



*Health Development Agency*

Closing the gap: setting local targets  
to reduce health inequalities

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# Introduction

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This briefing paper provides a summary of the policies, theory and practice of setting targets to reduce health inequalities. It offers some guidance for those responsible for setting local targets and sets this in the context of local experience drawn from documentary evidence from health improvement programmes (HIMPs), community strategies and health action zones (HAZs). It is a starting point for sharing local experience and helping local partnerships to reflect on their own development in this area. We hope it will be of interest to local strategic partnerships (LSPs), those responsible for the new health improvement and modernisation plans (HIMPs) and neighbourhood renewal strategies.

The paper is divided into four parts:

**Part one** gives the background and policy context to setting health inequalities targets at a local level and offers a preliminary review of the state of current practice

**Part two** outlines some of the theory and principles of target setting

**Part three** details the practical processes to go through in setting targets, what type of targets to set for what types of strategy, and provides local examples

**Part four** brings together the key processes involved in setting health inequalities targets and highlights the main implementation issues.

Examples used throughout this briefing are taken from documents relating to local HIMPs, community strategies and HAZs and reflect current practice. They are not necessarily given as examples of best practice.

The briefing should be read in conjunction with the following documents, which together provide the broader

cross-government context for local action on tackling key inequalities, and the technical details of the national health inequalities targets:

- *A New Commitment to Neighbourhood Renewal: National Strategy Action Plan* (Social Exclusion Unit, 2001) available at [www.dtlr.gov.uk](http://www.dtlr.gov.uk)
- *Tackling Health Inequalities: consultation on a plan for delivery* (Department of Health, 2001a) available at [www.doh.gov.uk/healthinequalities](http://www.doh.gov.uk/healthinequalities)
- *NHS Plan Technical Supplement on Target Setting for Health Improvement* (Department of Health, 2001b) available at [www.doh.gov.uk/nhsplantechnicalsupplement/index](http://www.doh.gov.uk/nhsplantechnicalsupplement/index)

Details of the Department of Health's documents and progress on health inequalities can be found at [www.doh.gov.uk/healthinequalities](http://www.doh.gov.uk/healthinequalities). See the references and appendices in this paper for further sources of information.

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# Part one: Background and policy context

## National targets to reduce health inequalities

For the first time, the Department of Health has set national health inequalities targets. These were promised in *The NHS Plan: A plan for investment; A plan for reform* (Department of Health, 2000a) and announced in February 2001. They set out the following aims:

- Starting with children under one year, by 2010 to reduce by at least 10% the gap in mortality between manual groups and the population as a whole
- Starting with health authorities, by 2010 to reduce by at least 10% the gap between the quintile of areas with the lowest life expectancy at birth and the population as a whole.  
(Department of Health, 2001c)

These health inequalities targets reflect the wider policy agenda, which commits the government to narrowing the gap between England's most deprived neighbourhoods and the rest of the country, across a range of indicators, including health. There are other national targets supporting the work on health inequalities, such as those to reduce child poverty, improve education, employment and housing and reduce crime (see Annexe A). To achieve these, all public services are expected to perform better within a clear, broad-based strategy. In particular:

- Sufficient priority must be given to the most deprived places and groups
- Services need to join up with each other and with other sectors
- Services must listen to and act upon the concerns of communities.

The policy was detailed in the *Government Interventions in Deprived Areas (GIDA) Spending Review* (HM Treasury,

2000), and *A New Commitment to Neighbourhood Renewal: National Strategy Action Plan*. Both commit government departments to set outcome targets for deprived areas, and ensure that resources are allocated to support the targets. The *National Strategy Action Plan* also commits the Department of Health to work on managing performance to tackle health inequalities.

The two headline targets, together with a supporting target for teenage conception, form the Department of Health's deprivation targets and part of its Public Service Agreement. This supporting target states:

*'By achieving agreed local conception reduction targets, to reduce the national under 18 conception rate by 15% by 2004 and 50% by 2010, while reducing the gap in rates between the worst fifth of wards and the average by at least a quarter.'*  
(Department of Health, 2001a)

The Department of Health has also set a specific smoking inequalities target:

*'To reduce smoking rates among manual groups from 32% in 1998 to 26% by 2010.'*  
(Department of Health, 2000b).

It is recognised that action on a range of fronts, within and outside the NHS, at national regional and local level, is needed to tackle health inequalities and to deliver on these targets. The *National Strategy Action Plan* provides the policy and implementation framework at national, regional and local level to focus attention and action on tackling deprivation. The Department of Health has recently published *Tackling Health Inequalities: consultation on a plan for delivery*, as part of a national

consultation exercise to agree the action needed to achieve their challenging targets, linked to work on neighbourhood renewal.

But what do we mean by reducing health inequalities? What do health inequalities targets look like and how might they be set at local level?

## The policy context

Work on health inequalities and 'variations' in health status is not new. However, since 1997 a commitment to reducing health inequalities by various means has been a central tenet of government policy. There have been several key stages in policy development which have involved:

- An analysis of the nature of the problem of health inequalities
- Identifying the proposed policy solutions
- Including them in cross-governmental strategies for reducing inequalities and improving public services
- Developing a national plan for action at regional and local level and identifying cost-effective practice (2001-2)
- Reviewing and improving regional and local delivery (2001-2).

These stages and the policies at each stage are listed in Annexe B.

The *Independent Inquiry into Inequalities in Health* (Acheson, 1998) brings together the research evidence setting out the main influences on health inequalities and the evidence of effectiveness of interventions. It sets out recommendations for central government to reduce health inequalities.

The government's response to Sir Donald's report, *Reducing Health Inequalities: An Action Report* (Department of Health, 1999a) and the white paper *Saving Lives: Our Healthier Nation* (Department of Health, 1999b), set out the government's commitment to 'improving the health of the worst off in society'. They emphasise the importance of assessing locally what needs to be done to reduce health inequalities, and the targets being set and outcomes identified at that level.

*'We shall ensure that challenging, but achievable, targets for closing the health gaps are set at local level and are monitored through the NHS Performance Assessment Framework. Health Action Zones are already leading the way. Three year health improvement programmes will identify local health needs, including inequalities, translate aims into measurable targets and establish monitoring and accountability arrangements with local partners.'* (Department of Health, 1999b)

At the same time, cross-government attention has been focusing on tackling deprivation. In 1997, the Prime Minister established the Social Exclusion Unit (SEU) with a remit to identify the barriers to reducing deprivation, which require input from a range of partners and which in the past have proved difficult to coordinate effectively. In 1998 the SEU published *Bringing Britain Together*, which explored the problems of England's most deprived communities, and set out the case for a national strategy for neighbourhood renewal. As a result of this report, 18 policy action teams were established to consider specific aspects of neighbourhood renewal. Their recommendations formed the basis of the *National Strategy for Neighbourhood Renewal: framework for consultation* (Social Exclusion Unit, 2000) and the *New Commitment to Neighbourhood Renewal: National Strategy Action Plan*, which was launched by the Prime Minister in January 2001.

The *National Strategy Action Plan* and *The NHS Plan* should be seen as complementary strategies for anyone tackling health inequalities across the NHS and local government. *The NHS Plan* gives an unprecedented focus on the prevention and inequalities agenda within the NHS, which has led to the setting of the national health inequalities targets. Steps are also being taken to integrate these into the mainstream NHS performance management framework.

*The NHS Plan Technical Supplement on Target Setting for Health Improvement* sets out in detail the issues surrounding target setting, health monitoring and the development and assessment of health indicators. It aims to provide support to those working locally to set and monitor targets.

The new consultation document *Tackling Health Inequalities: consultation on a plan for delivery* provides local partnerships with the opportunity to contribute

ideas to a national action plan which will link work across sectors. The plan will set out the priorities for action, the planning structures and systems that can support local action, the indicators to monitor progress and how best to build on good practice. It is being developed with other government departments to link closely with the work on the other inequalities targets.

The Treasury has also announced its priorities for the 2002 Spending Review, a process which reviews activity, expenditure and outcomes across government departments in key policy areas. Health inequality has been selected as a priority for one of the seven cross-cutting reviews. The overall review involves an assessment of the evidence on the effectiveness of existing programmes, and how different departments are delivering their current Public Service Agreement targets. The health inequalities review will:

*'Analyse the impact on health of poverty, employment, education, crime, transport, fuel poverty and related factors, and assess and improve the mechanisms for tackling these problems.'*

(HM Treasury, 2001)

The table in Annexe A sets out some of the main government initiatives/policies and the inequalities targets associated with them.

## Priorities and responsibilities for action

The Department of Health has set out the government's high level goals:

- Reducing inequalities and promoting equality of opportunity, with respect to the key determinants of good health
- Focusing on the needs of citizens from threats to health and wellbeing over which they have little control
- Providing modern, efficient public services which make sense to users at the point of delivery.

The following priority areas are proposed for local action:

- Providing a sure foundation through a healthy pregnancy and early childhood
- Improving opportunity for children and young people
- Improving NHS primary care services

- Tackling the major killers, coronary heart disease and cancer
- Strengthening disadvantaged communities
- Tackling the wider determinants of health inequalities (Department of Health, 2001a).

Tackling health inequalities requires action to reduce broader structural inequalities in society and many of the levers for change lie outside the NHS. *A New Commitment to Neighbourhood Renewal; National Strategy Action Plan*, sets out five key approaches required:

- Reviving local economies
- Improvements to core public services
- Involving communities
- Leadership and joint working
- Improving information and its use.

At the local level, local strategic partnerships (LSPs) will lead the work on neighbourhood renewal, initiated by local authorities and including private, public, voluntary and community sectors. The NHS will be a key member. LSPs will tackle deprivation and local inequalities through:

- Redirecting mainstream services and resources to focus on tackling deprivation
- The community strategy
- Local neighbourhood renewal strategies
- Local Public Service Agreements (in the pilot areas).

LSPs will be expected to set local targets for tackling deprivation, including local health inequalities targets. (DETR, 2001a). The NHS can take a lead in developing the health inequalities targets across the plans covered by the LSP.

All NHS organisations have undertaken local modernisation reviews during 2001, to agree how the NHS will work with its partners to deliver *The NHS Plan* and its targets. Reducing health inequalities and improving access to health and healthcare *'should be reflected in everything that the NHS does, and in every part of the NHS performance management and planning processes'*. (Department of Health, 2001d).

This includes the development of local measures of success to assess whether inequalities targets are being met. These will form part of the health improvement and modernisation plan (HIMP) 2002-2005/7. The HIMP

provides the strategic framework for action to reduce health inequalities, and should link across to the community strategy and neighbourhood renewal strategies, working within the LSP (Department of Health, 2001e). Primary care trusts (and care trusts as they develop) will take the lead role in the delivery of NHS services and programmes to reduce health inequalities, working with other NHS Trusts and in partnership with local authorities and other agencies and groups at local level.

A list of all *The NHS Plan* targets, milestones and associated strategic targets for the NHS is available at: [www.doh.gov.uk/nhsperformance/modreview](http://www.doh.gov.uk/nhsperformance/modreview)

## Measuring progress

The cross-government Neighbourhood Renewal Unit (NRU) has a remit to monitor government departments' delivery of their neighbourhood renewal commitments, and as such will have an important role in monitoring progress on health inequalities, alongside progress on other inequalities targets. Initially, the NRU will focus their monitoring in the 88 most deprived areas that are in receipt of the Neighbourhood Renewal Fund, and where LSPs have been accredited.

At the same time, the Department of Health is developing a broad cross-government and cross-sector set of indicators on health inequalities, of which NHS indicators will be a key component. These will show progress towards the targets across a range of partners, not just the NHS. They will also ensure that specific NHS indicators are agreed within the context of the wider determinants of health. The NHS inequalities indicators will become part of the NHS Performance Assessment Framework in 2002/3 (Department of Health, 2001f).

*Tackling Health Inequalities: consultation on a plan for delivery* proposes a framework for different levels of indicators:

- National targets (infant mortality and life expectancy)
- High level indicators (a small set covering key areas of delivery)
- National/regional basket of indicators (a broader set from which regions can choose their priorities)
- Local basket of indicators (from which local partnerships can choose).

These indicators will feed into existing local performance management systems. For example: (see over)

Dimensions of NHS Performance Assessment Framework/Best Value reviews	Examples of action on inequalities
Health improvement/social, economic or environmental improvement	Reducing health inequalities through economic, social and environmental action within and beyond the NHS
Fair access	Identifying potential inequalities as a result of geography, socio-economic group, ethnicity, age and sex
Effective delivery of appropriate healthcare/ local government service delivery	Addressing inequalities which result from care/services which are inappropriate for a particular group or community
Efficiency	Reducing inappropriate use of emergency services or non-attendance by individuals and groups experiencing access problems, eg reducing non-attendance rates among those with English as a second language
Patient/user experience	Reducing the inequalities created by services that are not people-centred
Health outcomes of NHS care/local authority service use	Identifying those users of services who need additional social support to rehabilitate following NHS care

- Local strategic partnerships will track progress on the health inequalities targets through the neighbourhood renewal strategies (in the 88 most deprived areas)
- The HIMP and community strategy
- Public Service Agreements, with agreed health inequalities targets (where they are being piloted)
- The performance of a number of the key initiatives focused on reducing inequalities, such as Health Action Zones, Sure Start, New Deal for Communities etc.
- The NHS Performance Assessment Framework, Personal Social Services, Performance Assessment Framework (for health and social services) and the use of the NHS Performance Fund.
- The Best Value Performance Indicators (especially 'interface indicators' in areas such as fair access to services).

*'Local benchmarking and analysis of the performance indicators ... is a key tool in addressing inequalities in service provision.'*

(Department of Health, 2001f)

## Indicators in current use

There are currently a limited number of performance indicators in the NHS Performance Assessment Framework which can be used to measure health inequalities. Local partnerships can use these as benchmarks to compare their data with other areas and to assess the progress they are making to reduce health inequalities among different socio-economic groups, ethnic groups, provision and access to services etc.

For example:

- Early detection of cancer, consisting of percentage of target population screened for breast and cervical cancer – to assess the access of different socio-economic groups to disease prevention services
- Number of people under 18 from ethnic minorities who register with a NHS funded community clinic which provides contraceptive services
- Percentage of smokers quitting at four weeks with NHS smoking cessation services who are from manual socio-economic groups (Department of Health, 2000c)

*NHS Performance Indicators: A Consultation* (Department of Health, 2001f) sets out some of the other existing health indicators which can be used to provide supporting information on narrowing health inequalities

between different health authority populations. These focus mainly on mortality and morbidity, and measures of individual risk factors, such as life expectancy, years of life lost, infant mortality, still birth rate, death rates and serious injury from accidents, limiting long-term illness, exercise levels, and fruit and vegetable consumption. These will only be useful in tracking health inequalities if differential data is gathered by area or socio-economic group.

There are also a number of indicator sets that can be used to track changes in the social, economic, environmental and educational factors influencing health inequalities. These allow inequalities in community health and wellbeing to be monitored alongside health inequalities among individuals and user groups. Considerable work has been done to develop sets of indicators for local government to measure quality of life and sustainable development, poverty and deprivation (see Annexe C).

The Best Value Performance Indicators could be developed locally to assess the extent of inequity in the provision of and access to local government services (DETR, 2001b). As with the health indicators, these indicators will only be useful in tracking inequalities if they are gathered according to socio-economic group, across deprived areas and key populations. The Health Action Zones have developed a set of High Level Performance Indicators which combine some of these indicator sets ([haznet.org.uk](http://haznet.org.uk)). More information on other sources of indicators is listed in Annexe C.

## Local target setting: where are we now?

Many local planning partnerships, including Health Improvement Programmes, (HIMPs), Health Action Zones, Healthy Cities programmes and other initiatives such as New Deal for Communities have been developing their own local health inequalities targets. Community strategies and neighbourhood renewal strategies are also providing opportunities to address health inequalities and set local targets, through newly forming local strategic partnerships.

Currently, all HIMPs include action to tackle health inequalities. However, a range of different approaches are being taken and HIMP partnerships are at different stages in the development of local inequalities targets.

Health Action Zones were required to be more clearly focused on work to address inequalities and deprivation and have been developing sets of indicators and targets against which they can monitor and measure progress.

Achieving equity is one of the seven key principles underpinning Health Action Zones. This is described as 'reducing health inequalities, promoting equality of access to services and improving equity in resource allocation'. This may mean that deprived neighbourhoods get a visibly greater share of new resources to match their greater need (as set out in the GIDA initiative). HAZs are required to set clear, measurable, challenging strategic targets (with milestones) to improve health and reduce local inequalities between areas and groups in:

- The determinants of health
- Health status
- Access to health and social care
- Access to other health supporting services.

And to do this for:

- Specific conditions
  - Care groups
  - Communities.
- (Department of Health, 1999c)

For examples, see [www.haznet.org.uk](http://www.haznet.org.uk)

The Department of Health and regional NHS offices have identified the need for development work on defining and setting local targets and in identifying ways of motivating partners (such as local authorities) to support HImP targets (unpublished report on HImP evaluation, Department of Health, 2000). These findings are reinforced by work undertaken by the Health Development Agency in its reviews of HImPs 1999 and 2000 (Health Development Agency, 2000; 2001). These reviews suggest that:

- There are considerable challenges at local level in describing local health inequalities and developing baseline data from which change can be measured
- There is a need across HImPs to convert local health needs assessment into clear measurable targets for change across all priority issues
- HImPs are trying to achieve a balance between the national targets and locally derived targets which have

meaning for a particular area. In terms of health inequalities targets, there has been no national prescription for local target setting to date (other than through HAZs as described above)

- There are many different interpretations of 'targets' in use at the local level. All health authorities have set specific targets for the national priorities – but there is considerable variety in terms of whether they are quantitative, qualitative or have a clear timeframe
- The majority of targets in the first two years have focused on inputs or processes rather than on outputs or outcomes. A number of HImPs make no reference to local targets at all
- National Service Frameworks are providing a framework for local target setting. Local targets have been agreed more commonly for National Service Framework priorities, based on the national milestones and targets. However, these tend not to measure inequalities unless they differentiate between socio-economic groups
- Many HImPs do not clearly state the actions required by other partners to achieve targets, or the targets other organisations might adopt within the HImP
- There is increasing demand for a cross-sectoral approach to setting local inequalities targets at neighbourhood level, and as part of community planning. The Public Service Agreements are likely to demonstrate this cross-sectoral approach
- Community strategies rely heavily on HImPs to provide health inequalities targets.

Many HImPs that have not yet reached a final stage in setting precise inequalities targets have indicated their intention to do so in the near future. However, target setting remains a clear area for development in local partnerships.

A number of the examples in this briefing, taken from HImPs and HAZs, illustrate the contributions that local authorities are currently making to reducing health inequalities. Local authorities need to link health inequalities targets within their community strategies to those in the HImP. Some authorities that have developed a community strategy or plan have already identified actions to address health inequalities. Some are now working more routinely with primary care group/trust partners to do this, especially where there are co-terminous boundaries.

Examples across the country suggest that local authorities' contribution to work on health inequalities is often linked to their targets to increase social inclusion and reduce poverty and deprivation (Improvement and Development Agency, 2001; Health Development Agency, 2001).

Community strategies are generating local targets, many of which will track inequalities across deprived areas, or inequalities across particular populations or services.

Many are in the early stages of target development, and are using HImP targets to track health inequalities. A small number of local authorities have developed their own local health strategy as the framework for their contribution to the HImP. These include targets to reduce inequalities and others which affect health.

There is also a need for national support for local authorities to identify ways in which all community and neighbourhood renewal strategies can contribute to achieving the health inequalities targets, as part of their broader goals to improve wellbeing and reduce poverty and deprivation.

## Local target setting: key issues and challenges

There are many reasons why setting local targets is difficult and setting targets to reduce health inequalities is a particular challenge. Much has been written about the potential pitfalls (Whitehead, Scott-Samuel and Dahlgreen, 1998).

- Relating the range of national initiatives, plans and targets is becoming ever more complex in the current policy context; deciding where to add value at a local level is dependent on both national imperatives and local needs
- Setting inequalities targets requires some understanding of a social model of health and relating this to the definition and measurement of the problem to be targeted
- Targets need to be set in relation to health inequalities which are amenable to remedial action, but evidence about the effectiveness or impact of interventions to tackle inequalities is not always available or precise about means and ends
- It is difficult to decide which health inequalities to target and to reconcile this with a twin objective of overall health improvement

- There is a need to engage with other partners in setting and delivering on targets to tackle health inequalities and so they must be 'owned' and have meaning for different stakeholders.

Despite these difficulties, targets are an important element of overall strategic planning and they should be seen as an integral part of this process rather than a discrete technical exercise. Indeed, local strategic partnerships are expected to reduce some of these burdens on integrated local planning.

Targets are a way of ensuring that resources and effort are directed at tackling health inequalities in an explicit and measurable way. Targets can serve different functions: they can inspire and motivate; serve as a technical tool for measuring progress; and offer a way of rationalising and making explicit, complex policy decisions. Targets reflect both values and priorities, so the setting of targets is a political as well as a managerial exercise. Target setting is a vehicle for consensus building among partners about priorities for health improvement and part of a continuous cycle of review and evaluation of local strategic planning. (Coote and Gowman, 2000).

The rest of this paper sets out some principles for target setting and grounds these in real life examples. It suggests how the process of target setting may be approached and sets out the key issues which need to be considered.

# Part two: Theory and principles

## 10 Understanding inequalities in health

The factors which influence health are many and complex, ranging from genetic pre-disposition to physical environment and lifestyle. There is now also a wealth of evidence demonstrating the links between socio-economic determinants (such as poverty, housing and education) and the health and wellbeing of individuals and populations (Wilkinson and Marmot, 1998; Marmot and Wilkinson, 1999; Acheson, 1998.) It is these social determinants of health that are known to be powerfully related to the various ways in which health inequalities are created and sustained. One working definition of health inequalities is provided by Kunst and Mackenbach:

*'Differences in the prevalence or incidence of health problems between individual people of higher and lower socio-economic status.'*

(Kunst and Mackenbach, 1994, p5)

Understanding inequalities in health requires that a social model of health is adopted, incorporating the wider determinants of health with concepts of health risk, health behaviours and health outcomes such as mortality and morbidity. Socio-economic status (SES) is usually the key variable by which health outcomes are then analysed. Issues of gender and ethnicity are then combined within this model. Socio-economic status is a term which encompasses several indicators, the most important being occupational status, level of education and income level. For a fuller discussion of the technical issues concerning the measurement of health inequalities see Kunst and Mackenbach (1994).

The inter-relationship between different aspects of the social context, the health behaviour of individuals, the workings of the health system and health outcomes can

be conceptualised within a framework or model. Such a model may also depict the potential pathways between social context and ill-health. Examples of such models/frameworks include those developed by Dahlgren and Whitehead (1991), Marmot (1998) or Diderichsen, Evans and Whitehead (2001).

Such models make various attempts to represent the inter-relationship of different domains of influence on health, some of which are fixed (such as biology or genetic make-up), some modifiable through changes in macro-economic policy and some of which may be amenable to improvement through local action. Thinking through such a model will help to determine these local policy levers in the context of national social policies. As many of these policy levers will relate to domains outside the influence of the local NHS, it is important that local targets are set, owned and monitored across sectors.

Targets can be set in any domain or layer of influence within such a model. They become inequalities targets only if they clearly state the improvement to be attained in a way which is differentiated by socio-economic group or relate to actions directed at particular socio-economic groups.

For example, Norfolk HIMP uses the following checklist of different dimensions of inequalities when developing strategies and policies:

- Inequality of the wider determinants of health (housing, education, transport, employment, nutrition)
- Financial and geographical inequality (some areas may receive a disproportionate amount of financial resources which are not based on need)
- Inequality of service provision (services vary unfairly between populations)

- Inequality of access to services (unequal opportunity to use services, inaccessibility to some members of the community)
- Inequality of service use (poor uptake of benefits advice, lack of awareness of services or the right to use them)
- Inequality of health and illness between individuals and groups (different illness and death rates for people from different social, ethnic groups and for men and women).

## Establishing a common language

There is no single definition of a target, nor is there an established set of processes or procedures for setting targets. The World Health Organization defines a target as:

*'An intermediate result towards the achievement of goals and objectives, it is more specific, has a time horizon and is frequently, though not always, quantified.'*

(WHO, 1993)

Other commentators echo this definition:

*'A health target is an explicit end point of public health or health care, expressed in terms of population health or its determinants, to be pursued within a given time with systematic monitoring of progress towards achievement.'*

(Walter and Herten, 1998)

Targets are easily confused with indicators, goals, objectives and milestones (Ford, 1997). Although in practice these are often blurred or overlapping, it is useful to think about the distinctions between these different terms.

### Goals

A goal is a very general or broad description – based on principles and values – of what should be achieved, for example, 'a longer and healthier life for the population' or 'the narrowing of the health divide'.

### Aims

An aim is a more well-defined outcome – such as the health needs or rights of the population. Setting an aim can be the focus of a strategy and will usually reflect

national priorities 'to reduce inequalities between minority ethnic groups and the rest of the population'; 'to eradicate child poverty'.

### Objectives

Objectives are a more concrete elaboration of goals or aims; they define the ways in which aims are to be achieved – often stated in the form of changes in attitudes, skills, practices and utilisation of services, eg 'to increase uptake of welfare benefits by older people'.

### Targets

Targets are more specific than objectives. They have a more concrete deadline and are often quantified, eg 'to reduce the number of workless households in the borough by 20% within five years'. They can measure outcomes or actions, eg 'to consult with the residents of merrytown estate through four focus groups to be organised by 2002'.

### Indicators

Indicators are selected to measure movement towards or away from a pre-defined target. They are attributes or variables used in the measurement of change, eg 'number of low income women attending smoking cessation clinic'.

The semantic distinctions between these different terms is not in itself important. However, they are useful ways of differentiating different stages in the process of priority setting with goals/aims preceding targets and indicators following from targets. This step-wise developmental process has been represented (Water and Gerten, 1998) as follows:

Principles/values/aims
Goals
Objectives
Targets – qualitative
Targets – quantitative
Indicators

In reality, the process of setting targets is unlikely to follow such a linear progression. It is more likely to form part of a continuous cycle of planning and reviewing progress and priorities. The above model might, however, help in understanding how the process of target setting might develop and how far the process in your area has progressed.

## Example of a process for developing local inequalities targets – North Essex

- A partnership between health authority PCG/Ts, local authorities and county council is developing a common approach to monitoring deprivation and developing inequalities indicators, using the Jarman Index, the Townsend and the Breadline Index.
- Work is building on the 1998 annual public health report which describes the geographical distribution of deprivation across the authority and applying the measures in terms of electoral ward.
- Workshops have been held across local authority areas and anti-poverty strategies have been developed in several local authorities.
- A 'hot-spot' approach is being taken – identifying common areas within the PCGs/Ts, districts and county council where inequalities of all kinds are high.
- This information is being used to develop partnership work through other initiatives such as the Education Action Zone, regeneration initiatives and the development of healthy living centres.
- Targets are being set from *Saving Lives: Our Healthier Nation* by PCG/T/local authority area and local targets developed for health inequalities within local action plans. Differential targets are being considered between PCG/T areas that reflect health inequalities.
- Equity audits are being undertaken by PCG/Ts and community service providers with deprivation measures overlaid, to identify possible inequalities in resource distribution.  
(North Essex Health Improvement Programme 2000-2003)

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## Principles and processes

Evidence from the literature on target setting, drawing on UK and international experience, identifies several criteria for successful targets. These provide a checklist for local target setting and are summarised below (Kendall, 1998; Whitehead, Scott-Samuel and Dahlgren, 1998; Water and Herten, 1998).

### *Credibility*

Targets must find a balance between being realistic – capable of being achieved within the timescale proposed – and being sufficiently ambitious. Experience shows that setting targets which would have been met in any case or setting targets which are overambitious fails to motivate the necessary people. This is not to deny the importance of 'early wins', ie making early tangible progress in the life of a partnership.

### *Relevance*

Targets should relate to an overall strategy. They should also relate to clearly identified health problems which are demonstrably amenable to action.

### *Evidence base*

Sufficient data should be available about the effectiveness of interventions required to tackle the problem to which the target relates. Targets should relate to actions/interventions which are based on evidence of what works. This evidence can be drawn from scientific research literature, from evidence of 'good practice', as well as expert and lay opinion. The existence of historical

trend data can add to the weight of evidence about what kind of change can be expected over what period. If, for example, a percentage change is required, it should be based on robust baseline data.

High level evidence of effectiveness about specific interventions to tackle health inequalities is often unavailable and this presents some difficulties with designing evidence-based interventions. It highlights the need for ongoing evaluation of local projects and for the results of evaluation activity to be carefully recorded and disseminated.

### *Ownership*

Targets should be meaningful and acceptable to all those who are to be responsible for their delivery. The best way to achieve this will be to involve all the key players in actually setting the targets. This is particularly important in the case of targets that require action across sectors for their successful implementation – the most likely scenario in any targets which relate to tackling health inequalities.

Local communities also have a role in setting broader local health priorities. This process of consensus building is an important but often neglected part of the target-setting process but it is as important as the technical dimensions of setting targets. For more information about consultation and involvement of local communities see Audit Commission (1999); NCC (1999); Active Communities Unit, Home Office, at [www.homeoffice.gov.uk/acu/acu.htm](http://www.homeoffice.gov.uk/acu/acu.htm); and the Community Development Foundation at [www.cdf.org.uk](http://www.cdf.org.uk)

### *Monitoring and evaluation*

The organisations responsible for achieving the target should be clearly identified and lead responsibility assigned. Lead organisations must be given the authority and responsibility to control and influence action to deliver the target. Continuous review mechanisms should be put in place with adequate resources for collection of measurement data to monitor progress. Thought should be given to incentives and to relating the targets to existing performance management frameworks.

\* \* \*

There are additional principles/issues to consider in the specific context of inequalities targets (Kendall, 1998; Whitehead, Scott-Samuel and Dahlgren, 1998).

### *Levelling up*

Inequalities targets need to specify a levelling up of the health of the worst-off in society, rather than a levelling down of the rest. Narrowing of the health gap should not be achieved by any deterioration in the health of other groups.

### *Differential targeting*

Related to the points about realism and ambition in the target-setting process, there is a risk that general targets could focus on groups in the population where health improvement might be quicker or easier to achieve, or 'those social and ethnic groups whose health problems are more easily tackled'. One way round this is to set differential targets. Differential targets take account of the differential causes and effects of ill-health in different sections of society. For example, higher targets can be set for deprived areas and particular ethnic groups, or gender-specific targets can be set where socio-economic inequalities are known to impact in different ways on the health of men and women.

A local example of geographically based differential targeting is given later in this paper.

### *'Focusing upstream'*

Given the established evidence base on the social determinants of ill-health, targets to address inequalities in health will need to move beyond specific disease-based or service-specific outcome targets. Inequalities targets need also to direct action towards wider determinants of health, 'closer to the point of causation' either by looking at risk factors, such as smoking, or on tackling

improvements in wider living and working conditions (Whitehead, Scott-Samuel and Dahlgren, 1998).

The Department of Health's *NHS Performance Indicators: A Consultation* (2001) proposes that targets should be 'Specific, Measurable, Achievable, Relevant and Time-limited'; and need to be:

- Related to the organisation/partnership's objectives, including applicable national objectives
- Seen to be reasonable by those who will be held to account for achieving them
- Monitored through the organisation/partnership's accountability systems (Department of Health, 2001f).

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It also sets out principles for the use of performance indicators, both in the development of targets and in comparing performance, tracking changes, allocating resources, quality improvement, efficiency and accountability.

The government's new Performance Information Strategy sets out principles and guidance to public sector bodies on making the best use of performance information and measurements.

For details see [www.hm-treasury.gov.uk/performance\\_info](http://www.hm-treasury.gov.uk/performance_info)

# Part three: Practical target setting

## – some examples

14 The first step in target setting involves deciding who to involve and how. Many local partnerships describe a similar process in developing action to reduce health inequalities through the health improvement programme. In most areas this has been led through the HImP partnership. Where there is a Health Action Zone, these have acted as 'trailblazers' in developing targets. In some areas, target setting has been part of the process to align or integrate the HImP and community strategy as part of a joint approach to reducing health inequalities and improving wellbeing in deprived communities (for example, in Wakefield and Hillingdon).

The majority of HImP partnerships are at the stage of mapping the extent and nature of the health inequalities in their area and populations and identifying initiatives and the resources which can influence them.

For example, Marks (2001) describes how HImPs across the Northern and Yorkshire region are mapping health and deprivation, and identifying which multi-agency partnerships and local partnerships can affect health inequalities. Prominent initiatives which focus on inequalities include examples related to housing; access to services; black and minority ethnic issues; coronary heart disease; accidents; smoking; and nutrition/food. However:

*'Inequalities in health are understood in different ways and this influences approaches and choices of targets. Wider determinants of health and relationships with emerging community strategies are emphasised to a varying extent, as is the significance of community development approaches in tackling disadvantage. Particularly important, given the key role to be played by PCG/Ts and local authorities, is the extent to which the inequalities agenda has been successfully "localised".'* (Marks, 2001)

The process of setting local health inequalities targets can be grouped into four key stages and these are described below with examples:

- Establishing a starting position
- Building a picture of local needs
- Developing a strategy
- Agreeing the types of targets

### Establishing a starting position

One place to start is in articulating a shared vision, a set of principles or values about how health inequalities are understood in your locality and why they are important for local policies. Existing frameworks, based on national or international policies on health inequalities, can be drawn on to depict your starting position.

A number of HImP partnerships across the country (eg Walsall, North Nottingham, West Hertfordshire, Cheshire, Manchester, Wakefield, East and North Hertfordshire) have used the recommendations from the Acheson report (1998) as a framework to identify local priorities for health inequalities. Other HImPs refer to various reports which provide a basic framework for setting local targets. For example, *Inequalities in Health: the Black Report* (1980), the King's Fund report *Tackling inequalities in health: An Agenda for Action* (Benzeval, Judge and Whitehead, 1995) and *Social Determinants of Health: The Solid Facts* (Wilkinson and Marmot, 1998).

In areas where there are World Health Organization Healthy City and Health for All initiatives, action on inequalities is based on the principles of Health for All and the WHO target to reduce health inequalities. For example, Manchester and Liverpool city health plans state the Health for All principles. (See [www.who.org.uk](http://www.who.org.uk)).

## Establishing a starting position – examples

North Essex HImP states the World Health Organization definition: 'Equity in health means that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no-one should be disadvantaged from achieving this potential (WHO 1990). To improve the population's health we need to concentrate more on narrowing the gaps that exist between different sub-groups and communities. This will in itself lead to improvements in the average health of the population as a whole. The promotion of health cannot be separated from action to promote equity.'

West Pennine HImP includes principles to reduce intra-authority health inequalities, promote the inclusion of disadvantaged groups and ensure equality of opportunity for members of ethnic minority groups.

Stockport HImP has a joint statement of values, which includes: 'With a choice wherever possible, services should be accessible to all in order actively to promote equality of opportunity for health and all aspects of life in our community.'

Rotherham HImP sets out its focus on health inequalities 'up front': 'We will particularly address the health problems of the worst off in Rotherham and try to narrow the health gap between them and the more affluent sections of our community.'

Plymouth's City Health and Wellbeing Plan aims 'to improve the health and wellbeing of people in Plymouth and to reduce health and social inequality by taking efficient and coordinated partnership action'. This is included in the community strategy.

Bradford's HImP, which forms part of the community strategy, aims to 'tackle inequalities in health by reversing the increasing polarisation between the "have not" areas, particularly the inner city and the wealthier outer areas'.

## Building a picture of local needs

Local health planners will need to consider where they might best focus their efforts and set targets accordingly. This requires the development of a clear map of local health inequalities, across population groups, areas and diseases; a health needs assessment; and a local equity audit of public services.

In mapping health inequalities, in particular, this will mean assembling data on the wider determinants

of health and using information sources which differentiate between socio-economic groups in terms of patterns of health risk, access and uptake of services and so on. Government guidance to Health Action Zones and health improvement programmes includes the requirement to undertake a health inequalities needs assessment and to develop a profile of local inequalities (Department of Health, NHS Executive, 1998 and 1999; Department of Health, 1999). HAZ guidance states that the identification of problems/needs and choice of priorities should be based on an evidence-based needs assessment. It should:

- Identify major inequalities among areas and groups in determinants of health
- Recognise the wider determinants of health, eg housing, environmental health, employment, household income
- Assess the health outcomes of better education, leisure, transport and other health supporting services
- Address inequalities in access to services.

Examples of target groups for the needs assessment are:

*'Black and minority ethnic groups, disabled people, homeless people, travellers, single parents and their children, housebound older people and disabled people, unemployed people, mentally ill people and former prisoners, vulnerable young people.'*  
(Department of Health, 1999c).

In a number of authorities, inequalities or equity audits and profiles have already been produced by directors of public health. These form the basis for the development of targets. There are different ways of measuring local health inequalities. A quick source guide to potential indices of deprivation and other indicators is provided in Annexe C.

## Building a picture of local needs – examples

Norfolk's director of public health report in 2000 described local health inequalities. As a consequence, all the strategic objectives in the HImP are backed up with evidence of inequalities and action is included to address inequalities under each objective.

Norfolk Health Improvement Programme has drawn up a charter for reducing inequalities in Norfolk and developed a checklist for assessing strategies, policies and action plans.

These set out a definition of inequalities and the different types of inequalities in health. They require a commitment that all partner agencies will:

- Ensure that new strategies, policies and plans specifically address these inequalities
- Consult partners on achieving change
- Allocate resources according to need and to the inequalities identified
- Produce an annual statement describing the contribution to the strategy, policy or plan to reducing health inequalities.

The charter is signed by a range of statutory and voluntary sector partners.

In South Essex, the director of public health's report sets out eight areas of work on health inequalities, based on local data profiles: the social gradient, stress, early life, social exclusion, employment, addiction, food, neighbourhoods.

St Helens and Knowsley's director of public health report outlines inequalities in health across Merseyside. From this, a document setting out action on health inequalities has been produced and targets are being set.

Walsall has undertaken an equity audit, using the Acheson report as a basis, to identify priorities for action to address inequalities in service provision and access.

Brent and Harrow has carried out an assessment of need within the borough and an audit of current activity to tackle poverty – to develop a common data set for health and social care needs. It is also developing tools to undertake a comprehensive audit of the health inequality impact of the current regeneration programme and regeneration expenditure. This was used to undertake a health impact assessment with at least two regeneration programmes by April 2001.

Tyne and Wear HAZ has established a health inequalities expert group and information action group (including the health authorities, HAZ partners, research and information unit funded by local councils and the university) to work together to:

- Identify key indicators and evidence to monitor HAZ progress in relation to health inequalities
- Coordinate existing information
- Develop and utilise indicators and evidence to monitor change
- Promote debate and action
- Raise the awareness of health inequalities across the Tyne and Wear HAZ partners.

## Developing a Strategy

In particular local contexts a number of policy options or strategies are possible. It will be necessary to decide on the best 'entry points' for local action (Dahlgren and Whitehead, 1992). These could focus on particular health outcomes which display a sharp social gradient, on population groups or areas where certain risk factors or adverse health outcomes are prevalent, or on determinants of health (which may well be outside the sphere of the health sector). There is no reason to consider that any of these are mutually exclusive, but it is worth bearing in mind experience shows that to set too many targets will dissipate efforts and possibly demotivate those responsible for their delivery.

### *Focus on areas*

Many localities look at differences between areas as a basis for developing strategies, for example by electoral ward or neighbourhoods within them. This allows for areas where health problems tend to cluster to be targeted for greater or faster improvement than those in better off areas. As described in Part one, an emphasis on deprived areas has been a feature of much national policy to tackle social inequality. A potential drawback of this approach is that it may exclude the significant number of disadvantaged people who do not live in areas defined as deprived. Many Hlms identify action on inequalities by area, using local indices of deprivation and other local data available at primary care or district level. This is usually in addition to action targeted towards particular groups or services.

North West Lancashire is monitoring progress in the differences in average life expectancy figures among the four NW Lancashire localities. The aim is to improve health by increasing life expectancy, particularly for people in the worst off localities. Data is being collected to establish changes that can be reasonably expected.

Wigan is focusing on the development of healthy neighbourhoods in areas with a concentration of death and ill-health. This includes bids for Healthy Living Centres and the recruitment of community champions to tackle inequalities in health. A target is 'to create 10 community champions and declare one healthy neighbourhood in 2000/2001'.

Community plans across Wiltshire have identified a number of area-based health and welfare targets, including 'to launch the South Wiltshire Credit Union by 2001'.

### *Focus on populations*

Evidence suggests that several health risk factors accumulate in the same population groups or that certain populations are particularly vulnerable to ill health. This makes the targeting of such populations another 'way in' to formulating local strategy.

Particular population group targets might include specific minority ethnic populations, teenage mothers or lone parents, young people leaving the care system, to name a few. An alternative is to select a particular age group where specific inequalities are prevalent or where a number of risk factors can be addressed at a critical stage in the life course. Interventions aimed at young children and young people, for example, are often chosen as a way of preventing ill-health and health inequalities in the next generation.

Ensure smoking cessation is aimed at ethnic minorities, young people and pregnant women (Lambeth, Southwark and Lewisham)

Develop 8 hostel places as move-on accommodation for homeless people (Croydon)

To monitor the employment of people from black and minority ethnic groups by NHS organisations (NW Lancashire)

Create and link employment and housing opportunities through a foyer scheme for 360 homeless disadvantaged young people by 2003 (Coventry)

### *Focus on the wider determinants of health*

Evidence suggests that the most important determinants of health inequalities lie outside the health sector and, therefore, improvements in the underlying determinants of health such as poor housing or education, low income or unemployment are very powerful levers in bringing about a reduction in health inequality. Formulating a health inequality strategy which addresses the wider determinants of health will involve partners who may not have identified the relevance of 'health' to their own agendas or who may need support to take the lead responsibility for achieving the target.

For further examples, see the range of 'exposure' targets later in this section on food, housing and homelessness, transport, employment, education, benefits/welfare, leisure and community development.

London area HImPs refer to 'high level indicators' set by the London Health Strategy from which they can develop local inequalities targets for areas and different socio-economic groups. These include the proportion of people in work, level of educational qualifications at age 19, expected years of healthy life.

Suffolk County Council has agreed indicators in the HImP, some of which will impact on inequalities such as developing local bus services in underserved areas and reducing the number of long-term unemployed.

Stockport has a target to ensure over a 10-year-period that all residents have access to affordable, good quality food and to maintain and support food cooperatives in the key deprived areas.

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### *Focus on risk factors*

Exposure to health risks of various kinds are often unevenly distributed throughout the population. Smoking prevalence is much higher for lower socio-economic groups, for example. The consumption of fruit and vegetables is also inversely related to socio-economic status. Targets which relate to reducing smoking prevalence, or increasing vegetable consumption in lower income groups are examples of risk-based inequalities targets. Such targets need to be related to a clear understanding of how specific interventions might effect such changes.

To reduce smoking prevalence among families with children under five, particularly low income families, such that the gap in smoking prevalence in families with children under five, between the lowest and highest income practice population, reduces from around 27% to below 24% by 2005. (Avon)

To reduce smoking in ethnic minority communities to 26% by 2005. (Bury and Rochdale)

To develop a coordinated child safety equipment scheme for disadvantaged neighbourhoods by the end of 2002. (Stockport)

### *Focus on health outcomes*

Certain diseases or health outcomes are significantly patterned by social gradients, including coronary heart disease, accidents, some cancers and infant mortality, among others. Inequalities targets can focus on narrowing the gap between social groups by targeting these health outcomes, with differential rates of improvement set for lower socio-economic status groups.

Once again, a clear sense of how this reduction is to be achieved, based on sound evidence, is needed.

North Nottinghamshire HImP sets a general target for a 10% reduction in all cause SMRs per 1,000 population in people aged 65-74 by 2005.

It has also set a target for a 20% reduction in all cause mortality rate for people aged 15-64 in the 10 most deprived wards with the highest SMRs.

Reduction in home accidents of 20% from 1988-2008 in targeted areas. (Lambeth, Southwark and Lewisham)

### Focus on access to services

Where there are clearly identified patterns of inequity in service use, targets can be directed at bringing about improvements in such inequalities. This will need to be linked to a programme of change to increase service use and requires careful monitoring. It is an approach to tackling health inequalities which needs to be complemented with targets relating to prevention.

Improve equality of access by siting a mobile mammography unit in areas of low uptake. Increase uptake rates in areas targeted by October 2000. (Lambeth, Southwark and Lewisham)

Information systems to monitor inequalities in access to and uptake of preventive treatment and rehabilitation services for heart disease, eg use/need ratio, patients' views, referral patterns established by April 2000 (South Yorkshire Coalfield HAZ)

Provide equitable provision of practice-based and community services within the PCG area ... particularly counselling and physiotherapy which have been identified as areas currently offering inequitable service access. (A Wigan PCG)

Increase provision of services to support women from ethnic minority communities affected by domestic violence by 2003. (Bury and Rochdale)

Ultimately the choice and success of targets will be influenced by pragmatic and political considerations. A balance has to be struck that takes account of a range of factors including the types and sources of data available, national requirements for performance management, the overall vision and framework being adopted in local strategic planning, the views of partners and communities, along with the profile and the context of the local area.

The agenda to reduce health and social inequalities is complex and multi-sectoral, and different professionals can make use of all the 'entry points' described previously. However, the different approaches must be 'joined-up' to form one local strategy which is coherent and in which any potential conflicts are debated and resolved.

*'Success in reaching targets will depend on how effectively a focus on inequalities in health is embedded within each programme, influences the choice of priorities, the flow of resources and sets the overall strategic direction. It will involve matching information on deprivation to plans and priorities; synergy between different projects targeted towards reducing inequalities; developing the role of PCG/PCTs; ensuring that a focus on inequalities is maintained within health and health-related programmes; and reorienting policies in order to narrow the health gap'* (Marks, 2001)

### Combining different strategies

Local health planners have tackled the issue of inequalities in a variety of ways, usually prioritising more than one type of inequality and adopting multiple strategies from the list above. For example:

- Sheffield is identifying gradients of ill health by ward as part of the needs assessment process. It is also focusing on equitable service use and vulnerable groups, namely black and minority groups, care leavers and asylum seekers.
- Lambeth, Southwark and Lewisham is working to reduce inequalities as a theme which undercuts work in disease areas, client groups, particular communities, services and policy development. It is now discussing equity profiling and target setting with key partners.
- The Cheshire HImP identifies action in four areas:
  - Work by the Economic and Social Disadvantage Panel in the County Council to establish priorities for local action
  - Establishing healthy living centre projects in deprived areas
  - Identifying the national priorities around inequalities – smoking, drugs and teenage pregnancy
  - The role of the community strategy in addressing inequalities.
- Bolton identifies a similar group of area, service and disease/topic-based priorities:
  - Action to achieve healthy communities (working to improve social, environmental and economic conditions)
  - Establishing welfare rights sessions in primary care settings in targeted areas
  - Including targets within national priorities to improve health outcomes in nine targeted areas.

## Agreeing the types of target

When a broad strategy has been agreed among all relevant partners with the menu of policy options selected, specific targets for measuring the desired change within a given timeframe can be set. Here, again, there is a choice to be made about the types of target to be set. Targets can be qualitative or quantitative and can serve different purposes.

Inequalities targets are distinguishable from general targets in that they should:

- Specify a change to be achieved (such as access to/uptake of a service) among lower socio-economic status groups
- Measure an activity or process directed to the reduction of health inequalities, or
- Disaggregate outcome to be achieved by socio-economic group, often with a greater improvement specified for some (low socio-economic status) groups or areas than others (differential targets)
- Target social determinants of health such as poverty, unemployment or bad housing.

It can be seen that not all of the targets included as examples in this paper meet these criteria; some simply target a health problem which is known to disproportionately affect lower socio-economic status groups without specifying the change to be achieved among these groups in relation to the average.

The following types of general target have been identified in the literature. Each of these types of target can be formulated as an inequality target.

### *Symbolic/aspirational targets*

These are intended to motivate and inspire. As such they may not be so specific in terms of quantifiable improvements in given timescales, or in terms of how change should be achieved. The WHO's target that 'the gap between socio-economic groups within countries should be reduced by at least one fourth' is an example of such a target. Symbolic targets may not be so achievable but have a useful role to play in expressing values or commitment. The danger is that they foster cynicism if they are not possible to meet. These targets on general intention/commitment to inequalities are common. They may not always be expressed as targets and they rarely

have any specified outcome, action or timescale attached. However, in some areas they are being used as a symbol of a joint commitment by the local strategic partnership and a lever to direct planning and resources:

North Tyneside community plan, HImP, Sure Start programme and HAZ have jointly agreed to 'reduce health inequalities and give specific consideration to the health of children and families'.

### *Process targets*

These are intermediate stages in a service or activity aimed to reduce health inequalities in the long term. They may be appropriate to monitor progress in the development of a new service or setting up new joint planning mechanisms to tackle health inequalities. They act as implementation milestones.

Develop and monitor a refugee strategy during 2000.  
Develop an ethnic monitoring report by October 2000.  
Develop a Sure Start bid. (Bromley)

Commission research on Cotswolds health inequalities through the community strategy. (Cotswold Council)

### *Activity targets*

If any activity is directed at reducing inequality, measures of such activity will act as a proxy for the intended health benefits. Examples include targets for uptake of services.

100% of all accepted homeless applicants to receive a permanent offer of accommodation within 28 actual days. (Portsmouth)

Develop a 'benefits on prescription' scheme with health service and voluntary sector partners as part of the neighbourhood renewal strategy. (Barnet)

At least one community-based heart disease prevention project established in each locality identified as experiencing greatest need in each district by March 2000 and roll out to other areas in the following years. (South Yorkshire Coalfield HAZ)

### *Outcome targets*

These targets specify a desired improvement in specific health outcomes or risk factors. Outcome targets may be split into targets for particular populations and areas.

Sandwell HAZ has set outcome targets for 2005 under each stage of the life course – babies, young people and adults, including:

- Low birth weight babies (% under 2.5kg) – target 8% from 10% baseline
- Perinatal mortality (rate/1,000 live births and stillbirths) – target 7.5/1,000 from baseline 10.8/1,000.

.....  
Lambeth, Southwark and Lewisham has set a reduction of 5% in proportion of low birth weight babies from the 1998 baseline by 2002.

.....  
To reduce the proportion of low birth weight babies in areas of special action by 3% against the 1998 baseline by 2002. (North Tyneside)

Outcome targets can also reflect changes in risk factors either among the population as a whole, or within targeted communities.

Lambeth, Southwark and Lewisham has also set a target to reduce by 15% the number of children going to school without breakfast in targeted schools by 2002. (Baseline to be established)

Differential outcome targets have also been set.

Norfolk Health Authority has adopted an approach to local inequalities target setting which adjusts national targets to regional variations by district. This is considered to be a compromise which sets higher targets for more deprived areas 'without making wholly unrealistic demands on areas with the greatest problems'. It aims to achieve overall health improvement but reduce the gap between areas by requiring a differential pace of achievement in areas with the greatest problems. The areas with the highest mortality rates need to make the greatest progress. Effectively the reduction in inequalities is defined as reducing each district's variance from the regional average by 50%.

A breakdown of all ages circulatory disease mortality rates per 100,000 population shows the effect of achieving a 40% reduction in each district will be overall health improvement but no change in the gap between the highest and lowest rates by district. To tackle this, the target adjusted for inequalities has been calculated by allowing for a 40% reduction in the regional average mortality rate and a 50% reduction in each district's variance from the regional average.

### *Exposure targets*

These are targets directed specifically at the social, economic or environmental determinants of health rather than disease based outcomes. They focus energy 'upstream' and relate to risks such as poor housing, or unemployment. Many HImPs and HAZs refer to action in other initiatives or plans (such as regeneration plans, Sure Start programmes and New Deal for Communities), which are directed specifically at disadvantaged groups or neighbourhoods. Many are not yet in the form of measurable targets, but these are being developed to form part of inequalities action plans in community and neighbourhood renewal strategies. Some examples are shown opposite.

## Exposure targets – examples

### Food

- Manchester has set inequalities targets by area throughout its priority areas, such as 'to reduce the number of food deserts in the city by 50% over a five year period' and 'to develop three parental food education projects in poorer areas of the city'. These aim to increase consumption of healthy food by increasing access and awareness/skills respectively.

### Transport

- To make food poverty a key consideration in community transport planning. (Stockport)
- Proportion of children cycling or walking to school in specific areas to be increased by 80% by 2005. (South Yorkshire Coalfield HAZ)

### Housing and homelessness

- Outreach teams working to reduce the number of people sleeping rough (various authorities), eg to reduce the level of rough sleeping in Bournemouth by two-thirds by 2002.
- 20% reduction in overcrowded households or households lacking in basic amenities by 2005. (North Nottinghamshire)
- Sandwell HAZ has developed a housing intervention called 'repairs on prescription' which aims to improve the health of asthmatic children in deprived communities. Targets include the reduction of asthma-related hospital admissions and reduction in the number of school days lost.

### Employment

- Luton HAZ has a range of targets related to employment. For example, a percentage improvement in employment figures within HAZ target wards, an increase in the number of people joining New Deal from target wards in the poorest health, and an increase in the numbers of people leaving New Deal in employment.

- Hull HAZ has set up a Healthy Living Network for disabled people. Among the outcome targets included is a 5% increase in the number of disabled people in employment, using a 2000/01 baseline.
- A reduction in unemployment in the most deprived areas to 5.9% by 2005. (North Nottinghamshire)

### Education

- Staying on rates in full-time education by ethnic group target 89.3% (overall by 2002). (Sandwell HAZ)
- Proportion of young people leaving care with a GCSE or GNVQ increased to at least 50% by 2001 and 75% by 2003. (South Yorkshire Coalfields HAZ)
- 10% increase in A-C grades at age 16 GCSE tests in the 10 most deprived wards. (North Nottinghamshire)

### Leisure

- Increase the take up of the Passport to Leisure and Learning scheme by 20% of those eligible by 2001. (Coventry)

### Benefits/welfare

- A reduction in the number of lone parents on income support in the 10 most deprived wards. (North Nottinghamshire)
- Reduce the number of residents seriously in debt by 10% by 2004. (Portsmouth)

### Community development

- Develop at least two health-related community regeneration schemes covering areas of special action (identified from poverty, health and deprivation profiles 2000), adopting a community development approach, eg rapid appraisal of the communities' expressed health needs. (Barnet)

# Part four: Bringing it all together

22 This section draws together the learning from local partnerships and the literature, and offers a series of steps to follow in developing local health inequalities targets. It ends with some of the key implementation issues which need to be resolved at local level if target setting is to become a useful part of local strategic planning.

## Steps in setting local targets

These steps are not a blueprint for all, but can be used as the basis for developing or reviewing your local processes.

### 1 Establish the process for setting inequalities targets firmly within the mainstream strategic planning cycle

- The strategic partnership/LSP in the area agrees a broad strategic approach to reducing health and other inequalities and identifies a vision or principles to guide action. A definition and framework for describing local inequalities is then agreed and shared among partner organisations.

### 2 Decide a process and structure for setting the targets – who should be involved, when and how?

- A group and lead organisation or team are identified within the planning processes for the HIMP, community strategy and neighbourhood renewal strategies to lead on work to reduce inequalities.

### 3 Identify relevant regional targets, performance frameworks and learning networks

- The regional health inequalities group, Government Office leads for LSPs and neighbourhood renewal, and

the public health observatory can provide support and share practice from across the region. Learning can be shared from existing initiatives such as HAZs.

### 4 Map inequalities and deprivation and undertake an equity audit

- A profile of health inequalities and deprivation across the area is developed. This requires action by the range of organisations across the LSP and HIMP partnerships, including the health authority, NHS trusts, primary care groups/trusts and the local authority (at all levels), plus information available from the voluntary and community sectors and from business. The equity audit provides details of differential service use, treatment/care patterns and outcomes across the range of local public services (including leisure, housing, education and so on).
- The public health observatory can be used as a source of regional data (eg lifestyle survey data) and for advice on sources of national data (eg Health Poverty Index, Indices of Deprivation), mapping of indicators and advice on the use of appropriate information and indicators.
- Support is provided through the local information strategy team – working to develop joint information systems for the HIMP/community strategy. Additional work on the development of neighbourhood and ward level data is required, linked to national developments (see Annexe C).

### 5 Review existing local targets and action being taken to achieve them

- The targets of all partner organisations, milestones and indicators are mapped and compared with the strategic vision for reducing inequalities. The local strategic partnership can coordinate this process, working with the HIMP/HAZ partnership.

- A summary of current activity to reduce inequalities is produced across each strategic priority (across sectors), service and area-based initiative. Information on current activity may be available from the NHS local modernisation reviews, Best Value reviews, existing mapping of activity for specific issues (such as teenage pregnancy) and from work on the development of the HAZ, community strategy or neighbourhood renewal strategy.

## **6 Identify and establish links with local communities to support the mapping and development of targets**

- A system of involving and engaging local communities in the process is established – to help identify and prioritise inequalities to be tackled. This links to the broader community involvement strategy developing jointly across the HIMP, community strategy and neighbourhood renewal strategy and other key partnerships.

## **7 Agree priorities for action and a set a number of targets around these**

- Priorities for reducing inequalities are agreed as part of the HIMP/community strategy priority setting process. This should reflect national priorities, the local vision and a framework combining audit results and community involvement.
- Data gathered is used to set objectives and targets for reducing health inequalities. These become part of the performance management systems across the partner organisations and are built into the development of service agreements and commissioning (see criteria for targets in Part two of this report).
- Different types of targets are identified as necessary, to reflect processes, activity and outcomes and in relation to different aspects of inequalities.

## **8 Relate targets to action across key strategic and local plans**

- All partnerships within the LSP and the HIMP are required to identify action to reduce inequalities in the priority areas, population groups and services selected. This may build on existing work, but is likely to require considerable changes to the focus and scale of current provision and activity.

- Evidence of effective interventions (as well as learning from ineffective interventions) is gathered and used to inform this action planning. Health inequalities impact assessment is used to consider the impact of potential and planned interventions on reducing the inequalities identified.
- Negotiation takes place to agree how work to reduce inequalities and deprivation will be incorporated within specific action plans (at cross-organisational level such as the community strategy, at departmental/service level, such as primary care trusts, and through area-based plans, such as the neighbourhood renewal strategy). This includes identifying responsibilities, funding requirements and timescales to meet the targets.

## **9 Agree a 'basket' of local indicators to monitor progress**

- Build the set from existing indicators in use at national, regional and local level (see Annexe C) and identify gaps where further work or data is needed (for example, indicators of communities' perceptions of their health).
- Agree a process for gathering baseline data for indicators where this does not exist and any research to identify appropriate local community indicators, working with the community and voluntary sectors.

## **10 Establish funding arrangements**

- The agreed targets are fed into the funding processes of all partner organisations and joint funding arrangements. Critically, mainstream funding will need to be redirected to resource the action required to achieve them.
- Some joint funding from existing initiatives such as New Deal for Communities, HAZ or Sure Start could be identified to pump prime action.
- A process will need to be agreed to develop the use of joint and pooled budgets across the range of health and local authority services and the establishment of integrated services (beyond health and social care).

## **11 Monitor and evaluate targets linked to performance management systems**

- A system for monitoring the targets across sectors is put in place – which feeds into the various reporting mechanisms for the LSP and links to the NHS

Performance Assessment Framework and Best Value Performance Plans.

- Regular reports on progress towards the targets are provided to partners, the public and regional agencies. Where the indicators suggest progress is not being made, action plans are reviewed through the relevant partnerships and groups responsible.
- New indicators are introduced as data becomes available and evidence of effective interventions is gathered and shared to inform future work.

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## Some key implementation issues

### *Changes in local systems and structures*

LSPs and PCTs are forming and growing at different stages across the country; so are their main strategic planning processes – the community strategy, neighbourhood renewal strategy and the HIMP. Setting health inequalities targets within this changing local system is a considerable challenge. LSPs and PCTs need to consider and agree their respective roles in coordinating this work according to their current stage of development.

### *Using the modernisation process and 'trailblazers'*

There is already a body of information about the nature of local health and other inequalities available from NHS modernisation reviews, community planning activities, Best Value reviews and audits across local systems. Specific initiatives such as Health Action Zones, Sure Start, New Deal for Communities and cross-cutting work on strategies, such as those to reduce teenage pregnancy, have also undertaken inequalities mapping and review exercises and can share data and learning.

### *The status of the targets*

It remains a challenge to ensure local health inequalities targets are given the same status as other service and modernisation targets across health and local government. A communication strategy is needed which provides all local partners with information about the ways in which they can contribute to reducing health inequalities and how this will also help them achieve other modernisation targets. The opportunities for mainstream NHS and local government services to reduce inequalities in provision, access, treatment and care need to be given a high profile through this communication strategy.

### *National versus local targets*

Local targets are an opportunity for partnerships to reflect the inequalities that matter most in their area. They provide a vehicle for involving the community and voluntary sector in local planning and in identifying their contribution to the targets. Local targets can do much more than contribute to national targets. They help partnerships to measure: differential changes in the views, perceptions and behaviours of particular communities or groups; the combined activity of local services working together in deprived areas; and the changes in funding across local organisations to target health inequalities and so on.

### *The evidence base*

It is essential that local action is evaluated and learning is analysed to feed into future plans and targets. Health impact assessment, which includes an assessment of the impact of a programme on health inequalities, is a key tool for bringing both national and local evidence to bear in planning.

### *Balancing types of targets*

Outcome targets, used in isolation, provide only limited incentive or direction for local action. Process and activity targets are essential to provide shorter term measures of local progress and to signal the methods and approaches the local strategic partnership is 'signing up to' in tackling health inequalities. Exposure targets on the determinants of health are critical in developing the role of partners beyond the NHS. They provide local authorities, in particular, with a focus for setting out their service and area-based contributions to achieving health inequalities outcome targets. All targets to reduce health inequalities need to differentiate between socio-economic groups, areas or in terms of other key disadvantaged population groups.

### *Involving communities and staff*

Meaningful local inequalities targets will reflect the concerns and experiences of communities and disadvantaged groups. This requires local strategic partnerships to work with local communities in the development of targets that matter to them, and to recognise the use of qualitative targets, such as changes in communities' perceptions of their health and neighbourhood. Targets must also have resonance with staff working in local agencies and organisations. This requires partners within LSPs to agree a process of target setting through organisational development – to enable

staff to explore how health inequalities are created and sustained by organisations and how to develop targets for action for their own teams or services, working with local communities.

### *Incentives and accountability*

Local health inequalities targets also need to be meaningful in the performance and funding systems linked to LSPs. It is no longer appropriate to fund work on inequalities targets through one-off initiatives and projects which do not affect mainstream service delivery or planning. All local targets can be used to guide mainstream funding and to shift the patterns of service delivery to benefit those with the poorest health experience. There will need to be agreements built into commissioning contracts, service level agreements, specifications for new facilities and premises and conditions for the use of pooled budgets, which specify how action will contribute to achieving local inequalities targets. Local partnerships, services and teams should also be asked to demonstrate how their objectives, actions and funding allocations are supporting local targets and where they are increasing their impacts through joint working with other partnerships and teams.

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# Annexe A: Key government policies for tackling inequalities

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Policy and aims	Key areas for action on health inequalities	Specific national targets identified
<p><i>Independent Inquiry into Inequalities in Health</i> Acheson, 1998 London: The Stationery Office.</p>	<p>Recommendations made in the areas of:</p> <ul style="list-style-type: none"> <li>• Poverty, income, tax and benefits</li> <li>• Education</li> <li>• Employment</li> <li>• Housing and environment</li> <li>• Mobility, transport and pollution</li> <li>• Nutrition and the Common Agricultural Policy</li> <li>• Mothers, children and families</li> <li>• Young people and adults of working age</li> <li>• Older people</li> <li>• Ethnicity</li> <li>• Gender</li> <li>• The NHS.</li> </ul> <p>Identifies the key role for local partnerships through the health improvement programme in reducing health inequalities.</p>	<p>No specific national targets set; this was an independent inquiry. However, recommendations in all areas could be used to develop local inequalities targets.</p> <p>Three key general recommendations were:</p> <ul style="list-style-type: none"> <li>• All policies likely to have a direct or indirect effect on health should be evaluated in terms of their impact on health inequalities</li> <li>• Establish mechanisms to monitor inequalities in health and to evaluate the effectiveness of measures taken to reduce them</li> <li>• A review of data is needed to improve the capacity to monitor inequalities in health and their determinants at a national and local level</li> <li>• High priority given to policies aimed at improving health and reducing health inequalities in women of childbearing age, expectant mothers and young children.</li> </ul>
<p><i>Opportunity for All – Tackling Poverty and Social Exclusion</i> DSS, 1999.</p>	<p>Goal to eradicate child poverty within 20 years.</p>	<p>This has since led to the Public Service Agreement target between HM Treasury and the Department of Work and Pensions to ‘make substantial progress towards eradicating child poverty by reducing the number of children in poverty by at least a quarter by 2004’.</p>

Policy and aims	Key areas for action on health inequalities	Specific national targets identified
<p><i>Reducing Health Inequalities: An Action Report</i> Department of Health, June 1999.</p>	<p>Sets out a response to the Acheson report and identifies action to be taken across government to reduce health inequalities.</p>	<p>No new targets identified other than those in <i>Saving Lives: Our Healthier Nation</i>. Provides a summary of all government action to reduce health inequalities which can be used as the basis for a local strategy.</p>
<p><i>Saving Lives: Our Healthier Nation</i> Department of Health, June 1999.</p> <p>Improve the health of the population as a whole by increasing length of life and number of years free from illness.</p> <p>Improve the health of the worst off.</p>	<p>Sets out action in the priority areas of coronary heart disease and stroke, cancer, accidents and mental health (including smoking, physical activity and nutrition) and wider action on sexual health and teenage pregnancy, drugs, alcohol, food safety, water fluoridation, communicable diseases, improving health of black and minority ethnic groups and developments in genetics. Recognises impacts of housing, transport, education, employment, environment, healthy neighbourhoods and security.</p> <p>National Service Frameworks for coronary heart disease, mental health, older people, the National Cancer Plan and Sexual Health Strategy provide the basis for achieving targets in the priority areas. These contain milestones for each target which should be incorporated within the HIMP and strategies contained within it.</p> <p>Sets out the requirement for local health inequalities targets to be set as part of HImPs.</p>	<p>Reduce death rates from CHD, stroke and related diseases in people under 75 by two fifths by 2010.</p> <p>Reduce death rates from cancer in people under 75 by a fifth by 2010.</p> <p>Reduce death rates from accidents by one fifth and to reduce the rate of serious injury from accidents by at least one tenth by 2010.</p> <p>To reduce adult smoking in all social classes so that the overall rate falls from 28% to 24% or less by the year 2010; with a fall to 26% by the year 2005 ( and to reduce the difference in smoking rates between manual and non-manual groups).</p> <p>To reduce the percentage of women who smoke during pregnancy from 23% to 15% by the year 2010; with a fall to 18% by the year 2005.</p> <p>To halve the rates of conception among under 18s in England by 2010 and to set a firmly established downward trend in the conception rates for under 16s by 2010.</p> <p>Reduce the number of people sleeping rough by two-thirds by 2002.</p>

Policy and aims	Key areas for action on health inequalities	Specific national targets identified
<p><i>NHS Plan and Implementation Programme (2000).</i></p>	<p>Sets out the priorities for transforming the health and social care system so that it provides faster, fairer services that deliver better health and tackle health inequalities.</p> <p>Objectives have been set to:</p> <ul style="list-style-type: none"> <li>• Improve health outcomes for everyone</li> <li>• Improve patient and carer experience of the NHS and social services</li> <li>• Effective delivery of appropriate care</li> <li>• Fair access</li> <li>• Value for money.</li> </ul> <p>It highlights the importance of the NHS role in neighbourhood renewal programmes and the development of local strategic partnerships.</p>	<p>In addition to the targets noted above, it sets out these targets:</p> <ul style="list-style-type: none"> <li>• Two-thirds of all outpatient appointments and inpatient elective admissions will be pre-booked by 2003-4 and 100% by 2005</li> <li>• Reduce maximum wait for an outpatient appointment to three months and for inpatient treatment to six months by 2005</li> <li>• Secure year-on-year improvements in patient satisfaction, including standards for cleanliness and food</li> <li>• Reducing preventable hospitalisation and year-on-year reductions in delays in moving people over 75 on from hospital</li> <li>• Improving level of education, training and employment outcomes for care leavers aged 19, so that levels for this group are at least 75% of those achieved by all young people in the same area by March 2004</li> <li>• Increasing from 6-15% from 1998-2004 the proportion of children leaving care aged 16 and over with five GCSEs at grade A-C</li> <li>• Narrow the gap by 2004 between the proportion of children in care who are cautioned and the rest</li> <li>• Increase adoption rates (target to be set)</li> <li>• Increase the participation of problem drug users in drug treatment programmes by 55% by 2004 and by 100% by 2008</li> <li>• Guaranteed access to a primary care professional within 24 hours and a primary care doctor within 48 hours by 2004</li> <li>• All NHS Trusts will be expected to reach the level of the best in terms of cost of care against indicators for fair access, quality and responsiveness over the next five years.</li> </ul>

Policy and aims	Key areas for action on health inequalities	Specific national targets identified
<p><i>Planning for Health and Social Care incorporating guidance for health and local authorities on Service and Financial Frameworks SAFF, 2001.</i></p> <p>Sets out the planning process for 2001-2002 and the organisational and service targets and milestones for the SAFF.</p>	<ul style="list-style-type: none"> <li>• Action to reduce child poverty and improve child health.</li>   <li>• Expand Sure Start programmes.</li>   <li>• Increase and improve primary care in deprived areas.</li>   <li>• New screening programmes for women and children.</li>   <li>• Increase smoking cessation services, especially for pregnant women and heavily dependent smokers.</li>   <li>• Increase provision and access to fruit and vegetables via free fruit in school for 4-6 year olds, food coops etc.</li> <li>• Increase support for breast feeding, parenting and welfare foods scheme.</li> <li>• Increase physical activity.</li> <li>• Increase support for treatment services for drug users and targeted drug prevention activity.</li> <li>• Improve access to and links between sexual health services.</li> <li>• Reduce teenage conception rates, through health and local authority 10 year teenage pregnancy strategies.</li> </ul>	<ul style="list-style-type: none"> <li>• Every looked-after child to have an annual health assessment.</li> <li>• Review the health and social services resources required by Youth Offending Teams to assess children and develop a service programme.</li> <li>• 6,000 severely disabled children to receive support services for the first time by April 2002.</li> <li>• All health and local authorities to have a joint Child and Adolescent Mental Health Services Strategy by May 2001.</li> <li>• NHS to contribute to all Sure Start programmes. Develop 250 new programmes by 2002.</li> <li>• Increase the number of GPs in deprived areas by 2002.</li>   <li>• Health authorities and partners to put in place the infrastructure to extend and improve children's health and antenatal screening services (by March 2002).</li> <li>• All primary care groups and trusts to review screening coverage rates and plan to improve access for women in socially excluded and minority groups.</li>   <li>• 50,000 smokers to have attended smoking cessation services and quit up to four weeks later, with emphasis on manual groups (by March 2002).</li>   <li>• Prepare quantified plans to increase consumption of fruit and vegetables, particularly among those on low incomes.</li>   <li>• 15% reduction in under 18 conception rates by 2004 and reduction in the range 40-60% by 2010. Joint reports on progress required by March 2002.</li> </ul>

Policy and aims	Key areas for action on health inequalities	Specific national targets identified
<p><i>National Strategy for Neighbourhood Renewal</i> (Social Exclusion Unit, Cabinet Office, 2000).</p> <p><i>A new Commitment to Neighbourhood Renewal; National Strategy Action Plan</i> (Social Exclusion Unit, Cabinet Office, 2001).</p> <p>Aims to arrest the wholesale decline of deprived neighbourhoods, to reverse it and prevent it from recurring.</p>	<p>Aims to narrow the gap between deprived areas and the rest of the country by improving outcomes: more jobs, better educational attainment, less crime and better health.</p> <p>Policies include extending Sure Start to cover a third of infants by 2004; extending coverage of the Excellence in Cities programme; creating a Children's Fund for work with vulnerable 5-13 year olds; creating the Connexions Service to keep 13-19 year olds in learning; establishing 6000 on-line centres; and an Adult Basic Skills Strategy to improve the basic skills of 750,000 by 2004.</p> <p>Making the New Deal permanent; 32 Action Teams for Jobs; large investment in childcare and transport; benefit changes and tax changes to make work pay; new Small Business Service and a Phoenix Fund to encourage enterprise in deprived areas; more funding and flexibility for Regional Development Agencies; and follow-up to the Social Investment Task Force.</p> <p>Increase in spending on the police by 2003-4; Neighbourhood Wardens Fund; Crime Reduction Programme and Crime and Disorder Reduction Partnerships to tackle anti-social behaviour and racist crime; new National Drug Treatment Agency.</p> <p>Investment in housing and housing management; expanding the transfer of local authority homes to Registered Social Landlords; measures to tackle low demand and abandonment.</p>	<p>Government departments have agreed targets following the Comprehensive Spending Review 2000.</p> <p>Increase the percentage of pupils obtaining five or more GCSEs at grades A to C (or equivalent) to at least 38% in every local education authority (and at least 25% in each school) by 2004. A further target will be set later in 2001 to ensure that no authority has fewer than a set percentage of pupils achieving the expected standards of literacy and numeracy.</p> <p>By 2004, taking account of the economic cycle, increase employment rates of the 30 local authority districts with the poorest initial labour market position; to reduce the difference between employment rates in these areas and the overall rate and to do the same for disadvantaged groups.</p> <p>Reduce the level of crime in deprived areas so that by 2005 no local authority area has a domestic burglary rate more than three times the national average – and reducing the national rate by 25%.</p> <p>All social housing to be of a decent standard by 2010 with the number of families living in non-decent social housing falling by one third by 2004, and with most of the improvement taking place in the most deprived local authority areas.</p> <p>Health targets agreed subsequently (see opposite).</p>

Policy and aims	Key areas for action on health inequalities	Specific national targets identified
<p><i>Tackling Health Inequalities: consultation on a plan for delivery</i> (2001).</p>	<p>Sets out the national health inequalities targets, proposed basket of indicators and priorities for action across sectors to achieve the targets. Priorities are:</p> <ul style="list-style-type: none"> <li>• Providing a sure foundation through a healthy pregnancy and early childhood</li> <li>• Improving opportunities for children and young people</li> <li>• Improving NHS primary care services</li> <li>• Tackling the major killers; coronary heart disease and cancer</li> <li>• Strengthening disadvantaged communities</li> <li>• Tackling the wider determinants of health.</li> </ul>	<p>Targets (announced in February 2001) include two headline targets:</p> <ul style="list-style-type: none"> <li>• Starting with children under one year, by 2010 to reduce by at least 10% the gap in mortality between manual groups and the population as a whole</li> <li>• Starting with health authorities, by 2010 to reduce by at least 10% the gap between the quintile of areas with the lowest life expectancy at birth and the population as a whole.</li> </ul> <p>The teenage conception target and smoking target aimed at manual groups provide the two supporting inequalities targets, focused on particular health issues.</p>

# Annexe B: Stages in health inequalities policy development

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<b>HEALTH INEQUALITIES POLICY DEVELOPMENT</b>	
The nature and extent of the problem of health inequalities.	<i>Independent Inquiry into Inequalities in Health</i> (Acheson, 1998).
The broad policy developments required to tackle health inequalities.	<p><i>Independent Inquiry into Inequalities in Health</i> (Acheson, 1998).</p> <p><i>Reducing Health Inequalities: An Action Report</i> (DH, 1999).</p> <p><i>Government Interventions in Deprived Areas (GIDA) Spending Review</i> (HM Treasury, 2000).</p> <p><i>A New Commitment to Neighbourhood Renewal: National Strategy Action Plan</i> (SEU, 2001).</p> <p><i>Tackling health inequalities; consultation on a plan for delivery</i> (DH, 2001).</p> <p><i>Spending Review 2002</i> (HM Treasury, in progress).</p>
The public service response required to both improve health and reduce health inequalities.	<p><i>Saving Lives: Our Healthier Nation</i> (DH, 1999) – requirement to set local health inequalities targets.</p> <p><i>Government Interventions in Deprived Areas (GIDA) Spending Review</i> (HM Treasury, 2000) – targets and resources through review of weighted capitation formula to support them.</p> <p><i>New Commitment to Neighbourhood Renewal; National Strategy Action Plan</i> (SEU, 2001) – as for GIDA, also performance management of targets through NHS Performance Assessment Framework, and extra resources to primary care in deprived areas etc.</p> <p><i>Tackling health inequalities; consultation on a plan for delivery</i> (DH, 2001).</p>

## HEALTH INEQUALITIES POLICY DEVELOPMENT

<p>Implementation in the NHS.</p>	<p><i>The NHS Plan</i> (DH, July 2000) and <i>Implementation Programme</i> (DH, Dec 2000).</p> <p><i>Planning for Health and Social Care</i> (DH, 2000).</p> <p>National Service Frameworks for coronary heart disease (DH, 2000), mental health (DH, 2000) and older people (DH, 2001).</p> <p><i>The NHS Cancer Plan</i> (DH, 2000).</p> <p><i>Government Interventions in Deprived Areas (GIDA) Spending Review</i> (2000) – resources and targets.</p> <p><i>A New Commitment to Neighbourhood Renewal: National Strategy Action Plan</i> (SEU, 2001).</p> <p><i>Local Modernisation Review</i> (DH, 2001).</p> <p><i>Tackling health inequalities; consultation on a plan for delivery</i> (DH, 2001).</p>
<p>Action and targets for reducing inequalities across government departments.</p>	<p><i>Opportunity for All; tackling poverty and social exclusion</i> (DSS, 1999).</p> <p><i>Government Initiative in Deprived Areas (GIDA) Spending Review</i> (HM Treasury, 2000) – actions, targets and resources.</p> <p><i>A New Commitment to Neighbourhood Renewal; National Strategy Action Plan</i> (SEU, Cabinet Office, 2001) – action and targets.</p> <p><i>Tackling health inequalities; consultation on a plan for delivery</i> (DH, 2001).</p> <p>Spending Review 2002 (HM Treasury, in progress).</p>
<p>Trailblazer initiatives which contribute to reducing health inequalities.</p>	<p>Health Action Zones and other action zones.</p> <p>Sure Start programme.</p> <p>New Deal for Communities.</p> <p>Public Service Agreement pilots.</p> <p>Neighbourhood Management Pathfinders.</p> <p>Healthy Living Centres.</p>

## HEALTH INEQUALITIES POLICY DEVELOPMENT

<p>Mainstream planning processes and plans for local delivery of the targets across the NHS and local government.</p>	<p>Local strategic partnerships (LSPs) as the lead partnership for:</p> <ul style="list-style-type: none"> <li>• Community strategies</li> <li>• Local neighbourhood renewal strategies</li> <li>• Local Public Service Agreements (PSAs).</li> </ul> <p>Health improvement and modernisation plans (HIMPs) – as the local strategic health plan, linked to the community strategy, within the LSP.</p> <p>Central government will rationalise plans and partnerships from different departments, to enable LSPs to act as the overarching strategic partnership and to simplify local planning arrangements.</p> <p>For example, Children and Young People’s partnerships which will lead Children’s Services Planning and will operate as a subset of the LSP.</p>
<p>Mechanisms for monitoring the targets.</p>	<p>The Neighbourhood Renewal Unit will use local neighbourhood renewal strategies to track progress on the National Strategy targets, including the health inequalities targets.</p> <p>A proposed basket of cross-government indicators is being developed by the Department of Health to track the health inequalities targets. See <i>Tackling health inequalities: consultation on a plan for delivery</i> (DH, 2001).</p> <p>NHS Performance Scheme and Performance Assessment Framework (performance indicators for health inequalities being developed).</p> <p>PSS Performance Assessment Framework.</p> <p>Best Value Performance Indicators (if used to identify differential service provision and use).</p>

# Annexe C: Indicators – a quick source guide

## Department of Health

### [www.doh.gov.uk/healthinequalities](http://www.doh.gov.uk/healthinequalities)

The Department's website that sets out policy on health inequalities, the national targets and the development of the basket of indicators. It also includes information on the national health inequalities taskforce. Information on the regional health inequalities taskforces can be found from NHS regional offices via [www.doh.gov.uk](http://www.doh.gov.uk).

### [www.doh.gov.uk/nhsplantechnicalsupplement/index.htm](http://www.doh.gov.uk/nhsplantechnicalsupplement/index.htm)

*The NHS Plan: Technical Supplement on Target Setting for Health Improvement* draws together information on data sources, signposts relevant government initiatives and provides reference material for those involved in setting targets and monitoring progress at national and local level.

### [www.doh.gov.uk/nhsexec/nhspaf.htm](http://www.doh.gov.uk/nhsexec/nhspaf.htm)

The NHS Performance Assessment Framework sets out the indicators to be collected and monitored by all NHS organisations. It includes some health inequalities indicators which will be added to in 2002.

### [www.nchod.nhs.uk](http://www.nchod.nhs.uk)

The National Centre for Health Outcomes Development provides data and information on measurement tools for public health. It is a key source of information on assessment of health and outcomes of health interventions at individual, health authority, hospital and community trust, primary care group/team and local authority levels for the English National Health Service and the government.

### [www.haznet.org.uk](http://www.haznet.org.uk)

An information and discussion website on the Health Action Zones. It includes the HAZ High Level Performance

Indicators and examples of local inequalities indicators used by the HAZs.

The Associated HAZ in the South East Region has also developed a set of indicators for local use, including inequalities indicators. Details via [haznet](http://haznet).

### [www.pho.gov.uk](http://www.pho.gov.uk)

The eight regional Public Health Observatories provide a range of data, information, analysis and support services to any local agency or group working to improve health and reduce health inequalities. This includes equity profiling, development of data sets and research methods, health inequalities impact assessment, effective practice and toolkits, monitoring and performance measurement, access to wider public health data sets and equity audits and reviews.

South East PHO and the Centre for Health Economics, University of York, are producing a report on recommended methods and measures for health inequalities in 2002. Contact [www.sepho.org.uk](http://www.sepho.org.uk).

### [www.phel.gov.uk](http://www.phel.gov.uk)

The Public Health electronic Library is being developed over the next year by the Department of Health and will become a gateway for all public health information sources, databases and websites.

## Other government departments

### [www.statistics.gov.uk/statbase/mainmenu.asp](http://www.statistics.gov.uk/statbase/mainmenu.asp)

StatBase is an online database which holds a large selection of government statistics. It also provides descriptions of all the UK government statistical services' data sources, derived analyses, all its statistical products and services and all the relevant contact points.

A set of standard neighbourhood statistics covering the social exclusion characteristics of a neighbourhood will be collated annually. This work is led by the Office for National Statistics and coordinated across government departments supported by local government and other public, private and voluntary sector organisations that collect relevant information. It is envisaged that this information will be available down to ward level. Information is collected within nine suggested domains which include access to services, community wellbeing/social environment, crime, economic deprivation, education, skills and training, health, housing, physical environment and work deprivation.

**[www.cabinet-office.gov.uk/seu/2000/pat18/depindices.htm](http://www.cabinet-office.gov.uk/seu/2000/pat18/depindices.htm)**

This working paper *Measuring Deprivation: A Review of indices in common use* was produced to inform and support the work of the Social Exclusion Unit's Policy Action Team (PAT) 18 on 'Better Information'. It reviews the most commonly used deprivation measures and highlights some of the issues surrounding their use.

**[www.environment.dtlr.gov.uk/sustainable/localind/nutshell/index.htm](http://www.environment.dtlr.gov.uk/sustainable/localind/nutshell/index.htm)**

*Quality of life counts; Indicators for a Strategy for Sustainable Development* (DETR, 1999) offers ideas for measuring sustainable development and quality of life in local communities. These include 15 headline indicators intended to make up a 'quality of life barometer' which will be used to measure overall progress. The indicators include success in tackling poverty and social exclusion and expected years of healthy life.

This has been followed by *Local Quality of Life Counts; A Summary of a menu of local indicators of sustainable development* (DETR, LGA, IdeA, 2000).

**[www.local-regions.dtlr.gov.uk/bestvalue/indicators/indicatorsindex.htm](http://www.local-regions.dtlr.gov.uk/bestvalue/indicators/indicatorsindex.htm)**

The DTLR's Best Value Performance Indicators 2000 are the indicators measured by all local authorities in their Best Value reviews.

**[www.regen.dtlr.gov.uk/research/id2000](http://www.regen.dtlr.gov.uk/research/id2000)**

The regeneration website for DTLR includes the key reports *Indices of Deprivation: Regeneration Research Report 31* (DETR, 2000) and *Measuring Multiple Deprivation at the small area level; the indices of deprivation 2000 Regeneration Research 37* (DETR, 2000).

**[www.clip.gov.uk](http://www.clip.gov.uk)**

The Central and Local Information Partnership is a government programme which provides ward-level information that can be used as a source of data for inequalities indicators.

## Non-governmental information sources

**[www.jrf.org.uk](http://www.jrf.org.uk)**

The Joseph Rowntree Foundation provides information relating to community development, health and social inclusion projects. Research includes the development of key indicators of poverty and social exclusion.

**[www.urbanforum.org.uk](http://www.urbanforum.org.uk)**

This site includes work on developing social inclusion indicators, using non-health data as evidence of social exclusion and impacts on health.