What can NHS Health Scotland do to reduce health inequalities? Questions for applying the Health Inequalities Action Framework

Introduction

Definition: 'health inequalities' are the differences in health experienced by people, depending on the circumstances in which they live and the opportunities they have for health and social wellbeing.

Different groups in Scotland experience big differences in health. The areas and the groups of people most affected by poor health are well known from years of research. *A Fairer Healthier Scotland* recognises that everyone has the right to the highest possible standard of health. It outlines why NHS Health Scotland considers these differences to be unacceptable and proposes that they can be reduced if the government and the public sector work together for change.

This paper offers a framework for planning actions that can contribute to reducing health inequalities in the form of a series of questions and prompts adapted from health inequalities theory (published by Whitehead and Dahlgren (2006), Macintyre (2007), Geronimus (2000) and Marmot (2010) – the full evidence base behind these concepts and principles can be found in NHS Health Scotland's *Health Inequalities Review for the Ministerial Task Force* when it is published in autumn 2013.

The actions most likely to reduce health inequalities are those that deliver changes in high level social organisational processes. These might include anti-discrimination legislation, policies that reduce the differences between the highest incomes and the lowest, or policies to enable more equal opportunities, for example, access to high quality living conditions, healthy food or the best education. Actions least likely to reduce health inequalities are those that are targeted at individuals and depend on people coming forward, creating the potential for missing or ruling out those who are unable to take up the intervention.

We know that factors such as being unable to speak English, reduced mobility, lack of social support, gender expectations, low income, discrimination and so on are linked to poor access to facilities and resources and poorer experience of service provision than the population in general. Therefore, services and prevention programmes that don't take diversity and disadvantage into account are at risk of increasing the health and social divide.

The link between social policy actions and health inequalities means that our contribution to reducing health inequalities needs to take life circumstances into

account when planning our work. Once we have considered this, we can then take one of three levels of action as follows:

- to mitigate against the harm to health already caused by social inequalities
- to prevent social (and therefore health) inequalities occurring or worsening
- to undo social inequalities.

We then need to know whether our actions contribute to reducing inequalities using clear evaluation questions and indicators for reviewing and measuring change.

Planning for addressing health inequalities

A series of questions are suggested below to help strengthen NHS Health Scotland's contribution to reducing health inequalities in the population. The questions are designed to be used in the planning stages for a new programme or project, in order to prioritise actions that can contribute to reducing inequalities before developing and agreeing the specific outcomes for the work. A health inequalities impact assessment, which uses the same theoretical base as the framework, is applied at a later stage in planning (such as before moving into the implementation phase) in order to identify and mitigate risk of unintended differential impact on minority or protected population groups.

1. Defining the problem

Are we doing enough on the 'life wreckers'?
We know that upstream causes of poor health (such as poverty, violence, discrimination and social isolation) are entrenched in some areas, with high risk of poor health for people suffering these circumstances.

Do we know the population we are working with?
Describe the population using whole population data from the census, together with local data to capture smaller groups (such as new migrant groups), and health and social outcomes such as mortality, morbidity, healthy life expectancy, educational attainment etc. Data from Census 2011 is expected to show a doubling of the percentage of the population recorded in the 'non-white' categories since 2001, from 4% to around 8%.

What are the living and working conditions experienced by the population?
Area profiles include social and economic data; environmental factors; facilities (such as housing stock); education and healthcare provision; employment available; car ownership etc. Self-reported health and social and housing surveys also provide a wealth of data about how people live, their aspirations and health behaviours.

What do we know about the social causes of the problem we are seeking to address?

Draw on academic studies on the links between social factors and health, such as how and why might poverty, gender or ethnicity impact on health?

What is it like to experience the problem?
It is important to learn from experience and, in particular, to capture the 'voice of the voiceless' to help understand the problem as well as to help develop relevant solutions. Experience might be gathered through, for example, local knowledge, academic qualitative research, local case studies and community or public involvement in democratic processes or service user panels.

2. Agreeing the aim

Is the aim of the action to improve population health or to reduce health inequalities?
Actions aiming to improve population health requiring buy-in from individuals risk increasing health inequalities, unless consideration of inequalities is taken as a starting point. Evidence that an action improves health for individuals does not mean that it can reduce health inequalities in the population.

Is the aim of the programme to address health inequalities?
Actions to reduce health inequalities will usually require action on social causes or system change as part or all of a programme of action. If system or structural change is considered to be beyond the scope of a programme team, the actions taken might not be able to demonstrate impact on health inequalities, although they might be able to demonstrate impact on health improvement for individuals.

Is the aim to target a particular group?
The perspective of the group to be targeted should be sought in order to understand the problem and to contribute to finding the solution. The group to be targeted should be clearly defined, for example, targeting a geographical area no matter how deprived will include people who are not at increased risk of poor health and will miss a substantial number of people at increased risk who live in more affluent areas. Targeting a group because of a single issue, for example, one type of health behaviour or legally protected characteristic, is unlikely to address the complexity of multiple causes and effects of health and social inequalities.

Is the aim to reduce a gap between one group and another?
To reduce a gap between groups we need to consider carefully not just the targeted group but also the group we intend to compare progress with. Any

comparator group is unlikely to remain static unless carrying out a carefully planned controlled study. Studies sometimes use population averages as the comparator, but attribution of an intervention's impact in the targeted group can be at risk using this method.

Is the aim to reduce health inequalities across the whole population?
Universal services and programmes can contribute to reducing health inequalities as they encourage non-stigmatised uptake. However, universal services and prevention programmes are often planned with the assumption of equitable uptake and there is plenty of evidence demonstrating that this is not the case. If our universal programmes are not designed with consideration of the groups and individuals furthest away from accessing services and opportunities, we are at risk of increasing inequalities. Universal programmes or services can work towards greater equity by being provided in relation to need and this might mean a degree of targeting or positive action to ensure equitable provision.

3. Seeking solutions: mitigating, preventing or undoing health inequalities?

***Mitigating:* What actions contribute to mitigating the impact of social inequality on health?**
Much of health and social care act at this level, where individuals are seeking help for problems. Services and programmes could increase their sensitivity to social inequalities in order to better understand the presenting problems and to seek multi-layered or multi-agency solutions. Positive action might be required in planning and delivery for service users with complex or diverse needs, for example, adjusting core programmes to include strategies for following-up missed appointments, including routine enquiry about social circumstances, or providing more intensive support for vulnerable groups.

***Preventing:* How can we prevent social inequalities leading to health inequalities?**
The NHS is not solely responsible for creating the living and working conditions that can prevent social inequalities leading to health inequalities, but could act to contribute in partnership with other public and third sector structures. For example, the focus on early years where equality in health and social outcomes is predicated on the best start in life (which includes full access to health and social care, education, income maximisation, housing and safe and healthy environments). Another example is that the NHS contributes to employability schemes and to implementing safe and equitable working conditions as an employer. For NHS Health Scotland, an example might be in working with Community Planning Partnerships to establish health and wellbeing as key

outcomes for local planning, supporting social network and community resource development for improving health, or income maximisation for families with young children. Another example is to advocate for a stronger focus on health and health inequalities in local strategies and national policies related to facilities and services with a big impact on health, such as transport policy or anti-poverty strategies.

***Undoing:* Can we act to reverse health inequalities gaps or gradients?**
The most powerful actions we could take to reduce health inequalities would be to advocate for, and influence changes in, policy and legislation to challenge the current distribution of wealth, power, and opportunities which favour those already wealthy, powerful and well connected. NHS Health Scotland's roles might include, for example, providing academic or epidemiological analyses to influence economic policy change, or reviewing the impact of policies on health inequalities.

Have we got the balance right between mitigating, preventing and undoing health inequalities within our programmes and the organisation as a whole?

4. Measuring the impact

Are the outcomes and evaluation questions right?
The complexity of the causes of health inequalities means that there are no easy solutions. We know that single interventions are unlikely to lead to reducing health inequalities in the population, although they would expect to improve health for those individuals who can take up the intervention. We need to consider all the complexity of inequality, to avoid assuming that an improvement in health will lead to a reduction in health inequalities, and link our evaluation questions clearly to this analysis.

Are our programme indicators realistic?
Building on the arguments given in this paper, the most powerful strategy for reducing health inequalities would be to influence policies for reversing inequalities in power and wealth, or working to prevent social inequalities such as reduced access to good housing or education. As part of the NHS, our actions at these levels would be to use the evidence base for the impact of social factors on health inequalities to influence and advocate for change. Action on prevention and reversing inequalities would be considered as long-term approaches and are unlikely to demonstrate change on health inequalities within a short timescale. Therefore, measurement of progress could include process measures, such as, evidence of impact on policy or strategy developments.

Is the aim of the action to target a particular group?
If so, the impact will be measured as change towards the planned outcome for the targeted group and will not be able to measure differences between groups, unless a comparator group and baselines for both are identified at the outset.

Is the aim to reduce health inequalities between a targeted group and a comparator group?
If so, impact will be described as differences between outcomes for the two groups and the question of whether inequalities were reduced between the two groups can be answered.

Is the aim to reduce inequalities across the population?
The public sector contribution to reducing health inequalities across the population requires action at all three levels of mitigating, preventing and reversing. Measuring progress will be most realistically done in most programmes using process measures towards the long-term outcome of reduced health inequalities, with some short-term outcomes demonstrating small changes for particular groups.