NHS Lothian
Health Inequalities Strategy

Consultation Draft
March 2014
NHS LOTHIAN HEALTH INEQUALITIES STRATEGY

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INTRODUCTION

Of all the challenges facing Scotland, the gaping health inequalities and high mortality rates are clearly our greatest.

Health Scotland Overview for Ministerial Taskforce on Health Inequalities Nov 2012

Health inequalities are ‘systematic, unfair differences in the health of the population that occur across social classes or population groups’.

In Scotland there are significant inequalities in health between people who are socially and economically well off, and those who are socially disadvantaged. In Lothian this means for example that people living in the most affluent communities in Lothian can expect to live twenty one years longer than people living in the most deprived communities. People living in the most deprived communities also have poorer physical and mental health throughout their lives.

Health inequalities do not just affect the most deprived communities and individuals. For almost every health indicator there is a clear gradient showing progressively poorer health with decreasing affluence and influence. Nor are health inequalities only related to socio-economic position. People who are disadvantaged by race, disability, gender and other factors also have poorer health.

This strategy sets out how NHS Lothian intends to respond to these inequalities. It recognises that health inequalities reflect much broader societal forces that the NHS cannot address on its own. However, NHS services play an important role in mitigating the effects of these wider social inequalities on health, and NHS organisations can also work with partners to try to address the underlying influences.

Much of the work to tackle health inequalities forms part of community planning arrangements in the four Lothian local authorities. This strategy focuses more specifically on the role that NHS Lothian can play through its own services.

This document contains:

- A profile of the most vulnerable populations in Lothian who have the poorest health
- A summary of the policy context and literature on the causes of health inequalities and types of interventions most likely to be effective
- An outline of current actions that NHS Lothian is taking to reduce health inequalities
- Proposed priority actions for the future
- A proposed action plan, with a monitoring and evaluation framework
The Health Inequalities Strategic Group used the following framework to identify the range of possible actions that NHS Lothian could take to mitigate, prevent or undo health inequalities. We prioritised actions according to their likely impact and the feasibility of implementing them. This produced a set of priority actions to focus on for the next 3 years.

<table>
<thead>
<tr>
<th>Types of action</th>
<th>Priority actions 2014-2017</th>
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<tbody>
<tr>
<td>Procurement</td>
<td>Develop use of community benefit clauses in contract specifications and procurement strategies</td>
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<td>Policies that support employment and income for populations with fewer economic levers</td>
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<td>NHS as Employer</td>
<td>Increase support and training for NHS Lothian staff on financial and IT literacy</td>
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<td>Actions relating to employment policies that support vulnerable people to gain employment or ensure fair terms and conditions for all staff</td>
<td>Continue to pay all staff at least the living wage</td>
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<td>Actions to support staff to support the most vulnerable patients</td>
<td>Increase recruitment opportunities for young people and vulnerable groups through socially responsible recruitment programme</td>
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<td>Staff training to enable them to respond to social &amp; economic circumstances affecting patients health</td>
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<td>Mainstream clinical services</td>
<td>Develop, learn from and build on initiatives that seek to increase capacity in primary care to mitigate health inequalities and identify ways to sustain these if successful</td>
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<td>Actions to target universal services to the most needy</td>
<td>Develop routine use of ‘work outcomes’ in patient recovery plans</td>
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<td>Actions to investigate and amend service provision to ensure appropriate for all groups – RIA, equity audit, deliver in other settings etc</td>
<td>Identify patients at risk of financial insecurity and enable access to appropriate services</td>
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<td>Services that are universal but most needed by people in specific populations</td>
<td>Continue routine use of impact assessment of new policies and plans</td>
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<td>Implement Learning Disability Health Inequalities Plan to ensure NHS services can meet needs of people with learning disability</td>
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<td>Ensure Health &amp; Social Care Partnership Strategic Needs Assessments explicitly assess significant inequalities in each area and identify opportunities to mitigate health inequalities</td>
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<td>Ensure patient pathways in the Strategic Plan identify vulnerable groups and ways to improve their ability to access effective care</td>
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| **Specialist services**  
Provision of support to access and use universal services  
Services that are only needed by particular population groups  
Prioritisation of early years provision |
| Increase number of practices with welfare advice and income maximisation services  
Ensure evidence based vocational rehabilitation services available to support those with health conditions to return to/retain employment  
Increase take up of healthy start vouchers |
| **Partnership**  
Services in above categories that are delivered in partnership with others, or that we fund but are delivered by others |
| Work with local authority partners to develop impact assessments that identify the impacts of their policies on health inequalities |
| **Exemplar/ advocacy role**  
NHS as advocate for wider actions by partners |
| Ensure public health/health promotion input to community planning partnerships including economic partnerships  
Advocate for routine payment of at least the living wage |
| **Monitoring and evaluation** |
| Develop measures of determinants of health inequalities and use these in monitoring the impacts of this and other strategies  
Review priority actions in 3 years |
POPULATION PROFILE

In 2012, 843,733 people lived in Lothian, 15.9% of the total Scottish population. Some groups of the population are more likely to experience poor health than others. The table below gives some demographic information showing the diversity of the population. It identifies some of the populations that differentially experience poor health, with some key issues to consider in providing healthcare.

<table>
<thead>
<tr>
<th>Population group</th>
<th>Key issues for NHS Lothian</th>
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<tbody>
<tr>
<td>Men and Women</td>
<td>Male life expectancy is 77 years, significantly lower than female life expectancy at 81.4 years. Men experience higher rates of most diseases eg lung and colorectal cancer, CHD and stroke. Young men more likely to commit suicide or be involved in accidents or violence. Women are more likely to suffer ill health particularly mental ill health, suggesting that women spend more years in poor health. Women are higher risk of domestic violence.</td>
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<tr>
<td>Older people</td>
<td>Approximately 7% of the Lothian population, around 60,000 people, is aged over 75 years. Women substantially outnumber men in older age groups. The population as a whole is ageing as people are living longer. However the average age in more deprived communities tends to be lower because life expectancy is lower. The risk of morbidity and mortality rises with age – but this rise occurs 10-15 years earlier in the most deprived populations. Isolation and poverty compound the health problems associated with old age.</td>
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<tr>
<td>Children and young people</td>
<td>Children and young people under 16 years make up approximately 17% of Lothian’s population. Socio-economic health inequalities are evident from a very young age, indeed from before birth.</td>
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<tr>
<td>Lesbian, Gay and Bisexual people</td>
<td>In 2010 the Integrated Household Survey reported that 1.4% of respondents indentified as gay or lesbian and 0.55% as bisexual. Between 5% and 12% of people are estimated to have had a same sex experience or contact. Experience of homophobic abuse and violence is associated with high rates of mental illness and self-harming behaviour.</td>
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Further information on these key issues is available in the Rapid Impact Assessment guidance at http://www.nhslothian.scot.nhs.uk/YourRights/EqualityDiversity/ImpactAssessment/Pages/default.aspx
<table>
<thead>
<tr>
<th>Population group</th>
<th>Key issues for NHS Lothian</th>
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<tbody>
<tr>
<td>Transgender people</td>
<td>Men who have sex with men are at risk of blood borne viruses.</td>
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<tr>
<td>People with physical disability</td>
<td>Transgender people frequently experience discrimination, abuse and violence and have high levels of substance use and self harm.</td>
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<td>Men who have sex with men are at risk of blood borne viruses.</td>
<td>Transgender people frequently experience discrimination, abuse and violence and have high levels of substance use and self harm.</td>
</tr>
<tr>
<td>People with learning disability</td>
<td>2011 census data suggest that 8% of Lothian residents’ day to day activities are limited a lot and 9% of residents’ activities are limited a little. These rates are higher among older people. People with a disability may find it more difficult to access services via public transport or walking, to retain employment, and may experience harassment. People with learning disabilities have higher than population average rates of morbidity and mortality from all diseases with notably higher rates of death from respiratory disease, cardiovascular disease and some of the rarer forms of cancer such as gall bladder, stomach and gullet. Prevention and health promotion is not always effective with people with learning disabilities. About 2% of the population has a learning disability but only a quarter to a fifth of these are identified to health and social care services. Based on national estimates, approximately 3700 schoolchildren and 3,500 adults in Lothian are identified as having learning disabilities.</td>
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<tr>
<td>People with mental health problems</td>
<td>About 2% of the population has a learning disability but only a quarter to a fifth of these are identified to health and social care services. Based on national estimates, approximately 3700 schoolchildren and 3,500 adults in Lothian are identified as having learning disabilities. People with learning disabilities have higher than population average rates of morbidity and mortality from all diseases with notably higher rates of death from respiratory disease, cardiovascular disease and some of the rarer forms of cancer such as gall bladder, stomach and gullet. Prevention and health promotion is not always effective with people with learning disabilities. About 2% of the population has a learning disability but only a quarter to a fifth of these are identified to health and social care services. Based on national estimates, approximately 3700 schoolchildren and 3,500 adults in Lothian are identified as having learning disabilities.</td>
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<td>Minority ethnic people</td>
<td>About 2% of the population has a learning disability but only a quarter to a fifth of these are identified to health and social care services. Based on national estimates, approximately 3700 schoolchildren and 3,500 adults in Lothian are identified as having learning disabilities. People with learning disabilities have higher than population average rates of morbidity and mortality from all diseases with notably higher rates of death from respiratory disease, cardiovascular disease and some of the rarer forms of cancer such as gall bladder, stomach and gullet. Prevention and health promotion is not always effective with people with learning disabilities. About 2% of the population has a learning disability but only a quarter to a fifth of these are identified to health and social care services. Based on national estimates, approximately 3700 schoolchildren and 3,500 adults in Lothian are identified as having learning disabilities.</td>
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</tr>
<tr>
<td>People with mental health problems</td>
<td>Most Lothian residents (94.3%) identify as White (European (including 17,350 Polish people), British or Scottish); this is slightly lower than the Scotland average. There are 31,000 (3.7%) Asian Scottish people in Lothian; in Edinburgh 5.5% of the population identify as Asian. No other area in Lothian has a rate above the Scotland average of 2.7%. South Asians experience higher rates of diabetes and heart disease. Black Africans have a high rate of HIV diagnosis. Gypsy Travellers experience high levels of morbidity and have lower life expectancy. Many people from minority ethnic communities experience difficulties accessing services related to language or cultural barriers, or lack of familiarity with services. 43% of the Lothian population identified as no religion, 47% Christian, 2%</td>
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<tr>
<td>Population group</td>
<td>Key issues for NHS Lothian</td>
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<tr>
<td>different religions or beliefs</td>
<td>Muslim in the 2011 census.</td>
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<tr>
<td>People living in poverty</td>
<td>11% of the Lothian population is classified as income deprived by SIMD 2012</td>
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<td>Average pay is lower in West Lothian than the Scottish average. Pay for Midlothian residents and people who work in East Lothian is also low.</td>
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<td>Research suggest that between £350 and £550 per working adult is being lost in Lothian households as a result of welfare reform. Most of these financial losses will affect people already on low incomes, notably people with disabilities and lone parents with children.</td>
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<td>Poverty often clusters in certain geographical neighbourhoods, but most people who are income deprived do not live in the most deprived neighbourhoods. This is particularly the case for some minority ethnic groups.</td>
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<td>Poverty is a strong risk factor for poor health and lower life expectancy. For almost every health indicator there is a clear gradient showing better health with increasing affluence. Poverty compounds the impact of social inequalities.</td>
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<tr>
<td>Homeless people</td>
<td>Homeless people suffer substantially poorer physical and mental health than the rest of the population. Health starts to deteriorate within two weeks of homelessness.</td>
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<tr>
<td>People involved in the criminal</td>
<td>Prisoners are predominantly young, male, white and from disadvantaged backgrounds. Three quarters (73%) of prisoners have an Alcohol Use Disorder, with 36% possibly alcohol dependent. When studied. 73% tested positive for illegal drugs on admission to prison and 17% tested positive on liberation. 76% of prisoners smoke. 1 in 5 are estimated to be Hepatitis C positive.</td>
</tr>
<tr>
<td>justice system</td>
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<td>The NHS is now responsible for Prison Health.</td>
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<tr>
<td>People with low literacy/numeracy</td>
<td>Educational inequalities have a significant and independent impact on health. 27% of Scottish adults face occasional challenges and constrained opportunities due to literacy difficulties, but will generally cope with their day-to-day lives. 4% have problems that affect their ability to cope with day-to-day life.</td>
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<tr>
<td></td>
<td>Health literacy is the ability to obtain, read, understand and use healthcare information. People with poor health literacy have poorer outcomes but simple tools can mitigate this.</td>
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<tr>
<td>Carers</td>
<td>9% of Lothian adults provide unpaid care. 5% provide between 1 and 19 hours per week, 2% provide more than 50 hours.</td>
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Key issues for NHS Lothian

Unpaid carers are disproportionately women and older. Being a carer can lead to isolation, loss of income and harm to the carer's own health.

NHS Lothian Staff NHS Lothian is a large employer and directly employs over 23,000 people. 78% of the workforce is female, 5% is from a non-white ethnic group, 34% is aged over 50 years.

The inequalities gradient in Lothian

The graph below shows the gradient in health outcomes by deprivation, measured by the Scottish Index of Multiple Deprivation (SIMD). For almost any measure of health there is a gradient showing poorer outcomes with increasing deprivation. This has a significant human cost in suffering, mortality and morbidity.

There is also a financial cost, as increasing morbidity due to deprivation results in higher need for health care, with higher rates of outpatient attendances, hospital admissions and use of primary care services. The graph below shows the gradient in emergency hospital admissions.
EMERGENCY ADMISSIONS RATES: 2010/11
AGE-SEX STANDARDISED RATES PER 1,000 POPULATION

Least Deprived

Most Deprived
POLICY CONTEXT, CAUSES AND INTERVENTIONS

Policy context

Social injustice is killing people on a grand scale.


Health inequalities are recognised as a priority locally, nationally and internationally. The Scottish Government produced Equally Well, the report of the ministerial review of health inequalities, in 2008. This recognised the need for cross sectoral work to reduce health inequalities. It contained 78 recommendations across a range of policy areas including actions relating to the early years, improving physical environments, tackling poverty, addressing specific harms to health and support for vulnerable groups. Equally Well was reviewed in 2010 and again in 2012/13, with support from NHS Health Scotland which led a policy review to identify the areas to focus on.

In 2008 the World Health Organisation published the report on the Global Commission on the Social Determinants of Health, led by Sir Michael Marmot. This contained three overarching priority recommendations: improve daily living conditions; tackle the inequitable distribution of power, money and resources; measure and understand the problem and assess the impact of action. Michael Marmot has subsequently led a European review of health inequalities and a review for the English Department of Health that resulted in the Fair Society Healthy Lives report. This contained six strategic objectives:

- Give every child the best start in life
- Enable all children, young people and adults to maximize their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and developing sustainable places and communities
- Strengthen the role and impact of ill-health prevention.

Although these reports have been produced in different contexts for different audiences, they all recognise that health inequalities reflect wider social inequalities, and cannot be tackled by the health sector alone.
Understanding the causes of health inequalities

Put simply, the higher one’s social position, the better one’s health is likely to be...These serious health inequalities do not arise by chance, and they cannot be attributed simply to genetic makeup, ‘bad’, unhealthy behaviour, or difficulties in access to medical care, important as those factors may be. Social and economic differences in health status reflect, and are caused by, social and economic inequalities in society.’

Fair Society, Healthy Lives, 2010

The existence and width of health inequalities cannot be attributed to a single clinical or behavioural risk factor. They are the result of social circumstances and reflect the underlying distribution of power and resources in the population.

It is now accepted that the underlying roots of health inequalities relate to the unfair distribution of power, money and resources. The social and political forces that maintain this unfair distribution are termed the ‘fundamental causes’ of health inequalities. These fundamental causes affect the distribution of wider environmental influences such as the availability of jobs, good quality housing, education and learning opportunities, access to services, social status. This results in differences in individual experiences of, for example, discrimination, prejudice, low income, poor opportunities. This is illustrated in the model below.

Figure: Fundamental Causes of Health Inequalities

These differences in individual experiences affect people’s health in three main ways:

- **Differential exposure** to environmental, cultural, socio-economic and educational influences that impact on health.

- The psychosocial consequences of **differences in social status**. There is now strong evidence that ‘status anxiety’ leads to psychological and physiological changes that affect health.

- Accumulation of these effects over the **lifecourse**. The inequalities in health that are observed now will reflect not only current status but also differences in experiences at earlier stages in life. This is why interventions targeting families and the early years are so important.

**What should we do about health inequalities?**

> **Tackling health inequalities is a matter of social justice.** It’s unacceptable in 21st century Scotland that some people can expect to die earlier than others, simply due to an accident of birth or circumstances.

> , Equally Well 2008

The description of the causes of health inequalities suggests that no single approach is sufficient to reduce health inequalities - concerted efforts are required across many partners at local and national levels.

There are three types of action that are needed:

- Actions that **mitigate** the health and social consequences of social inequalities. People who are socially disadvantaged have higher health needs and the level and intensity of service provision should reflect that. These actions target the effects - shown on the far right of Figure 1.

- Actions that help individuals and communities **resist** the effects of inequality on health and wellbeing. These include targeted health improvement activities, community development activities that increase social capital in deprived areas, improvements to
the physical environment in deprived areas. These are predominantly addressing individual experiences and environmental influences as shown in Figure 1.

- Actions that **undo** the underlying structural inequalities in power and resources. These are the most challenging to implement. They include provision of high quality universal services such as education, housing, employment and improved environments particularly in the most deprived areas. But ultimately undoing structural inequalities requires fundamental socio-economic and political measures. These may include economic policies that support social mobility and prevent high wage differentials; income maximisation services; reducing the democratic deficit across the social spectrum; increasing the number of people on the electoral roll. Key policy areas for action to reduce social and health inequalities are *employment, income and education*.

**Structural, population approaches – v- individual approaches**

Evidence from the scientific literature suggests that interventions that are *most likely to be* effective in reducing health inequalities are structural changes to the environment, legislation and regulatory controls, fiscal policies, reducing price barriers, income support, accessibility of public services, prioritising disadvantaged groups, and intensive support for vulnerable population groups.

Interventions *least likely* to reduce health inequalities include mass media campaigns, written materials, campaigns reliant on people opting in; messages designed for the whole population, or approaches that involve significant cost or other barriers.

**Health improvement – v - health inequalities**

It is important to distinguish between Health improvement activities and actions to reduce health inequalities, as they are often confused. Health improvement includes policies, actions and interventions designed to improve health and prevent ill health. They target people who are currently well, rather than healthcare interventions for people who are, or perceive that they are, unwell. Health improvement activities are usually delivered to groups or whole populations rather than individuals. Health improvement activities do not necessarily reduce health inequalities unless specifically targeting disadvantaged groups. They may actually increase inequalities if affluent people are better able to act on them.
Actions to tackle health inequalities may include targeted delivery of healthcare to mitigate health inequalities; targeting of health improvement activities; and actions that seek to address the fundamental causes discussed above.

**Targeting of interventions**

A common approach to tackling health inequalities is to target support and interventions to the geographical areas identified as being deprived, most commonly the most deprived 15% areas measured by the Scottish Index of Multiple Deprivation (SIMD). There are several reasons why this approach cannot reduce health inequalities on its own:

- Many disadvantaged people do not live in these deprived areas – only about half of people who are income deprived live in the 15% most deprived areas by SIMD. So if an intervention is provided only to people living in targeted areas, other equally needy people will miss out.
- As noted earlier, health inequalities do not only affect the most disadvantaged groups of people but occur across the socio-economic gradient. Even if these targeted interventions could raise the level of health of the people in the targeted areas to that of people in the most affluent areas, there would still be a gradient in the rest of the population.
- Similarly, this approach is only concerned with socio-economic inequalities (using geography as a crude proxy) and misses inequalities relating to other characteristics such as race or disability.
- Actions that only target the most deprived communities implicitly situate the problem with those communities rather than with the fundamental causes and are unlikely to tackle these fundamental causes.
- Explicit targeting may actually exacerbate harm by labelling and stigmatising those communities.

Despite these caveats, targeting is appropriate for many situations. Clearly, interventions seeking to improve health and mitigate health inequalities should be provided in proportion to the level of ill health. And poor physical and social environments in some communities leads to poorer health in the people who live there. So it often makes sense to target environmental interventions geographically – examples would include improvements to greenspace or interventions to increase social capital, especially linking social capital that supports people to link with others in other groups and communities. But for the reasons above, it is important that individually focused interventions are provided universally, but with
greater quantity of service, and strong locality working, in the areas where the need is greatest. The Fair Society Healthy Lives report called this ‘proportionate universalism’.

The role of healthcare organisations

Although all the major policy documents identify that health inequalities requires a multi-sectoral response, some recent reports have considered the specific role of health organisations. The most obvious role is to mitigate and prevent health inequalities by providing healthcare and health improvement interventions in proportion to need.

High quality, universal healthcare that is available to everyone with no or minimal cost barriers is in itself important to mitigate and reduce health inequalities. But within the universal service there are often other barriers that prevent some disadvantaged groups of people from receiving care. These include physical, social, environmental and practical barriers such as mismatch between service design and patient need, cultural differences between patients and staff, low expectations, poor experience, transport costs and lack of capacity where the need is highest.

A Canadian report identified the following priorities to ensure health services meet the needs of a culturally and linguistically diverse population:

- Develop health equity targets and plans in consultation with communities and community members.
- Improve health literacy.
- Increase equitable access to prevention and curative services for underserved populations.
- Develop inter-sectoral collaborative and knowledge exchange mechanisms.
- Increase the capacity of the health system to serve the needs of the diverse population.

The Institute for Health Equity identifies the following areas of work:

- Workforce education and training – to build awareness of health inequalities and skills to work with all communities.
• Working with individuals and communities – build relationships of trust and respect, take a social history and use to tailor support to individuals’ needs, refer to services that address root causes.
• NHS organisations – ensure NHS provides good work for its staff, use purchasing power to support local community, culture of equality and fairness.
• Work in partnership
• Advocacy

This has been summarised further in a NHS Health Scotland document as follows:
• The quality of services the NHS plans and provides
• What the NHS does in partnership
• The NHS as an employer and procurer
• The advocacy role of the NHS

These reflect the mitigate/prevent/undo framework outlined above.
CURRENT ACTION IN NHS LOTHIAN

Reducing health inequalities requires effective partnership working across a range of organisations.


NHS Lothian has recognised health inequalities as a priority for many years. In 2006 the NHS Board approved a strategic framework that outlined its role to take forward three strands of work:

1. Work to ensure that mainstream services are accessible by and appropriate for all groups within the population. This includes use of impact assessment to ensure new services are planned to be equitable, and equity audits of service areas to identify and address inequalities in access or outcomes.
2. Work to provide additional support to ensure that specific disadvantaged groups can access NHS services. This includes provision of targeted services or advocacy that helps people access services.
3. Partnership work with other organizations to help address the determinants of health inequalities. NHS Lothian action with partners to address underlying causes of health inequality includes targeting of health improvement activities; provision of welfare advice in health settings; partnership with employability services and providing intensive support to vulnerable families.

Strands 1 and 2 are ways in which NHS Lothian can target its work to mitigate health inequalities, whereas strand 3 contributes to help prevent and undo inequalities. Since the strategic framework was approved, it has been used to structure health inequalities work. As a framework rather than a strategy, there was no overall action plan or separate monitoring framework but NHS Lothian has implemented a series of interventions to meet the needs of particular vulnerable populations. In addition, Rapid Impact Assessment is now used routinely to ensure new plans consider differential impacts.

The strategic group leading the development of this strategy undertook some scoping of the range of work that NHS Lothian is currently doing to mitigate, prevent, and undo health inequalities. This is summarised below.
## Current NHS Lothian actions to address health inequalities

<table>
<thead>
<tr>
<th>Action on health inequalities</th>
<th>Mainstream Services</th>
<th>Specialist Services</th>
<th>NHS as employer</th>
<th>Procurement and capital planning</th>
<th>Wider Partnerships</th>
<th>Outcomes</th>
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<tr>
<td><strong>Mitigate</strong> the severity of the health and social consequences of social inequalities</td>
<td>High quality universal primary care</td>
<td>Services that are specifically for disadvantaged populations such as Keep Well; Access Practice; MEHIS; Willow; advocacy support etc</td>
<td>Staff training and support to ensure staff understand impact of deprivation and respond appropriately</td>
<td>New NHS buildings meet the standards set out in the Healthy Built Environment strategy.</td>
<td>Social care/voluntary sector provision that is targeted according to need</td>
<td>Reduced mortality and morbidity in identified disadvantaged groups</td>
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<td>Amendments to mainstream services to ensure they are appropriate for all groups – eg communication support/transport/location of service/reminders etc</td>
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<td></td>
<td>Delivery of services that mitigate poverty and disadvantage in partnership with other agencies eg drugs/alcohol services</td>
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<td>Use of RIA, equity audit etc to assess whether services are equitable, with changes accordingly</td>
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<td>Case management approaches are often most effective for people who need multiple services</td>
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<td>Higher provision of mainstream community services in communities with higher needs</td>
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<td></td>
<td>Prioritisation of the universal services</td>
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| Prevent the effects of inequality on health and wellbeing. | Prioritisation of services for early years  
Prioritisation of health promotion, preventive, community and primary care services – these all are needed most by the most disadvantaged | Health improvement initiatives that are targeted specifically to disadvantaged groups | HR policies that minimise job strain and increase job control | Implementation of actions in Sustainable Development Action Plan – to minimise future inequalities arising from climate change | Input to SOA indicators  
CPP Health improvement partnerships – programmes targeting vulnerable communities  
Public health support/ HIA work for activities that enhance public space/ physical environments – these most benefit the most vulnerable eg work on policies such as 20mph zones  
Support for community development activities | Reduced gap in health determinants  
OR improved health determinants in disadvantaged groups |
| **Undo** the underlying structural inequalities in power and resources | Services within health settings that address poverty and inequality eg: Benefits and money advice Health literacy support | HR policies that reduce social gradients
- Targeted recruitment/support to access employment for people furthest from labour market
- Equal opportunities policies | Procurement policies that provide community benefit – particularly employment of groups that are furthest from the labour market | NHS as advocate: Input to SOA indicators Support for universal services/policy that reduces gaps - especially related to education, employment, income max etc | Reduced gap across population in resources/power/status |
NEXT STEPS

The NHS Lothian Health Inequalities Strategy Group has reviewed the evidence presented in this document in order to develop a set of proposed priority future actions for NHS Lothian to take over the next three years. This is shown on page 2. Following consultation, this set of proposed actions will be reviewed and a more detailed action plan developed. The group will develop a monitoring framework to allow us to review implementation of these short term actions. It will also use the framework above to identify further actions that NHS Lothian will take beyond this time period to mitigate, prevent and undo health inequalities.

SELECTED BIBLIOGRAPHY


