging*. Within the charging zone during charging hours traffic has been reduced by some 30%. Monitoring data from central London is indicating that congestion charging is making a positive contribution towards reducing other adverse impacts of traffic, such as emissions of pollutants.
- Since 2002, total *crime* has fallen every year. Almost every category of crime is down, including burglary, rape and violent The Metropolitan Police Service are also detecting more crime.
- The *Safer Neighbourhoods* performance framework statistics show that there has been a slight improvement in the proportion of people feeling safe walking alone during the night (+4 percentage points) but it is difficult to relate this to Safer Neighbourhoods as they operate during the day.
- *Poverty amongst pensioners* in London fell some 13% between 2000/01 and 2003/04. The fall in measured pensioner poverty in inner London coincides with the introduction of measures specifically intended to raise the incomes of the poorest pensioners, and in particular increases in the Minimum Income Guarantee for pensioners in April 2001 and the introduction of the Pension Credit in October 2003. There are therefore grounds for optimism that targeted support for the lowest income pensioners is beginning to have the intended effect on poverty levels.
- Some aspects of *Londoners' diet* have already improved markedly. According to DEFRA 2004 Family and Food Survey consumption of fresh fruit has increased by 55% since 1975, and in 2003 recorded an annual increase of 4.3%. Furthermore, consumption is higher in London (1,376 grams per person per week) than the average for England (1,242 grams pppw).
- *Educational achievement* as measured by the percentage of pupils achieving five GCSEs at grades A\*–C or equivalent has improved at a faster rate in London between 2001 and 2005 than the national average. There was a rise of 9.4 percentage points in London, compared with 7.1 in England.

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- There was a decrease between 2001 and 2004 in the number of *homes classed as unfit* in London, by 7% for private sector housing, 13% for council housing fell by 13% and 5% for registered social landlords.
- In November 2005 the Mayor announced his *Childcare Affordability Programme* which will provide 10,000 subsidised childcare places over the three years of the programme.

### **3.2 Progress in health outcomes**

- According to research published by the London Health Observatory in November 2006, the *inequality gap in male and female life expectancy* between the London Spearhead Group and England has narrowed since the baseline (1995- 1997), and the London Spearhead Group as a whole is on track to meet the national targets by 2010. For life expectancy and mortality from cancers the London Spearhead Group, as a whole, is progressing well towards meeting the targets. However, for heart disease and stroke, the inequality gap is widening, and based on current trends, the target is unlikely to be met.
- By the end of 2004, *child fatal or serious casualties* due to traffic accidents were 48% below the 1994-98 average, virtually meeting the 50% reduction target by 2010 and the Mayor is now consulting the boroughs on raising this target to 60%.
- Compared with 2003, *fatalities due to traffic accidents* in 2004 fell by 21% from 272 to 216. Serious injuries decreased by 19% and slight injuries decreased by 9%. Overall, casualties in 2004 decreased by 10% compared with 2003.
- Over the last five years, there has been a 20% *reduction in deaths from accidental dwelling fires*. There has also been a 23% reduction in deaths from non-accidental fires in the home. Total injuries from fire have reduced by 20%, and hoax calls by 30%, exceeding the 20% target reduction set by government.

## 4 Current and planned action to reduce health inequalities

This section describes existing initiatives at national, regional and local level in the capital, and indicates the kind of outcomes looked for

### 4.1 What is happening at national and local level?....

A series of reviews by Wanless concluded that there was a need for greater investment in public health and that this investment should be targeted on interventions where the long-term impact on poor health would be greatest. Subsequent Spending Reviews concluded that action had to be taken to integrate initiatives on health inequalities into mainstream service delivery.

The 2002 Spending Review put in place deprivation targets in relation to education, employment, crime, health, housing, enterprise, road accidents and regional growth. Government departments are required to publish performance against these targets every Spring and Autumn.

The 2004 Spending Review also saw specific health inequalities elements added to other key PSA targets for cardiovascular disease, cancer, adult smoking, childhood obesity (joint with DfES and DCMS) and the under-18 conception rate (joint with DfES).

*Tackling Health Inequalities, A Programme for Action* was published in 2004. Action was to be taken across traditional boundaries through work in partnership with front-line staff, voluntary, community and business sectors as well as with service-users to achieve the 2010 health inequalities targets.

The Programme for Action recognised the need to prioritise tackling the underlying determinants of inequalities with action across government on:

- Early years support for children & families
- Improved social housing and reduced fuel poverty among the vulnerable
- Improved access to public services in disadvantaged communities
- Reduced unemployment and improved income among the poorest

Key interventions to contribute to closing the life expectancy gap include:

- improving ante-natal care and early years support
- Reducing smoking in manual groups
- Action on risk factors for CHD and cancer (poor diet, obesity, physical activity, hypertension)
- Improving housing quality and reducing accidents at home and on the road.

Interventions to close the infant mortality gap include:

- Improving ante natal care and early years support
- Reduced smoking and improved nutrition in pregnancy and early years
- Preventing teenage pregnancy and supporting teenage parents
- Improving housing conditions for children in disadvantaged areas

The ethos of the *Programme for Action* is not to focus only on the most disadvantaged but to improve the health of the poorest fastest. Achieving the health inequalities targets will mean improving the health of the poorest 30-40 per cent of the population where the greatest burden of disease exists.

The *Programme for Action* recognises that local action is key to achieving the health inequalities targets and highlights the role of local strategic partnerships as key agents for success. This work is assisted at regional level by the Regional Directors of Public Health being co-located in regional Government Offices and in London the Regional Director of Public Health acting as Health Adviser to the Mayor and GLA.

The specific workstream on health inequalities is accompanied by significant and relevant policy initiatives in the following areas.

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### Health service reform

As well as having the responsibility of commissioning services for their residents, PCTs also have a clear role in improving the health of their population and narrowing health inequalities in their area. Many Directors of Public Health are joint appointments with their local authority, in recognition of the role they play both in leadership terms and in influence over the determinants of health.

#### **Local Government White Paper and new LAAs**

The Local Government White Paper (LGWP) 'Strong and Prosperous Communities' sets out new arrangements for promoting local leadership and responsibility and decision making to local government. It puts in place new arrangements for making services more relevant to local people, and offers new opportunities for tackling health inequalities.

All local agencies will now be expected to deliver shared outcomes within a new Local Area Agreement (LAA) delivery framework.

#### **The Local Government and Health Bill**

Government is keen to ensure that local partnerships exist at the local level to support delivery of new PSAs expected in the Autumn of 2007 when the Comprehensive Spending Review is published. In order for this to happen, the Local Government and Health Bill is expected to include a requirement of formal partnership between PCTs and LAs with the specific purpose of producing a statutory *Joint Strategic Needs Assessment* (JSNA).

#### **Current health policy**

Responding to the challenges set out by Wanless, the Department of Health published the white paper *Choosing Health: making healthy choices easier* in 2004. The white paper aimed to tackle health inequalities and engage people in looking after their own health. It covers action to increase physical activity, promote healthier eating and drinking, and tackle sexual health issues. [DN: further information on priorities to be included here.]

*Health Challenge England - next steps for Choosing Health* published earlier this year sets out how the Department has been developing a new approach to public health, which aims to ensure that all sectors of society can contribute to the nation's health.

Other health policy contributing to this agenda includes the 2006, white paper *Our health, our care, our say* aimed at improving access, quality and choice in 'out of hospital' or community settings and will now be taken forward through the *Health & Well-being Commissioning Framework* currently under consultation and due to be finalised later this year. National Service Frameworks have also been published for a range of issues including mental health, coronary heart disease, older people's services, diabetes, renal services, children's services and long term conditions.

[DN: Information to be included on the new alcohol strategy. Also on drugs, including CDRPs.]

The Department of Health has also played a key role in working with other government departments on policy to improve the health and life chances of children and young people, such as the Teenage Pregnancy Strategy, SureStart, and *Every Child Matters*.

For the first time, tackling health inequalities is one of the top 6 priorities for the NHS as set out in the NHS Operating Framework 2006/7.

### **Initiatives being taken on the wider determinants of health**

Relevant initiatives are in place in relation to:

- employment
- education and skills
- poverty
- transport
- housing and homelessness
- crime and community safety
- urban environment, climate change and air quality.

## 4.2 ...and at regional level?

### Led by the GLA

This section focuses on action led by the GLA as the provider of strategic, citywide government for London. Since its establishment in 2000, the GLA has undertaken a wealth of strategic activity in London, together with the other organisations that form part of the GLA group and in partnership with other regional agencies, national bodies, local authorities, voluntary organisations and community groups and the involvement of individual Londoners. To give examples of actions could risk distorting the balance of aims and to attempt to summarise could not do justice to the huge breadth of activity. Therefore, instead this section describes the overall framework of regional activity led by the GLA, its aims and objectives and the types of interventions undertaken.

The overarching framework for this regional strategic activity is the Spatial Development Plan – known as the London Plan – which the Mayor is required to produce and review. The London Plan replaced government's strategic guidance and boroughs' development plans must be in 'general conformity' with it.

As well as the London Plan, the GLA Act 1999 gave the Mayor a duty to produce seven more statutory strategies covering air quality, biodiversity, ambient noise, municipal waste, culture, transport and economic development. In addition to these, many more strategies and action plans have been developed under the Mayor's general power to promote economic and social development, and environmental improvement in London including the Agenda for Action on Alcohol, Animal Welfare, Anti-social Behaviour, Childcare, Children and Young People, Cocaine, Domestic Violence, E-government, Energy, Housing Advice, Rough Sleepers, Tourism, a Tree & Woodland Framework, Climate Change, Food, Older People and Water..

All the strategies seek to realise a single vision for London, articulated by the Mayor, of London as an exemplary, sustainable world city based on three underlying principles: strong and diverse economic growth; social inclusion to allow all Londoners to share in London's future success; and fundamental improvements in environmental management and use of resources. Work to achieve this vision is organised around seven aims and 19 objectives over the coming 3 year period. These are:

*Aim 1: To meet the challenge of climate change and improve London's environment in a sustainable way*

1. Reduce greenhouse gases & other harmful emissions & promote sustainable, decentralised energy
2. Ensuring London is prepared for the impact of climate change
3. Consume fewer & recycle more resources
4. Improve access to London's environment

*Aim 2: To expand and improve transport provision in London*

5. Delivering improvements in public transport performance, especially London Underground
6. Ensuring delivery of key transport infrastructure projects
7. Achieving a more sustainable transport network

*Aim 3: To improve public safety*

8. Overseeing a fall in crime in the capital
9. Ensuring Londoners feel safer
10. Reflecting the diversity of London in its police and fire services
11. Being prepared for terrorism and other major emergencies

*Aim 4: To deliver sustainable economic growth within a changing global marketplace*

*Aim 5: To promote London at home and abroad as a world class city*

12. Regenerating London to deliver sustainable improvement in the living standards and quality of life of all Londoners
13. Increasing employment opportunities and productivity to enhance London's position as Europe's leading world city
14. Supporting the successful delivery of the 2012 Olympic Games and Paralympic Games
15. Promoting London as a leading world city for the 21st century – socially, culturally and economically

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*Aim 6: To remove inequality and increase social inclusion*

*Aim 7: To increase housing supply and reduce homelessness*

16. Removing the barriers preventing Londoners getting out to work
17. Promoting fair business practices
18. Ensuring a fair share of economic prosperity for minority groups
19. Accelerating the increase in London's housing supply and affordable homes

The strategies include many different types of interventions to achieve these aims and objectives. The types of intervention can be grouped into the following broad categories:

- *Strategic leadership* to develop a vision for London across London's public sector organisations, private business, voluntary sector and Londoners themselves by the Mayor.
- *Influencing central government* to change, extend or introduce new policies that will benefit London.
- *Using specific Mayoral powers* to implement the vision and strategies, including planning powers.
- *Working with the GLA group* to provide key services for London, including transport, policing, fire and emergency provision and economic development.
- *Building partnerships* with public sector organisations, private businesses, voluntary sector and Londoners themselves by the Mayor.
- *Influencing local delivery* by working with local authorities, primary care trusts and voluntary organisations by using funding and approval powers where available and partnership engagement where they are not.
- *Undertaking and disseminating research* into London's particular challenges and possible solutions.
- *Building international links* to see how London can benefit from the experience of other cities.

### **Key strategic partnerships**

Strategic partnerships have played an important role in achieving success in interventions. Key partnerships include:

*Board for Refugee Integration in London (BRIL)* This small high-level board brings together leaders of London services and refugee representation chaired by the Mayor. Its main tasks are to:

- draw up a strategy for refugee integration in London
- consult on this strategy
- oversee its implementation and review.

*London Child Poverty Commission (LCPC)* An independent body, the Commission was established by the Mayor of London and London Councils (previously the Association of London Government) to monitor progress in London against the Government's target to halve the number of children in poverty by 2010.

The Commission has been set up to:

- evaluate the effectiveness of the Government's national anti-child poverty policies.
- analyse the causes and impact of child poverty on the groups and communities in London who are most affected.
- draw on best practice at regional and local level
- identify new approaches to improving the life-chances of children
- raise awareness of child poverty issues in London with Government, London MPs and a wide range of other stakeholders.
- publish annual reports on progress towards the 2010 target and promote an annual conference on child poverty in the capital.

### **Led by the NHS**

NHS London, the Strategic Health Authority for London, is responsible for developing and implementing a strategy for health and healthcare in London; holding local organisations to account for the quality of the care which they provide; and ensuring capacity through the development of the workforce, technology and buildings. As part of its work to develop and implement a strategy for healthcare for London, NHS London has instigated a major review

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of healthcare in London. "Healthcare for London: A Framework for Action", is looking at healthcare systems around the world and at best practice in the United Kingdom. It will provide the framework for reshaping services in London over the next decade and more.

## 5 Potential risks associated with action to reduce health inequalities

This section identifies potential areas of risk for existing initiatives – what factors might prevent them from being successful in reducing health inequalities in London?

The mapping exercise revealed that considerable effort and investment have gone into initiatives intended to counter health inequalities and the conditions that contribute to bringing about these inequalities (for example, poor housing conditions). But there is much less evidence of sustainable or transferable learning arising from these initiatives. Where there is evidence of learning for good practice (for instance, in regeneration), there is little indication that this is implemented in a systematic way.

If the HIS is to be dynamic and effective, it needs to build on secure foundations, develop existing connections and make new ones across a range of different areas and dimensions. It is most likely to achieve this if the strategy is rooted in a learning culture, where all those involved in initiatives are keen to identify the key learning points when things do not turn out as expected, and to share the lessons of success.

### 5.1 Risks associated with lack of impact of initiatives

#### Health inequalities persist, despite efforts to tackle them through concerted policy initiatives

Despite inequality rising up the Government's agenda, it is clear that while health is generally improving overall in England, the gap between the most deprived areas and England as a whole is generally either static or widening. *Tackling Health Inequalities: Status Report 2006* set out national progress against achieving the 2012 targets in the 2004 Programme for Action. The report indicates that gaps in life expectancy, infant mortality, circulatory disease, and smoking in pregnancy have widened, whilst gaps in teenage conceptions, smoking, diet and road traffic accidents have stayed the same.

In terms of wider determinants, there has been some narrowing of the gap in educational attainment, housing standards and child poverty. However, these issues, which are well evidenced determinants of inequalities, remain particular issues for London.

The exercise of mapping national policy in relation to health inequalities has indicated that there is broad coverage in terms of both health policy and policy on wider determinants. Indeed, for ten years the Government has specifically prioritised tackling health inequalities with PSA targets aimed at narrowing the gap. However, it is also clear that health inequalities persist.

Questions about how effective policy has been are only partly answerable through formal evaluation and it is clear that there is a difference between achieving policy commitments and changing actual outcomes. The lack of progress in many areas affecting health inequalities prompts the following questions:

- Is the lack of progress due to problems being highly complex or intractable?
- Has policy been too small in scale to address the issues fully?
- Has policy not been in place long enough to achieve the desired effects?

#### Improved health for most, no health benefit for many

Many commentators have noted that government led interventions seeking to reduce health inequalities often have the opposite affect. This is because measures to improve health are often enthusiastically taken up by individuals in middle and higher socio-economic groups while they are ignored by many in the lowest group and particularly individuals experiencing multiple deprivation. This means that mortality and morbidity improves for the general population but stays the same for those experiencing deprivation, resulting in an increase in health inequalities. One example of this is the differences in smoking cessation rates amongst different groups.

Interventions relating to the wider determinants of health are equally at risk of increasing health inequalities by achieving general improvements that do not benefit the worst off. For example, reducing age discrimination in employment may allow many older people to work

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for longer which may improve their health. However, older people who are unable to work will not benefit.

Many commentators have also observed that the relatively better off tend to hijack improvements in services or new initiatives. This may be because they are more likely to receive information about such initiatives and be able to act on it. One implication of the introduction of choice into public services is that the better off may continue to access the best services leaving those most in need with the worst.

### **5.2 The risks of unintended consequences**

Some policies or interventions that seek to improve health, quality of life or access to services may have unintended consequences that could impact on health inequalities. For example, introducing free travel for children and young people on buses may contribute to older people's fears about crime on public transport. Road pricing provides another example. Road pricing appears on the surface to have health benefits attached to reduced congestion – a reduction in vehicle emissions and road traffic accidents which disproportionately affect people in deprived or BME communities. However, as road pricing reduces traffic volumes, it also has the potential to increase traffic speeds and hence potentially to increase the number and severity of injuries to pedestrians and cyclists and increase inequalities.

### **5.3 Risks associated with lack of coordination**

Because health inequalities are a cross-cutting issue with responsibility lying across many government departments there is also the risk that responsibility for reducing inequalities falls between the stalls and accountability is lacking. In Government, while the Department for Transport focuses on transport policy to relieve congestion and reduce accidents, the Department of Health aims to promote physical activity through 'active travel' and Communities and Local Government are responsible for urban development. This can be problematic when, for example, policies to promote public transport in order to reduce car journeys (such as the Mayor's free bus travel for children) have the potential to reduce the numbers walking and cycling which could in turn impact on childhood obesity.

This is evident too at a local level, where deprived communities are often subject to multiple environmental exposure, e.g. poor air quality, contaminated land, waste disposal sites, industrial process. These issues are regulated by separate agencies and so there is no overview of environmental exposure.

### **5.4 National policy may not address London's particular circumstances**

Poverty example - Parental worklessness is the main driver for child poverty. Child poverty rates have fallen less quickly in London probably due to the higher competition for unskilled jobs in inner London and higher levels of need. Other issues such as the higher cost of housing, goods and services and wider polarisation of household income exacerbate child poverty in London.

Road traffic accidents examples - while progress on PSA targets has been good generally, some groups remain at much greater risk. In London, it is believed that the 'deprivation effect' in injury risk is greater with high levels of child poverty and unemployment affecting some BME groups and lone parents. Other differences in London include the number of daily commuters and work-related traffic, higher access to public transport and movement (see the recent study, 'Deprivation and Road Safety in London', carried out by researchers from the London School of Hygiene and Tropical Medicine).

In terms of measures used to assess achievement in reducing health inequalities, it is clear that the national PSAs do not show the whole picture. Nationally, progress in narrowing the gap is measured by taking the average from the Spearhead Group of local authorities (fifth of areas with the worst health and deprivation indicators) and England as a whole. In London, a focus on borough averages can be misleading in assessing needs, as extreme wealth in some boroughs can mask huge inequalities. In Westminster, for example, life expectancy in the lowest fifth of wards is 75.4 years compared with 84.7 years in the highest fifth – a gap of 9 years.

### **5.5 Structural risks – what are the vulnerable points in the system?**

They are several important structural risks which threaten the delivery of action. For the *Mayoral Strategies* these include:

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- They are high level strategies dependent on quality of delivery projects for success.
- Some of the Strategies are dependent to a large degree on wider economic developments.
- The implementation of the strategies is dependent on action by a number of different implementing agencies at the local and regional level.
- Many provisions are dependent on market driven factors for employment creation that are determined by developments outside the control of the GLA.
- Many of the activities must be delivered by agencies with far broader remits so could become marginalized or lost.
- The ability of the initiatives to reduce inequalities that are targeted at certain population groups, such as older people or people from black and ethnic minorities, will depend on whether they can involve those individuals who are risk from or experiencing deprivation, poverty and poor health outcomes as well as those who are relatively better off.
- The GLA has few powers. Delivery is therefore dependent on the actions of other agencies, including institutions and organisations with very large budgets, subject to additional policy and budgetary pressures.
- Many provisions of the strategies are dependent on actions of private developers that are determined by developments outside the control of the Plan.
- London is also affected by air pollution produced elsewhere and brought to London by weather conditions.
- Many key priorities are led by partnerships with no statutory powers or resources (eg the London Child Poverty Commission).
- Lack of available funding.
- Lack of available staff.

For the *NHS* these include:

- The availability of health services is subject to the availability of qualified staff to work in the health sector in London. There is a particular shortage of GPs in some areas of London which could threaten the provision of primary care.
- The infrastructure of the NHS and the provision of health services are highly dependent on national government policy and funding.
- London NHS is currently undertaking a thorough review of health service provision across London which could develop proposals contrary to the London Plan.
- There is a threat previous work and expertise could be lost through the current reorganisation of the NHS in London.

## **5.6 Impact of national priorities versus local needs**

- To date, nationally driven policy through local agencies via separate programmes etc. has meant that resources have been geared towards the delivery of these programmes only. The impact of this is that the scope for local areas to work in partnership on shared priorities has been undermined.
- In some areas, delivery of some national targets have, in effect, provided disincentives for targeting those people in most need. For example, the national priority to increase the numbers of people quitting smoking has meant that services have felt compelled to treat the easiest-to-reach smokers as this would be easiest way to reach the target set by Government. In this case, health inequalities would widen.
- In areas that are expected to focus on inequalities and deliver to national priorities such as Spearhead authorities or those boroughs in receipt of Neighbourhood Renewal Funds, the opportunity to focus on inequalities is clear, however for other areas good performance at a borough level might mask variations at the ward and neighbourhood level (as discussed above).

## **5.7 Challenges of local level working**

- The capacity of local partnerships (and the partners themselves) to operate and deliver to a high enough quality and standard to reduce health inequalities and the negative impact of wider determinants is patchy across London and difficult to maintain. Local partnerships are developed in London boroughs to varying degrees. In addition, many LSPs operate through a series of theme groups focusing on strategic issues such as health and well-being, children & young people, crime and drugs or housing and environment.

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- The co-ordination of these groups and management of complex local infrastructure is often a difficult task that is easily affected by problems specific to one or more partners. Financial challenges for a Local Authorities or PCT for instance would limit the level of engagement possible in working towards shared priorities. As government puts increasing pressure on local authorities and their partners to make cost savings, working on health inequalities becomes more of a challenge. For example the cost of supporting a non-English speaking smoker to quit using the NHS Smoking Cessation Service would be increased by the need for an interpreter.
- Information and access to data and information on the impact of wider determinants at a local level is often difficult to access and in some cases does not exist at a borough or sub-borough level. Data to support delivery of outcomes is usually driven by performance management requirements and resources allocated on the basis of agreed activity. There is little scope for working more broadly and in partnership on local priorities unless disinvestments are agreed with government.
- A strong element of LSPs is the involvement of locally elected Council Members who usually represent a political view point. The risk of political ideology not including or prioritising tackling health inequalities could mean that for some of the most marginalised and disenfranchised communities health inequalities will persist and even widen.

## 6 Opportunities for London-wide action to reduce health inequalities

The mapping shows the complex patchwork of action being taken at national, regional and local levels to tackle health inequalities in relation to the identified themes. The researchers used the following review questions to help identify potential opportunities for constructive action.

- Are all the determinants of health being addressed by existing roles, strategies and activities?
- Are all vulnerable groups adequately targeted by existing roles, strategies and activities?
- Are all good sources of information being used (e.g. 'community voices')?
- Are particular health problems that are over-represented in the capital (e.g. smoking rates, drug and alcohol abuse, HIV/Aids) adequately targeted by existing roles, strategies and activities?
- Where the answer is no, does the gap arise because of a lack of clarity about roles or is it a strategic omission or is there a failure to translate existing strategy into action? Or is it due to a failure in implementation that might be important for the evidence base?

This section summarises potential areas of opportunity for the Mayor to build on and challenge nationally, and to lead, support and influence at regional and local levels.

### 6.1 National policy initiatives on health

#### New health performance arrangements

Health indicators along with all other Government indicators are currently being reviewed as part of the 2007 Comprehensive Spending Review. Indicators are expected to become much more outcomes-focused and relate to the three Departmental Strategic Objectives for the Department of Health. These focus on improving health and well-being, improving care and access to services, and improving value for money both in terms of cost and efficiency of services, but also of the wider contribution the NHS makes to the wider economy.

Future indicators are likely to include some of those already being measured including, 'all-age, all-cause' mortality and life expectancy. Proposed changes to indicators such as moving from smoking cessation to smoking prevalence may improve the targeting of action to reduce inequalities

The Department of Health will agree targets with local areas through Local Area Agreements and Local Delivery Plans (LDPs). LDPs will include those targets which can only be delivered by the NHS and do not rely on the involvement of other local partners. The vast majority of national targets that will require partnerships approaches to delivery will be agreed through the LAA process described above. This will increase the potential to impact on the wider determinants of health and to take a whole systems approach.

#### New accountability measures

In addition both LDPs and LAAs will be expected to include local targets locally agreed and locally accountable. The recent legislation puts in place measures for significant improvements to local accountability mechanisms to ensure local targets become just as important as national targets, aiming to rebalance the emphasis between national and local priorities. Enhancement of the role of local Councillors, the choice in the options for local democratic processes, and the development of more robust local community involvement frameworks are all expected to contribute to strengthened local accountability.

There is scope to include a wide range of social care outcomes in LAAs – a sphere for action that could potentially contribute to the Health Inequalities Strategy.

#### Role of the GLA in LAAs

The Local Government White Paper has significant implications for the GLA and its functional bodies, affecting in particular:

- their relationship with boroughs, especially in regard to the White Paper's strengthened role for LAAs; and

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- changes to their performance framework given their local authority status for finance and corporate issues.

The White Paper's emphasis on local authorities as strategic leaders and place-makers, and the strengthened role for Sustainable Community Strategies and LAAs to achieve this, has particular implications for the GLA family and their relationship with boroughs.

The White Paper emphasises that boroughs will continue to be responsible for the preparation of Sustainable Community Strategies and LAAs for their area. But given the unique existence in London of a directly-elected Mayor responsible for the production of statutory London-wide strategies, boroughs will have to have regard to these strategies when preparing their Sustainable Community Strategies and agreeing LAA targets. The aim is for the different service providers to work towards the same set of targets and for there to be as much synergy as possible between the Mayor's and boroughs' plans. It is expected that this requirement will be set out in statutory guidance.

Three of the Mayor's functional bodies – the Metropolitan Police Authority, London Fire and Emergency Planning Authority and London Development Agency – are included on the White Paper's list of named partners subject to the duty to cooperate on the agreement of LAA targets.

The GLA and Transport for London are not included on the list. They already have statutory duties in the GLA Act to consult boroughs on the preparation of Mayoral strategies. Transport is also subject to a separate statutory process (the Local Implementation Plan process) requiring boroughs to implement the Mayor's transport strategy. However, the White Paper expects both bodies still to be actively engaged in the LAA process.

### **Performance framework arrangements for the GLA family**

The White Paper's wider changes to the local authority performance framework will also impact on the GLA family, given their local authority status. In particular:

- the best value changes which will see the removal of the requirement on the GLA family to produce best value performance plans and conduct best value reviews, to be replaced by a new best value duty to encourage citizen participation in the delivery of functions, where appropriate, based on the four concepts of participation (informing, consulting, involving, devolving) to be set out in statutory guidance.
- a more streamlined performance framework for the GLA, TfL and the LDA replacing the IPA assessment, involving the Audit Commission undertaking annual risk assessments, Direction of Travel statements, and Use of Resource judgements. Ministers will retain the same power of intervention to tackle poor performance, although further work needs to be undertaken on how this performance framework will work in practice with the GLA family.

## **6.2 Building on the developing role of the Mayor**

The Draft GLA Bill currently going through Parliament presents a huge opportunity for London wide strategic action to tackle some of the most pressing social and economic problems in the capital. In addition to the new duty to prepare a strategy to tackle London's health inequalities and promote the reduction of health inequalities in London, the Mayor will assume new powers and duties that will enable action to improve the determinants of health. These new powers and duties include:

- *Housing:* The responsibilities of the London Housing Board will transfer to the Mayor. He will prepare and publish a statutory London Housing Strategy and a strategic Housing Investment Plan, setting out the priorities to meet the housing needs of all Londoners and decide the broad distribution of the affordable housing part of the Regional Housing Pot in line with the strategy.
- *Learning and Skills:* The Mayor will have a statutory duty to promote skills in London and will chair a new London Skills and Employment Board, drawn from business and other key sectors and will prepare a new statutory Skills Strategy for London, setting priorities and budgets.
- *Planning:* The Mayor will be able to direct changes to boroughs' programmes for the local development plans they produce and will have the discretion to determine planning applications of strategic importance.
- *Waste:* The Mayor will lead a London-wide waste and recycling forum, working in collaboration with the boroughs to improve performance in waste management and recycling. London's waste authorities will be required to be in general conformity with

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the Mayor's Municipal Waste Management Strategy, backed up by the Mayor's power of direction.

- *Climate Change and Energy*: The Mayor will prepare and publish a statutory Climate Change and Energy Strategy for London, stating how the capital should minimise emissions of carbon dioxide by the use of energy in London, help to eradicate fuel poverty; and harness economic opportunities for London from investment and innovation in energy technologies and energy efficiency. The Greater London Authority will be subject to a specific duty to take action to mitigate the effects of climate change and help London adapt to its unavoidable impacts.
- *Water*: The Secretary of State will have regard to the Mayor's Water Action Framework when framing guidance to regulators in preparation for a review of water price limits.

## 6.3 Opportunities for action on the determinants of health

The opportunities highlighted below relate directly to the findings of the mapping exercise carried out at national, regional and local levels. They indicate specific areas where further action is likely to be constructive, but they do not present a full picture of how things stand in London. They need to be considered in conjunction with the findings from the HIS call for evidence, the developing evidence base on health inequalities in London, and the work with community groups.

Some headings recur across the areas of opportunity, reflecting different aspects, such as learning and action.

### Housing

The lack of affordable, good quality housing is an major problem which affects health both directly, as poor or temporary housing negatively impacts on health, and indirectly, as the lack of affordable housing for health, social care and other key workers compromises services. The new powers granted him by the Draft GLA Bill present the Mayor with opportunities to direct the provision, location and design of affordable housing.

### Hosting the 2012 Olympic and Paralympic Games

London hosting the 2012 Olympic and Paralympic Games provides a 'once in a lifetime' opportunity to achieve a range of goals including job creation, upskilling the workforce, the physical regeneration of East London and improving health. In particular, there needs to be activity to ensure that the huge expenditure on urban development and regeneration incorporates good practice relating to how urban environments can contribute to the health and well-being of the most deprived Londoners..

### Health promotion and public campaigns

Health promotion campaigns are not generally undertaken on a London wide basis. They are either undertaken nationally or locally. There may be opportunities to apply some of the types of material and strategies previously used successfully by the GLA group in other London wide campaigns (such as transport) to health issues. These could be healthy lifestyle messages, information about health problems particular to the capital or updates about services. (Some specific suggestions are given below.)

### Reducing poverty: tackling a multi-level challenge

- According to the DMAG June 2006 briefing, one quarter of London's children in benefits families were those where the main adult claimant was sick or disabled. In addition to measures to improve labour market access and create employment, there is a need for measures to move families out of poverty where the main carer is unable to work in order to reduce child poverty.
- Increasing employment amongst economically excluded communities may not in itself improve health and reduce health inequalities. This depends on the types and quality of jobs created. This will involve working with employers and could incorporate the recommendations of the London Works for Better Health for improved quality employment.
- There does not seem to be sufficient understanding of the impact of higher prices in London on poverty levels for individuals and families reliant on benefits. Therefore, further work to look at the feasibility and advisability of London weighting benefits could be useful.

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- Given the possible impact on health inequality of improving fuel poverty, this may deserve inclusion in the Health Inequality Strategy.
- Free and universal childcare is necessary to ensure that all vulnerable families can benefit as not all families can afford subsidised childcare. Free childcare should be provided outside deprived areas as most deprived families do not live in pockets of deprivation. In addition, there is a need to recognise that childcare can offer broader benefits to the health and well being of parents and children than those directly associated with employment. Parents who cannot work also need to have access to childcare.
- The expansion of the London economy provides a huge opportunity to increase the wealth of Londoners but the challenge will be to ensure that in future more people share in that success. Also, the recent work of the Child Poverty Commission which has led to Treasury and DWP commitment to address this problem is to be welcomed as is the new Skills and Employment Board for London, chaired by the Mayor.
- London's child poverty problem will affect the ability of the government to reach the national target. London's Child Poverty Commission will play a key role in addressing this problem. It is likely that City Strategy pilots will test out some radical new approaches to tackling worklessness among families with children in London.

## Taking a broad view of education and skills training

- There is a danger that the focus of basic skills and ESOL training is in practice confined to those individuals who may wish to and are able to enter employment. Many of those experiencing the worst health outcomes may not be able to work but they could still experience health benefits from ESOL and basic skills training. Therefore, the provision of basic skills and ESOL training that is not marketed only as a route to employment is important.
- There has been significant research into the effectiveness of the healthy schools initiative. There may be scope for a regional intervention to build on best practice identified and spread this London wide.

## Encouraging further involvement of, and in, the voluntary and community sector

- The recent publication by the Department of Communities and Local Government of the "Third Sector Strategy for Communities & Local Government" sets out to consult on how to improve relations with the third sector – there is opportunity for the Health Inequalities Strategy and the Mayor's other strategies to influence how this rolls out in London
- Volunteering has been demonstrated to have beneficial affects on well-being. Further work to look at involving excluded communities and individuals in volunteering could warrant inclusion in the health inequalities strategy.

## Climate change and air quality

- Public campaigns on the negative health impacts of climate change may contribute to a change in behaviour.
- Further work is needed to identify and mitigate the possible negative impacts of improving air quality, notably a possible increase in UV radiation causing skin cancer.

## Access to, and affordability, of good food

- Further work is needed to understand what influences dietary decision making and how to effectively change behaviour amongst groups with the most established unhealthy eating habits.
- Identifying food deserts, implementing mechanisms to improve the physical accessibility and affordability of healthy food in these areas and monitoring changes. This will involve working with food retailers to find incentives for these retailers to operate in areas which they may not consider profitable.
- Further support of London Food who are working to develop activities and policies which support a sustainable food system in the capital.

## Physical exercise

- Identification of good practice and further work with local authorities to make sporting facilities more accessible, particularly to low income groups, women and older people.

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- Identification of good practice and further work with schools to encourage exercise amongst children, including walking to school initiatives. In addition, further information on how national curriculum requirements on physical exercise in education are being met in London and if there are sufficient sporting facilities to meet them.

## Use of tobacco and other drugs

[DN: Info on drugs and alcohol info to be included here.]

- High profile information on the smoking cessation ban linked to access to support to quit smoking.
- It may be useful to provide information on tobacco and qhat/mirha chewing on a London wide basis. This is more common among people from BAME so may contribute to health inequalities between ethnic groups.

## 6.4 Opportunities to improve access for vulnerable groups

The opportunities highlighted below relate directly to the findings of the mapping exercise carried out at national, regional and local levels. They indicate specific areas where further action is likely to be constructive, but they do not present a full picture of how things stand in London. They need to be considered in conjunction with the findings from the HIS call for evidence, the developing evidence base on health inequalities in London, and the work with community groups.

### People from black and minority ethnic groups

Some black and minority ethnic groups have worse access to the determinants of health than white British and other ethnic groups. Examples include: unemployment among BAME Londoners is twice the rate of white Londoners, with considerable differences between ethnic groups; London's black pupils are twice as likely as its white pupils to be excluded from school; Bangladeshi, black African and Pakistani households are more than five times more likely to be in overcrowded homes than white British households. Ensuring equality of access to the determinants of health needs to be central to the Health Inequalities Strategy.

### Refugees and asylum seekers

- Refugees' health may be improved by ensuring their inclusion in activities to improve access to employment.
- Action to improve the access to health services of unaccompanied refugees and asylum seekers and more research on their numbers and health status.

### People with mental health issues

- People with mental health problems can be vulnerable to falling into deteriorating spiral of ill health without proper support. They are more likely to be homeless or live in unfit accommodation, be living in poverty and have insufficient access to services, including mental health services. They are also more likely to be using alcohol and drugs harmfully. Work undertaken by Dr Foster for the GLA showed that service provision for people with mental health problems varies greatly across London. Because of their vulnerability, the disparities in service provision across London and the complex interaction of agencies involved, the needs of people with mental health problems may deserve inclusion in the HIS.
- There is a need to address disparities in funding and service provision of mental health support services across London
- There is a need to improve mental health support services available at the level of primary health care.

### Disabled people

- Further work to identify the barriers to accessing services for people with disabilities, and action to remove these barriers.

### Homeless people and those with acute housing needs

- Further work to address the difficulties homeless people face in accessing health services. There may be opportunities to build advice-giving on access to health services into housing advice.
- Work to ensure the housing needs of individuals and families who are not able to access shared ownership and other intermediate housing can be met.

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- Zero carbon housing developments provide an opportunity for lower-income households to gain from energy savings and an improved living environment as long as they have the opportunity to access what is likely to be housing that is more costly to build

## Some users of public transport

- Public transport continues to be seen as unsafe by many individuals, especially women and older people. Furthermore, the increase in the use of transport by young people may reduce its use by older people because of perceptions about safety. Therefore, additional action to improve safety and perceptions of safety on public transport may increase access.
- Transport for London has shown a willingness to set targets that are more ambitious than national targets and has made funding available for schemes to reduce traffic (building on the travel plan work in schools, 28 NHS trusts will receive funding to develop travel plans in London in 07/08). Nationally, there are relatively high levels of funding for road safety work and relative security from the five-year local implementation plans. Many road safety initiatives now focus on disadvantage and are required to contribute to the evidence base around what works to reduce accidents in disadvantaged areas.

## Carers

There is little discussion about the needs of carers in the regional strategies reviewed. Carers often experience high levels of stress because of their responsibilities. They are also vulnerable to physical injury due to lifting and other heavy work. Access to proper services for the person they are caring for and for themselves is likely to improve their health. Children, older people, women and people from black and ethnic minorities are especially affected by caring responsibilities. Further work is needed to understand the extent of informal caring in London, what the needs of carers are and identification of good practice in supporting carers at a local level. The needs of carers may warrant inclusion in the Health Inequality Strategy. Children with caring responsibilities may warrant special attention because of their particular needs.

## Other equalities groups

The creation of the new Commission for Equalities and Human Rights in October 2007 will extend the focus on achieving equality for black and minority ethnic groups and disabled groups to other equalities groups, including older people and gay, lesbian, bisexual and transgender people.

## **6.5 Opportunities to improve information and understanding**

The opportunities highlighted below relate to potential ways in which the GLA and its partners might improve their information about, and understanding of, health inequalities in the capital and the kind of initiatives that are likely to be successful in tackling them. The key aim is to focus future effort as effectively as possible.

These opportunities relate directly to the findings of the mapping exercise carried out at national, regional and local levels. They indicate specific areas where further action is likely to be constructive, but they do not present a full picture of how things stand in London. They need to be considered in conjunction with the findings from the call for evidence, the developing evidence base on health inequalities in London, and the work with community groups.

### **2012 Olympics and Paralympics**

To improve understanding of the health benefits of the economic and employment opportunities created by the 2012 Olympic Games and introduce this more clearly into the debate around and planning for the Games.

### **Effects of child poverty and poor education**

- Further work to understand the impact that the very high levels of child poverty in London have on health inequalities.
- Further work to identify what evidence there is to indicate links between poor education and poor health outcomes later in life.

### **Needs of those living in poor quality and/or temporary accommodation**

- Information on the numbers of families and individuals living in existing poor quality accommodation in the social and private sectors who do not qualify for rehousing to understand the extent of the impact on health inequalities of those “trapped” in poor quality accommodation.
- Further information is needed on how people in temporary accommodation access health services.

### **Use, and non-use, of public transport**

- Further research to look at public transport use and barriers to use.
- Further research to see if Safer Transport Teams and Safer Neighbourhood Teams improve people’s sense of safety and how this affects their well-being.

### **Effects of climate change and change in air quality**

- Further work to model the potential health impacts of climate change in London and to understand which of these are now inevitable and should be planned for. In particular this should focus on the specific health implications faced by Londoners as opposed to UK residents generally because of the exacerbating factor of the urban heat island affect.
- Further work to understand the link between deprivation and increased mortality and morbidity due to higher temperatures and modelling to establish what this could mean for health inequalities in London with climate change.
- Further research on the affects of air pollutants on health, especially at what level of exposure health can be damaged and which sorts of particle matter are most harmful.
- Further work to highlight any adverse consequences on health of an improvement in air quality and action to mitigate against these (eg awareness raising on skin cancer).

### **Access to health services and health outcomes**

- There is insufficient monitoring and evaluation of who accesses services. There is also a lack of information about which groups are likely to be most affected by inadequate access. Work to update the information collected as part of the London Assembly’s scrutiny of access to primary care. This should include access for disabled people and more information on who is most affected by inadequate access. Is it those living in pockets of deprivation? Are older people or children more adversely affected?
- Information from the Health Survey for England London boost sample, commissioned by the London Health Observatory and due in Summer 2007.

### **Understanding differences in health outcomes amongst different black and minority ethnic groups**

We often do not have enough information on differences in health outcomes between different ethnic groups to understand the extent of and reasons for these differences. The systematic collection and interpretation of data on morbidity and mortality broken down according to ethnic group needs to be improved.

### **Use of tobacco and other drugs**

[DN: Info on drugs and alcohol info to be included here.]

- Better information on smoking rates and smoking cessation rates with a view to evaluating the success of interventions.

### **Carers**

More information on the number of carers in London, including young carers, and what their mental health support needs could be.

## **6.6 Opportunities for action on health problems in London**

The opportunities highlighted below relate directly to the findings of the mapping exercise carried out at national, regional and local levels. They indicate specific areas where further action is likely to be constructive, but they do not present a full picture of how things stand in London. They need to be considered in conjunction with the findings from the HIS call for evidence, the developing evidence base on health inequalities in London, and the work with community groups.

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### **Mental health**

The wide range of cross-cutting issues identified as problems suggests that more attention needs to be paid to mental health and wellbeing across the board, including – but not confined to – challenging stigma and exclusion faced by people with mental health issues in services and employment.

### **TB in London**

There may be opportunities for non-NHS organisations to make contributions to the work of the Stop TB in London group, particularly around prevention and awareness-raising.

### **Teenage mothers**

Further research on the health outcomes of teenage mothers and their children needs to be identified. Work needs to take account of how different BAME groups view teenage pregnancy. We cannot assume teenage pregnancy has a negative impact on the health and well-being of all teenage mothers and their children.

### **Immunisation rates**

Information on immunisation rates could be collated across London and used to inform targeted or London wide campaigns.

### **Breast feeding rates**

Identification of evidence and research on breast feeding rates. This could inform the development of new types of campaigns to increase breastfeeding. [Note that that Food Standard Agency is currently transposing the EU directive on formula milk into a statutory instrument. This may be a golden opportunity for Britain to lead from the front by bringing things into line with the WHO code on the marketing of breast-milk substitutes?]

### **HIV**

London has more than 32,000 people living with HIV and there are a large number of organisations in the voluntary and community sectors working to support people with living with HIV. In view of this, HIV may warrant inclusion in the HIS. There may be opportunities for non-NHS organisations to make further contributions, particularly around prevention and awareness raising.

## **7 Challenging assumptions about health inequalities – and moving towards policy options**

This section identifies some of the key issues raised by the experience of reviewing a mass of wide-ranging measures relating to health inequalities, and suggests some ways of moving forward on addressing complex challenges with meaningful policy options and action.

The following Q&As crystallise some of the key challenges, dilemmas and paradoxes that the mapping exercise produced. The aim is not to discourage or disincentivise (such a complex challenge! so many difficult questions!) The purpose, rather, is to help readers concentrate on the essence of what they want to see the Health Inequalities Strategy achieve – and to provide a framework for ensuring that they will support decisions and actions that will genuinely contribute to these achievements.

### **7.1 Challenging assumptions**

#### **What do we mean by health inequalities?**

This question is discussed at some length in section 2.1 of this report. The discussion is duplicated here for the convenience of the reader.

National government action and targets have focused on the gap in infant mortality across social groups and the difference in life expectancy between those living in the most disadvantaged areas and those living elsewhere as key indicators of health inequalities. However, as recognised by the Government's Cross-Cutting Review and subsequent Public Service Agreements (PSA), there are many other possible definitions and indicators of health inequalities. Some of them relate to changes across the whole distribution of health

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outcomes, whereas others focus on the position of the lowest group relative to the average or to the group at the top. These may also be relevant to the challenges involved in developing the Mayor's Health Inequalities Strategy.

These definitions and indicators include the *groups to be compared* in order to measure health inequalities. The difference between geographical areas where populations have the worst health outcomes and the best could be used. However, it is also important to recognise that some people experiencing deprivation do not live in geographical pockets of deprivation so a geographical focus alone will not be effective. Socio-economic groups, usually defined by income and/or occupation, are sometimes used to measure health inequalities. The difference in health outcomes between ethnic groups, between men and women, between gay men and lesbians and heterosexual people and between other groups can also be significant.

Different types of indicators can also cover the *outcomes to be compared*. These include life expectancy, morbidity such as incidence of CVD and cancer, excess morbidity and mortality. Self assessed health – how well people feel themselves to be – may also be an important factor in health inequalities.

Focusing on a single type of indicator may miss the complexity of the interaction of factors that contribute to health inequalities as well as the individual's experience of health and well-being.

## Improving health versus reducing health inequalities?

Reducing health inequalities implies reducing the gap between differences in health outcomes. This means either reducing health outcomes for these with the best or improving them for those with the worst. Clearly, reducing the best outcomes is neither ethical nor desirable. However, action that seeks to improve quality of life or increase access to services for the general population can disproportionately benefit middle and higher income groups at the expense of the poorest or most excluded groups. For example, improvements in leisure and sporting facilities will not benefit low income groups if the charges for use remain too high for them.

If general health improves but those with the worst health outcomes do not benefit, health inequalities will get worse. Enabling those with the worst health outcomes to make lifestyle changes has been very challenging while the population as a whole has been able to benefit from such changes, as illustrated by the differential smoking quit rates across socio-economic groups. Choice – including choice of lifestyle – figures prominently in government agendas across a range of different dimensions of life. Given the kind of findings above, how is increased choice, as currently presented, likely to impact on health inequalities?

Similarly improvements in access to services or opportunities has benefited many individuals and groups while excluding the most vulnerable. For example, reducing age discrimination to enable older people to compete for jobs and stay in work longer is unlikely to benefit older people who have been out of the labour market for a long time or those who have never worked but these older people are likely to be amongst the worst off. Therefore, an important challenge for the Health Inequalities Strategy will be ensuring action does not just deliver further benefits to most Londoners, while failing to reach those worst off. *This makes the Health Inequalities Strategy quite different from most of the other Mayoral Strategies, which while they may include some actions targeting inequalities – for example fuel poverty – are in the main concerned with ensuring improvements for all Londoners.*

## Why a health inequality strategy?

This may come under the heading of 'inconvenient question' rather than dilemma or paradox. The other way of framing the question might be, 'If you really want to reduce health inequalities, why not simply go for a strategy that focuses on income inequalities?'. There is evidence that the health outcomes of an individual can be more accurately predicted using parental income than any other income. There is also evidence that income mobility has reduced in the last generation. The Centre for Economic Performance has compared the experience of two different generations and concluded that the income of those born in 1958 was less closely related to parental income than it was for those born in 1970. If poor health is a consequence of poverty and income mobility is limited, interventions that address the inequalities in health cannot be effective. Only by reducing income inequalities as the cause can health inequalities be reduced.

## **What does choice mean?**

Many of the policies and activities looked at in this mapping focus on choice. People are encouraged to choose lifestyles that improve their health and well-being and to choose which services they wish to access. To enable them to make these choices, they are given more information. But how real is this choice? People on low income and living in deprived communities may not be in a position to benefit from these so-called choices. Benefiting from choice requires more than information. It requires economic and geographic access, as well as a culture that holds the same outcomes to be desirable.

## **Who/what contributes to creating and maintaining health inequalities? Are they the same agencies/forces as those expected to work against such inequalities?**

Developing a strategy to combat health inequalities must surely involve identifying the interests involved in keeping the status quo. In some cases, it may be that certain agencies – supermarkets, for example – are seen as benefiting from the status quo but also having a potentially important role to play in bringing about change. What are the implications of identifying several agencies with a potential dual role of this kind?

## **Who cares about health inequalities?**

The issue of health inequalities has attracted growing interest, in the UK and globally. Concern can be seen expressed both in political agendas and debate and in academic research and debate. Some of the academic work scrutinises and critically evaluates government policy and action; some of it provides evidence on which government initiatives are based. What relationship between the political and academic domains is likely to be most helpful in creating a framework for thinking and action that will address the genuinely complex and sometimes paradoxical challenges lying at the heart of health inequalities? What steps can be taken to ensure that the Health Inequalities Strategy benefits from a relationship of this kind?

And who else cares about health inequalities? A key question for the development and presentation of the HIS will be: how will the issue of health inequalities be seen by large swathes of London's predominantly youthful population who may not see the issue as relevant in any way to their lives? Is the message to be that health inequalities are of concern only in relation to the lives of certain vulnerable groups? If so, why should others care? If not, what is the message to be?

## **Which health inequalities matter most?**

The Health Inequalities Strategy will need to focus action where it can make a significant difference to health inequalities. Rationally, this would be action that affects the largest possible number of people experiencing the worst health outcomes. There are many small groups who may not be sufficiently numerically significant to make an impact on health inequalities as measured at a population level. *However, some of these groups may be experiencing an intensity of health inequalities that, nevertheless, creates an imperative for action.* For example, the health outcomes of unaccompanied asylum seekers aged under 18 will not significantly change differences in life expectancy across London but may still warrant inclusion in the Strategy because of the particular difficulties these individuals experience.

## **How do the determinants of health impact on health outcomes and health inequalities?**

Over the last decade the broad public health community in the UK have argued for recognition of the importance of the determinants of health to be taken into account in formulating policy and action improve health outcomes and reduce health inequalities, rather than looking at health service provision alone. This advocacy seems to have been successful, as illustrated by the high profile given to health improvement in the regional strategies reviewed as part of this mapping although they are not concerned with action on health services. The fact that the Mayor is to be tasked with developing a Health Inequalities Strategy focusing on action on the wider determinants of health is further evidence that the message that health determinants are crucial to health inequalities has been heard. Therefore, now seems an important opportunity to deepen the debate around the determinants of health and health inequalities with a view to understanding *how, why, how much and when* they impact on health outcomes, rather than to keep stating that a

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particular action will improve health *because* it is a key determinant of health. *With this in mind, it may be useful to develop a framework that describes the possible interactions between the health determinants and health outcomes at key stages of an individual's life.*

### **What are the challenges in attributing health improvements to specific strategies or other interventions?**

Health outcomes, and therefore health inequalities, are influenced by individual factors, health care interventions and the wider determinants of health. Some of the individual factors, such as diet, are themselves influenced by the determinants of health. Others, such as genetic factors, are not. Some of the interactions between individual factors, health care interventions and the determinants of health are not clearly understood. For example, heavy drinking in people in higher socio-economic groups seems to be less harmful than in lower socio-economic groups. This could be because of the protective influence of diet, housing, health care or other factors. Furthermore, the influences on individual behaviour are complex. For example, some children who grow up in pockets of deprivation become problem drug users but the majority do not. This complexity makes attributing change in health outcomes to any one intervention very difficult. In turn, this creates problems in evaluating the success of interventions.

Attempts at attribution are further complicated by the fact that an agency or several agencies may be running different interventions for the same target group and with the same aim or aims. It may not be possible to measure which intervention made the key difference, if it was their combined benefit, or if the change would have happened anyway. The impact of strategic interventions which seek to influence outcomes indirectly by changing the way front line organisations interact with individuals are even more difficult to evaluate. For example, does an organisation change the way a service is delivered because of a regional strategy, a national policy or an internal organisation development that would have happened anyway? And does this change in service have any impact on the users?

Increasingly, these problems are being recognised. For instance, with its major new funding programme for organisations offering community-level services, *Partners for Health in London*, the King's Fund is currently using an approach to evaluation that aims to identify and share learning from practice in order to influence policy.

### **How do we define groups of individuals?**

There are a number of terms that are widely used to describe groups of individuals who may be at risk from health inequalities. These reflect the terminology widely used in the public policy as well as the definitions used in research into health outcomes. Therefore, the terms socio-economic groups, social class, lower quintile, deprived communities, socially excluded groups and others are used, sometimes imprecisely and interchangeably. The proper definition and precise use of these terms is important.

## **7.2 Moving towards policy options**

The Draft GLA Bill currently going through Parliament presents a huge opportunity for London-wide strategic action to tackle some of the most pressing social and economic problems in London. In addition to the new duty to prepare a strategy to tackle London's health inequalities and promote the reduction of health inequalities in London, the Mayor will assume new powers and duties that will enable action to improve the determinants of health.

This paper has presented a range of areas of opportunity along with a framework designed to help in the critique of broad policy options. It is anticipated that it will be of most use when considered alongside the other sources of information and evidence being made available.