The English experience in promoting intersectoral collaboration in tackling health inequalities

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SUMMARY

Developing effective intersectoral collaboration has been a key part of the national health inequalities strategy in England. Traditionally, much of government has worked in “silos”. Efforts to deploy intersectoral collaboration has meant breaking down these “silos” by working horizontally across government departments and vertically through local, regional and national bodies. This approach also requires effective joint working within the same government department.

The mechanisms to promote action on health inequalities and facilitate this collaboration have been

- a national health inequalities target on life expectancy and infant mortality, with lead responsibility for delivering the target with the Department of Health (DH)
- a national health inequalities strategy (the Programme for Action), signed up to by 12 government departments and covering both health service/health prevention issues and the wider, social determinants of health
- a regular reporting mechanism against the target and other strategy indicators

An assessment of the factors most likely to contribute to the target confirmed that the national health service (NHS) had the leading role in delivering on the target. The NHS has used several mechanisms to promote action, including through public health, health care and performance and planning functions. Local government has a key partnership role in delivering on the targets at local level through local area agreements and working with the NHS. Action on the wider, social determinants such as poverty, education and employment will help achieve a long-term, sustainable reduction in health inequalities.

Different arrangements combine to promote effective intersectoral working from cross-departmental ministerial committees at national level to local strategic partnerships that engage a range of local partners. The link between national and local understanding has emerged as a key issue for delivering the target due to the monitoring, audit and review process built into the strategy.

A strong focus on the health inequalities target backed by a national health inequalities strategy supported by Treasury has been a powerful way of engaging partners and promoting intersectoral collaboration on the health inequalities agenda. The relatively high level of political investment in this agenda makes it potentially vulnerable to shifts in political perceptions and priorities. Achieving a seamless chain of understanding and action across all partners has also been a challenge.

The opportunity to focus on the substance of the strategy has been helped because the strategy had no programme of its own but explicitly relied on working in partnership with others at all levels through a range of mainstream programmes. This has raised the possibility of embedding health inequalities as part of everyday business, whether in the health sector or in the programmes of other departments.
SUBJECT/SCOPE

This paper considers the development of intersectoral collaboration around the health inequalities agenda in England since 1997.

The newly elected Labour government was committed to a programme that extended social justice, addressed poverty and tackled health inequalities. New ways of working together across government was seen as a key lever for the delivery of this programme. In practical terms, this meant promoting effective intersectoral working between all arms of government, both horizontally across departments of national government and vertically between local, regional and national government. It also meant working with a range of other agencies, including voluntary agencies and the private sector, and engaging with the target populations.

Methodology
The focus of the paper is the emergence of a national health inequalities strategy and sustaining the priority of (and engagement with) the national strategy. While many of the developments reflect the particular social and political context of England, other developments provide general lessons that are of wider value.

The paper draws on policy and political developments over the last 10 years, employing official policy documents and data sources. It describes in narrative form the process of developing a strategic approach to tackling health inequalities in a cross government framework. The key documents include the Independent Inquiry into Inequalities in Health (Acheson) report, Tackling Health Inequalities – A Cross Cutting Review and Tackling Health Inequalities – A Programme for Action and other papers. Data is mainly drawn from the Office of National Statistics.
CONTEXT

Health inequalities in England have been defined mainly in terms of socio-economic status. This approach to health inequalities has a strong historical tradition and remains the primary focus in exploring these issues. Thus, while the health of the nation has improved steadily over the last 50 years, a wide gap persists between different socio-economic groups.

The Acheson inquiry was set up to clarify what was happening to health inequalities in England. It found that the health gap between social groups had widened between the mid-1970s and the early 1990s.

Over the last 20 years, death rates have fallen among both men and women and across all social groups. However, the difference in rates between those at the top and bottom of the social scale has widened. For example, in the early 1970s, the mortality among men of working age was almost twice as high for those in class V (unskilled) as for those in class I (professional). By the early 1990s, it was almost three times higher.

The Acheson inquiry also looked at – and acknowledged - other dimensions of inequalities including by area, by age, by gender, and by ethnicity.

Key characteristics of the policy environment

England is the largest part of the UK with around 51 million out of 61 million citizens. The current Labour government has been in office since May 1997 with one change of prime minister when in June 2007 Gordon Brown succeeded Tony Blair.

Health matters, including public health, are the responsibility of the secretary of state for health in England. Health ministers are supported by the Department of Health, the relevant civil service department. Scotland, Wales and Northern Ireland, the other parts of the UK have their own elected assemblies with a different degree of responsibility over their domestic affairs, but including health policy.

Policies are a mixture of public and private action. There has been greater emphasis on private provision in recent years, constrained by regulation and competition, particularly for the essential services – power, water, transport and communications – that were public monopolies but have been privatised since the 1980s.

The National Health Service (NHS) funded by general taxation and free at the point of use provides health care. Established in 1948, it is highly valued. The high esteem in which the service is held reflects the importance placed on health. Only a small proportion of health services are privately provided, around 5%.

A high proportion of the population own their own homes – around 70%. Education is an important vehicle of social mobility – and a way of breaking out of poverty. The UK government has actively sought to meet the challenge of globalisation.

Previous initiatives on health inequalities that have focused on the social determinants of health include Report of the Working Group on Inequalities in Health (the Black report, 1980). A working group was set up under the last Labour government in 1977.
Nature of the policy problem

The key issue for the new government in 1997 was the inequalities and poverty generated by the structural and economic changes in the 1980s and 90s. This had left a legacy of poverty and deprivation in many of the industrial areas of the north and midlands. The widening gap in health inequalities was part of this overall concern.

The policy problem had three dimensions, namely to

- define the appropriate focus for action on health inequalities, i.e. whether to act on social-economic, area or other inequalities
- develop an approach to enable action on these issues across government, with appropriate mechanisms, systems and processes
- adapt an approach which recognised that health inequalities had an impact on a significant part of the population, not just the most socially excluded groups.

For Acheson, the health inequalities issue could be resolved by a commitment to action on a “broad front”. The report examined the contribution to health inequalities of many of the wider determinants of health taking account of models like Dahlgren and Whitehead. Poverty was a concern but other factors were also important, especially education and employment but also housing, environment and crime. It identified 39 main recommendations.

Origins of policy programme

The key driver for the health inequalities programme was political change. The new Labour government elected in 1997 with a big majority and a mandate for change - allied to a strong commitment to public health. This was reflected in the commitment in the party manifesto to appoint a (first-ever) minister of public health.

There was also a strong awareness among many of the new Labour ministers and MPs of the fate of the Black report, discarded in 1980 at the beginning of a decade that had seen inequalities widen. This awareness informed the commitment to promote a greater degree of social justice across a range of social determinants and, as a result, the Acheson inquiry was established.

The inquiry report provided evidence for action. With over 500 scientific references, the report’s diagnosis and prescriptions received a wide range of support. This was because it emphasised the science rather than any political approach.

The inquiry recommendations also chimed with other early changes across government. These changes included action on child poverty through the introduction of tax credits, the introduction of early year’s programmes, such as through the Sure Start programme for disadvantaged families and children under 4 years, programmes on urban regeneration, housing and neighbourhood renewal that emphasised the social and community aspects of regeneration, and a strategy to reduce teenage pregnancy.

All of these activities loosely fitted together within a framework to reduce inequalities and improve social justice. While programmes were complementary and mutually
supportive, formal accountability for expenditure and action was to different ministers and departments.

**Policy/programme objectives**

Following Acheson, health inequalities emerged as a higher priority with the announcement of the first-ever national health inequalities target in the *NHS Plan*. This called for a 10% reduction in the gap in health outcomes in infant mortality and life expectancy by 2010.

This was a significant step – an explicit commitment to reduce health inequalities against a national measure. Part of the pressure for a national target came from a new openness in the process of policy development. Experts, academics and practitioners assisted ministers and officials develop the future priorities of a modern health service. A national health inequalities target was prominent among these emerging priorities, strongly advocated by these experts and accepted by ministers.

While the placing of the national target in the *NHS Plan* gave the prime role in tackling these inequalities to the NHS, it was also a signal for greater intersectoral collaboration across government. It recognised that while the health department might be in the lead on the issue, it could not deliver the target on its own and without the support of other parts of government.

**APPROACHES**

Action on social justice and health inequalities required a joined up approach to link these activities. This approach explicitly recognised the need for closer links between policy areas such as education, health, housing and poverty. These areas - normally separated by different lines of administrative accountability – were characterised as working in “silos”. Intersectoral working was also problematic in areas with the same lines of accountability. Breaking down or bridging these lines into effective partnership was a major challenge for a national health inequalities strategy.

**Nature of intersectoral action**

Intersectoral action in this area was prompted by the announcement of the national health inequalities target. It was already clear that such action was central to modernising the machinery of government for the new. A white paper, *Modernising Government* (1999) said

*To improve the way we provide services, we need all parts of government to work together better. We need joined up government. We need integrated government.*

This approach would be developed across government by identifying and spreading good practice, focusing on programme outcomes rather than programme inputs, and developing incentives and levers to effect change. The public spending cycle was also revised to operate on a three year rather than one-year basis to encourage a strategic approach to public expenditure, and targets, priorities and resources were aligned through a Treasury-led comprehensive spending review (CSR).

The health inequalities issue was identified by the Treasury for the 2002 CSR exercise as cross cutting issue. Treasury convened a group of all relevant departments with a
possible interest to see how they could contribute to tackling health inequalities across government.

Treasury leadership through the CSR process was a powerful incentive for encouraging participation of other government departments and units. 18 departments and units sat around the table during the review. This process helped develop a series of cross-government commitments that provided a strategic framework for delivering the target and contributing to a sustainable, long-term reduction in health inequalities.

The time limited nature of the national target (to 2010) alongside longer-term objectives shaped the priorities for action adopted by the review. While it was clear that a cross government and intersectoral approach was needed at local as well as national level, the most promising interventions likely to contribute to the target were health-based interventions.

For the life expectancy element of the target the key interventions were
- reducing smoking in manual groups
- prevention and effective management of other risk factors in primary care through lifestyle and therapeutic interventions
- environmental improvements to improve housing quality, increase safety and prevent accidents, and
- targeting the over-50s where the greatest short-term impact on life expectancy will be made

Similarly, for the infant mortality aspect of the target, the key interventions focused on reducing smoking in pregnancy, preventing teenage pregnancy and other early NHS interventions, such as increasing immunisation, improving diet and nutrition, including breastfeeding as well as early years’ support and housing.

Building on the evidence and priorities identified in Acheson, the CSR cross cutting review stressed that the strong correlation between health inequalities, poverty and deprivation begins at birth, continues throughout life and through into the next generation. This meant that the wider determinants such as education and employment policies had a crucial role to play in enabling children from low income families to take full advantage of opportunities at school and subsequently at work and through this to help break the cycle of deprivation.

This framework for intersectoral action created by the CSR review was consolidated in the national health inequalities strategy (the Programme for Action 2003). 82 specific cross-government commitments were included in the national strategy from 12 government departments.

The strategy identified roles and responsibilities for cross-government collaboration at every level – local, regional and national. It made it clear that

*a clear understanding of roles and responsibilities will be crucial to the delivery of the Programme for Action in meeting both the national health inequalities target and tackling wider determinants. At national, regional and local level, the key challenge will be to work in partnership across traditional boundaries at a time of change in the NHS and other services, and to effectively involve local communities*
Policy entry points

The aim of the strategy was to close the gap between disadvantaged groups and areas and the rest of the population. The target could only be met by adopting a definition of disadvantage that recognised that action needed to address the needs of the poorest third of the population, the part of the population with the greatest burden of disease. This meant improving the health of the poor – including the working poor – faster than other groups and so narrow the gap. This reflected the way the target was structured with its emphasis on disadvantaged groups and areas within a population health approach. Meeting the target required major change among disadvantaged populations.

This was different from many other government programmes that targeted the relatively small group of the social excluded and most deprived, though it was also covered by the health inequalities target. A social exclusion unit had been set up in 1997 in the Cabinet Office to address the interest of these groups in government and develop targeted policies.

The life expectancy element of the target was an area-based measure against the whole population. This element of the target was revised in 2004 to create a fixed “spearhead” group of 70 (out of 354) local authority areas with the worst health and deprivation indicators. This group covered around 28% of the population and provided a fixed group of areas as a focus for action until the 2010 target date. The aim of the spearhead group was to ensure continuous and close working with these populations to improve their health and narrow the gap. This included rolling out public health and other initiatives, such as the introduction of health trainers resulting from the Choosing Health white paper (2004). It also provided a focus for extra resources for primary care services as well as a reference point for health planning as health inequalities became more embedded in the NHS and wider government agenda.

The infant mortality aspect of the target took a socio-economic approach across the country by seeking to reduce the gap in health outcomes between the routine and manual (R&M) social group and the rest of the population. Based on occupational classification of the father, this socio-economic measure left out from consideration some disadvantaged groups such as sole registered births – those babies registered by the mother (or father) alone. Policy around the target has, however, tried to reflect the needs of this group as part of a wider approach to meeting the target.

Mechanisms and tools

While the delivery of the national strategy was built on earlier efforts to achieve a more effective style of cross government working at national and local level, it was not a simple matter to translate theory into practice. Traditional lines of accountability, cultural differences and styles between departments, pressure of competing agendas and lack of – or an uneven distribution of - capacity were all barriers to these new ways of working. New tools and mechanisms were needed.

Nationally, this required effective co-ordination between different departments. The lead responsibility for the PSA target vested in the Department of Health was also shared across government by the departments that had signed up to the Programme for Action. A cabinet (ministerial) committee, chaired by the deputy prime minister,
led the process, most recently the domestic affairs (public health) sub-committee. A cross-departmental official group initially supported this work. This engagement continues through the monitoring and reporting mechanisms in the Status Report on the Programme for Action that is published each year. The Treasury also monitored progress.

For the NHS, the national target was backed by programme planning priorities that highlighted the importance of health inequalities, such as National Standards, Local Action (2004). Performance management was a key tool for the Department in its dealings with the NHS. Shaped at national level, this framework encouraged action at local level to ensure local delivery of the Department’s priorities. Setting targets, identifying priorities and rewarding good performance are essential levers in an NHS where responsibility has increasingly shifted from the centre of government to the front-line.

Making sense of the target at local level has been a particular challenge. The target was set by ministers and a major public consultation followed to see how it could be delivered. National leadership and effective coordination of national policies was essential, but effective partnerships were needed at all levels, and particularly to secure the full engagement of the NHS locally alongside other local partners to break down local silo working between NHS and local government.

One response was the establishment of local strategic partnerships (LSPs) to provide a local action focus. Local authorities and local NHS organisations were the key players for the health inequalities agenda in this arena. Jointly appointed directors of public health were another mechanism for promoting this collaboration.

LSPs were the key vehicle for local partnership in many spearhead areas. Some spearheads overlapped with the 43 priority areas for infant mortality. These efforts to encourage NHS/local government partnerships have been extended by aligning priorities, planning and performance through local area agreements (LAAs). There were also new programmes to promote healthier communities and local authorities were awarded new powers to scrutinise and review local health policies, including the delivery of local health services.

In the NHS, tools were developed to facilitate action on health inequalities in the context of local needs. Health equity audits sought to use local evidence and data to inform local service planning and delivery by matching needs and resources, a local basket of indicators was developed as an aid to local monitoring, and a health poverty index commissioned to assess local performance against national average. More recently, a health inequalities intervention tool shows spearheads the state of their local gap and the impact of different interventions on the target. A national health inequalities support team also provides tailored advice and guidance against an assessment of local systems and processes for individual NHS areas.

**Actors and roles**

Effective intersectoral working had to take account of changes in NHS organisational form and structure. This meant that not only changing faces among the principal actors but changing roles and functions as well. Political priorities have also fluctuated over the last 10 years.
Ministers and officials from the Department of Health have been constant players in building a cross government approach in tackling health inequalities. The views of Treasury have been extremely influential in shaping the nature of this approach and the high priority to poverty and inequality by the former chancellor and now prime minister Gordon Brown has been crucial in creating a context for action.

The 2004 CSR exercise extended the health inequalities dimension into other targets, such as cancer, coronary heart disease and stroke. Targets for other departments also took more account of these issues and promoted closer working.

The Wanless report (2004) on promoting good health for the whole population emphasised the importance of tackling health inequalities as a way of limiting avoidable NHS expenditure. The aim was to encourage a “fully engaged” scenario by which the public used greater knowledge and awareness to achieve more control over their lifestyles to improve their health – and relieve pressure on NHS services.

The development and oversight of the health inequalities strategy has included engagement with stakeholders through consultation and, more formally, through health inequalities reference groups. These two groups provide an insight into the impact of policy locally and help monitor progress on the target. The scientific reference group led by Michael Marmot has overseen the development of the annual status reports that provides detail on the target and a range of health and wider social determinants of health.

**Budgeting and finance**

The Programme for Action assumed no separate funding for the health inequalities strategy. Rather than develop specific, funded programmes, the strategy focused on promoting health inequalities issue among mainstream public service programmes to make these services more responsive to the needs of disadvantaged groups and areas.

The health inequalities team was to be an “influencer” in the development and funding of these major programmes. This investment created an opportunity and some space for health inequalities and wider public health issues, especially with the increased investment in health and education after 2000. While this space could be difficult to inhabit in established areas with additional pressures, there were opportunities to influence new programmes such as Sure Start, the child poverty strategy and neighbourhood renewal. This approach required getting health inequalities onto the agenda of other services and programmes and making it a priority. In terms of the NHS, this meant getting the issue onto the agenda of the priorities and planning agenda (as in National Standards, Local Action, 2004) and promoting it as a key priority as in the recent “top six” priority setting exercise.

It also meant that the health inequalities team was not burdened with programme administration and the financial and political uncertainty that such an administrative function can create.
IMPACT

Developing intersectoral action to support the health inequalities strategy in England has been a major challenge. A key test has been the sustained and renewed interest in the issue across a range of players over the last 10 years. Notwithstanding ministerial changes, changes in priorities and other events, health inequalities has survived and, more recently, its importance magnified in the health secretary’s announcement (September 2007) of a new comprehensive strategy for reducing health inequalities. This strategy will cover both health services issues, like access to services, and the wider, social determinants. Its remit will be a prompt for further intersectoral action.

Outcomes

Health inequalities have generated activity across government with DH in “co-ordinator” mode with others recognising it as a relevant factor in the work they do. This applies nationally and locally, for example with health inequalities being designated a mandatory element of LAAs. This was facilitated by the emergence of a national strategy (the Programme for Action) in which key players had a degree of ownership. The Treasury-led cross cutting review was the precursor for this strategy. It brought together a range of departments with different priorities but a common, if not always immediately obvious, interest in health inequalities.

The strategy has been translated into reality by bilateral and multilateral interaction between these players and by the process of monitoring, audit and review built into it. The annual status reports with their emphasis on quantitative change have kept the focus on the collaboration that underpins the wider, social determinants of health. Some of these 12 headline indicators have shown important progress

- on poverty – the proportion of children living in low-income households has fallen (by around 700,000) on all measures between 1998-99 and 2004-05
- on housing quality - the proportion of vulnerable households living in poor quality housing decreased, with a narrowing of inequalities between these groups and other households between 1996 and 2004
- on educational attainment – the proportion of poor pupils achieving the educational standard at 16 increased, with a slight narrowing of the gap between these and other students, and with faster improvements in some black and ethnic minority groups and the England average
- on accidents – there have been improvements in child road accident casualty rates since 1998, with a narrowing of inequalities in absolute terms.

The reports have also show a narrowing of health inequalities in absolute terms in key health indicators such as coronary heart disease and stroke, and cancer. While there have been improvements for all groups in other areas – for example, reductions in smoking prevalence and teenage pregnancies – there has been no narrowing of the health inequalities gap.

The results reflected in these reports show that strongly supported and sustained programmes delivered on the appropriate scale can deliver a change in outcomes and narrow inequalities. However, these improvements have not contributed to any narrowing of the gap in life expectancy and infant mortality. The latest data (2003-05) shows that the life expectancy gap had widened by 2% for males and 8% for females.
compared to the target baseline (1995-97) and while the infant mortality had narrowed from 19% (2001-03 and 2002-04) to 18%, it was still greater than the 1997-99 baseline.

The challenge created by a widening rather than a narrowing gap served as a stimulus for further action. The results of monitoring the target created the opportunity for an audit and review of the programme, both in terms of life expectancy and infant mortality. This process involved further intersectoral collaboration that was energetically pursued. The terms of the review of the health inequalities infant mortality PSA target were agreed with Treasury, the work undertaken by a cross-departmental group. This group explored data issues around the target, the impact of different interventions on the target group and local performance in working on the target. The review report highlighted gaps and barriers and made a series of recommendations to sharpen local delivery of the target.

The key issue was improving the effectiveness of local action. The report identified five challenges or barriers to local action, namely:

- no recognition of the target or the widening gap between the R&M group and the overall population
- services were not fully delivering to the target group
- lack of leadership and systems to support delivery
- lack of knowledge and understanding of the target
- poor handling of data and gaps in the evidence base

The review provided for further engagement with local partners and professional groups through workshops and conferences. The process illuminated how differences can emerge between an established target, supported by a national strategy backed by a range of different partners, and the realities on the ground. Lack of clarity, lack of supporting systems and processes and poor local data can inhibit local effective local action in a situation where different priorities compete for attention.

Target recognition and an awareness of the necessary steps for effective action was crucial. A lack of clarity could also hinder the application and use of tools that would help meet the target. The identification of a fixed spearhead group of local areas for the life expectancy target has helped promote local engagement through LSPs in the delivery of this target, such as through the use of health equity audit and examples of good practice. This has been encouraged by the use of a “beacon” awards scheme to promote innovation and good practice in local government on priority issues, including health inequalities. Health impact assessments have been used in a limited way in some areas to assess the impact of housing, transport and other issues.

**LESSONS LEARNED**

The difference between national and local understanding has hindered effective action on the ground. It has also worked against partnership and collaboration between the different sectors. Securing closer alignment between national and local views through a process of monitoring, audit and review has been a key lesson. There were other
lessons from the development and pursuit of the strategy that have provided general lessons. These included

- **Political engagement**
  In England, politics provided the impetus to action rather than evidence or data. Political engagement was of vital importance in terms of political support and commitment to the overall objective of tackling health inequalities, and the means to deliver it through intersectoral collaboration and other new ways of working. Evidence and data highlighted the most fruitful paths for that collaboration. This political approach meant ensuring that health inequalities issues were prominent in the minds of ministers and other key players. Any lack or loss of interest or other distractions could have damaging consequences for the strategy.

- **Working through the mainstream**
  This approach meant that the focus of the programme was working and promoting the strategy through others with established programmes. This offered potential access to much bigger sources of funding than could ever have been available to a single health inequalities programme. This “piggy back” approach released energies to focus on the substance of the strategy rather than programme administration. It also meant that there was little reliance on separate, time-limited funding with its attendant pressures.

- **Treasury support**
  The support of the Treasury was vital in breaking down a “silo” working mentality and bringing cross government partners to the table once a health inequalities target had been set. It secured commitments from these partners to support a national health inequalities strategy in which they had role, detailed in the 82 commitments in the *Programme for Action*. Its monitoring role was important in developing an audit and review response to the continuing challenge of meeting the target.

- **Developing and using appropriate levers, systems and processes**
  This helped sustain momentum and respond to change in an acknowledged long-term programme. These developments were of two kinds: structural developments, such as locally through the opportunities of LSPs or LAAs to promote the agenda, or nationally by developing champions for the health inequalities strategy and setting up health inequalities (expert and stakeholder) reference groups. The second approach was the development and deployment of monitoring and other tools, such as the 12 headline indicators in the status report, the basket of indicators, the health equity audit and health inequalities implementation tool.

The ultimate aim of the strategy was to embed the strategy in other programmes so that tackling health inequalities becomes part of the way business is done across government as a way of ensuring a narrowing health inequalities on a long-term sustainable basis. This work continues.
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