

Final report of Task Group 7:

Delivery systems and mechanisms for reducing inequalities in both social determinants and health outcomes

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EXECUTIVE SUMMARY

Task Group 7: Delivery systems and mechanisms

What is the task?

The task set for Group 7 was:

“To assess new and under-exploited evidence on the most effective structures and organisations for jointly delivering reductions in health inequalities. In particular, this will include and assessment of the roles of health services, governance arrangements, national policy organisations, government departments, local government and the third sector in reducing inequalities, in both social determinants and health outcomes”

Values are of central importance to this task. We therefore asked throughout our analyses: what *practical* steps can be taken at various levels to maintain shared public service values when striving to deliver reductions in health inequalities?

To tackle our remit, we took the Global Commission’s recommendations on delivery systems and mechanisms, and asked what these meant for the UK policy context. Six policy case studies were developed on issues selected for the insights they reveal about how systems in the UK operate to support or undermine equity objectives. Each case study combined a) synthesis of the evidence with b) policy analysis and c) interviews with a small number of key informants, to tell an illuminating story from which suggestions for future action could be generated. From the case studies we have tried to distil “principles for action” as well as indicating “what does not work” or “areas for disinvestment.

What is the relationship with health inequalities?

PART 1 covers the relationship of delivery mechanisms and systems with health inequalities. We are asked to consider the role of health services, among other public systems. Conceptually, access to effective health services can be seen as a social determinant of population health and inadequate access a potential cause of inequalities in health status. With the NHS in the UK, however, inadequate access to health services is not considered to be a *major cause* of the observed social inequalities in health in the country. We consider, however, that the health system does have a pivotal role to play in the *solution* to the problem of inequalities in health in four main areas of activity:

- Putting its own house in order: maintaining an equitable NHS and addressing those inequalities in health *care* that are contributing to the observed inequalities in *health status*.
- Preventing or ameliorating the health damage caused by living and growing in disadvantaged circumstances (i.e. the health damage caused by wider social determinants of health).
- Acting as a champion and facilitator to influence other sectors to take action to reduce inequalities in health.
- Directly influencing other social determinants of health, such as local employment and economies, and acting as a good “corporate citizen”.

What are the policy options for the UK?

PART 2 summarises the policy options under the following six key roles for the health system, which are then examined in greater depth in a series of case studies in **PARTS 3 to 8**.

Maintaining the universal health care system and addressing inequalities in service delivery:

The Global Report calls for the building of universal health care systems based on equity principles. What the UK is faced with (in common with other European health systems) is not the *building*, but the *maintaining* of the equitable system that the country already has, in the face of potential erosion of the fundamental principles on which it is built. At the same time, the system needs to improve the mechanisms for identifying and rectifying inequalities in delivery of the services and develop further the capability to take social determinants of health approach.

We illustrate the type of assessment that needs to be done with the case study in **PART 3** on the Quality and Outcomes Framework (QOF) introduced as part of the 2003 General Medical Services contract. The evaluation identified both positive and negative impacts on health inequalities and discovered that the quality of care was already improving prior to the introduction of the QOF: highlighting the importance of looking at underlying trends. Crucially, this kind of assessment provides pointers on how the system could be improved in the future from an equity perspective.

Key recommendation 1: equity assessments

Equity assessments should be carried out on system changes (planned or implemented) to assess not only whether they are meeting their stated aims, but also whether they are having detrimental effects on the values and equity objectives of the wider system as a whole. There should be provision built into the system for taking action on the findings of these assessments.

Sustaining a strong population health perspective within the health system

The Global Report recommends “*expand the health sector policy and programmes in health promotion, disease prevention and health care, to include a social determinant of health approach, with leadership from the Minister of Health*”.

Above all, this requires a system that takes a population health perspective, capable of going beyond the individual needs of registered patients or users of services. The UK system is already oriented towards prevention and health promotion to a greater extent than in many other countries, in that it includes these services within the comprehensive package covered by the NHS. Most importantly, it has had highly developed systems for taking a population health perspective on monitoring needs and delivering appropriate responses. This population health perspective contrasts with an approach limited to registered patients or users of services, where sections of the population can slip between two stools and only expressed needs for treatment services are addressed. The case study in **PART 4** on structural reorganisations illustrates the questions that need to be asked of the impacts of the various UK reorganisations on the vital public health function, and what mechanisms might be developed to address strengths and shortcomings.

Key recommendation 2: ability of system to take population health perspective

The UK’s highly developed system for taking a population health perspective on assessing needs and delivering appropriate public preventive and health promotion services should be safeguarded and enhanced in planned system changes.

Championing local multi-sectoral work on social determinants

The health system has a major role in acting as a champion and facilitator to influence other sectors to take action to reduce inequalities in health. The case study in **PART 5** on local multi-sectoral working synthesises the evidence from attempts by different public sector agencies in the UK to work together over the past two decades on the social determinants of health. This evidence indicates a range of common facilitators and barriers to this kind of working and ways in which the conditions for effective partnership working can be enhanced in the future.

Key recommendation 3: Local leadership on facilitating joint working

Local mechanisms need to be initiated to make multi-sectoral work on social determinants of health both easier and more effective. These include health and local authority leaders demonstrating the legitimacy and priority given to this kind of work by: agreement on common goals and targets between agencies focused on addressing inequalities in health and wellbeing; the setting up of joint appointments and joint operational units, the increasing use of joint funding mechanisms which are sustainable (moving away from reliance on short-term project funding); and the provision of long-term timescales for the processes of setting up and maintaining partnerships.

Key recommendation 4: National and local synergy

Government departments need to support rather than undermine local joint working on the social determinants of health and inequalities. This includes demonstrating that this kind of work is valued nationally through the targets and performance management mechanisms that are put in place; through the setting of adequate timeframes for setting up the joint work and evaluating impact.

Key recommendation 5: Workforce development on determinants of health

Government departments and regional workforce development agencies need to expand capability to understand and act on the social determinants of health in the non-specialist, as well as the specialist, workforce. This requires both reaching out to include practitioners in sectors other than health, as well as expanding capacity in educational establishments to carry out this development work.

Having a direct influence on wider social determinants of health

Evidence is accumulating on the role of the health and social care sectors as major local employers and with purchasing power that can influence the local economy in their own right. There is also a role of the NHS as a model employer and in helping people with illness back to work. The case study in **PART 6** presents examples of this kind of work in one region of the UK and leads to several principles for action.

Key recommendation 6:

Local public agencies should be proactive in assessing how they can confront poverty, unemployment and disadvantage in their communities more directly. This includes using opportunities in health care settings to help patients get the social welfare benefits they are entitled to; contributing to rehabilitation of people with longterm sickness to help them get fit for work; and using their organisation's employment and purchasing power for the benefit of the local communities that they serve.

Co-ordinating efforts across the whole of government

The Global Report emphasises the need to ensure that health equity is embedded in all policies, systems and programmes across the whole of government:

What does this mean for the UK? We are not starting with a blank sheet. There is a long tradition of using targets, for example, which have emerged as key drivers of the public policy system in the UK. Targets have been used to try to achieve improved performance, indeed to measure performance, across a range of government departments and goals. From this UK experience to date, there are lessons to be learnt, both negative and positive, in the use of this kind of mechanism. The case study in **PART 7** on targets as a planning mechanism in public policy and service systems draws out these lessons. It traces the way in which the regime of targets in the UK has evolved over several decades and has produced unintended consequences along the way, including fragmentation or silo-based working. This goes against the coordinated efforts on equity across the whole of government that are needed. However, the case also identifies emergent action that is being undertaken that shows more promise in serving an equity purpose.

Key recommendation 7: Developing common view

Policy makers, professionals and service managers across the system need to escape from the blame culture which has emerged during the operation of previous target regimes. They need to harness the considerable scope for developing common ground, and particularly the scope for developing a common view about the key priorities and how they should be tackled. The new generation of Public Service Agreements (PSA) and the creation of the Local Area Agreement (LAA) system provide promising vehicles for developing the desired common ground on values and outcomes.

Key recommendation 8: shared targets on shared objectives

Targets which are based on shared objectives, and driven through relationships based on mutual respect and appreciation of the logics which drive different players, stand every chance of helping to influence the social determinants of health inequalities.

Considering the global equity impacts of UK initiatives

Increased resourcing of the UK health system may have far reaching impacts on health systems in other parts of the world. As part of the NHS 10-year Plan published in 2000, for example, the UK identified the need for 10,000 more doctors and 20,000 more nurses to improve access and quality of care. The policy of recruiting overseas health workers to fill these gaps has had serious repercussions in middle- and low-income countries and raised issues about ethical international recruitment. The case study in **PART 8** synthesises the evidence on the origin, progress and unintended side effects of UK policy on this front and discusses what would be needed to ameliorate these adverse effects.

Key recommendation 9: assessment of global impact

Policies which lead to increased health resourcing in England need to be assessed in terms of their impact on health and health equity in other countries.

Key recommendation 10: sustainable workforce development

Expansion of the England's Health work force needs to be planned in a sustainable way so that it does not exacerbate the health workforce deficiencies in developing countries.

What principles for action and what not to do?

These are detailed in **PART 9** and include:

Principles for action:

1. Completing the jigsaw

Strategies that rely just on local interventions will be insufficient to make a lasting and profound difference to the patterns of inequality across the country. Action at all levels of government and active engagement with civil society and the business sector is required over a sustained period of time (probably a decade or longer).

2. Recognise existing contributions

Much of the NHS and other welfare services make a remarkable contribution to reducing (health) inequality and addressing SDH. Without them, the situation would be far worse. Specific areas of note here are primary health care, universal benefits, and open access (free at the point of delivery)

3. Resist regular re-organisation

Health reform should take full account of the wider effects/impacts including the anticipated consequences (positive and negative) upon health equity and the social determinants of health. Formal re-organisation and 'natural evolution' of local organisational forms disrupt local partnership working and create planning blight over a period of 18-24 months.

4. Secure local accountability

Accountability for action and inaction (to reduce health inequality and address SDH) should be more explicit and transparent at the local level, not just to national reporting mechanisms. Such accountability mechanisms would be enhanced by much closer working (and possibly, integration) between welfare agencies at the local level. Recent thinking on systems approaches point toward the benefits of this approach.

5. Create a culture of equity

Reducing health inequality and addressing the SDH should not be seen as additional activities or objectives but integral to the conduct of a well-functioning health system (in the widest sense of the term). It should become as much as part of the culture of an organisation as quality improvement, for example.

6. Equity starts at home

The NHS and local government should take greater recognition of their potential to influence patterns of inequality locally through their decision-making (such as employment practices, procurement strategies and internal management of organisations). Inevitably, the extent of reliance of locally-inspired, developed and implemented policies will create the potential for wider variations between areas. This approach should be clearly justified as a response to local needs.

What does not work?

- The research evidence on what does not work has become more unequivocal, including:
 - Top-down implementation on its own

- Strategies that rely solely on behaviour change
- Strategies that ignore the role of context as a mediating factor

What should be stopped?

- Each department should examine how to reduce compliance requirements on local public service bodies, and the assumptions should be that systems extraneous to PSAs should be removed.
- Central government administrative resources should be re-configured to remove those posts predominantly involved in monitoring compliance with centrally set targets outside the PSA / LAA system.
- 'Tactical' tweaking of activities which leads to 'hitting the target but missing the point' should cease, despite the fact that missing the target may be reported as a failure by audit bodies or the media.

Part 1

THE TASK AND THE RELATIONSHIP WITH INEQUALITIES

1.1 What is the task?

The task set for Group 7 was:

“To assess new and under-exploited evidence on the most effective structures and organisations for jointly delivering reductions in health inequalities. In particular, this will include and assessment of the roles of health services, governance arrangements, national policy organisations, government departments, local government and the third sector in reducing inequalities, in both social determinants and health outcomes”

We see the central issue as dealing with a complex system that is dynamic and changing, and therefore the question for the group is essentially “How do we influence complex systems over time to reduce health inequalities and move towards health equity?”

In all aspects of this pivotal role, we consider it essential to highlight values. Values are important firstly as an expression of society’s commitment to health equity, and secondly because complex systems can only operate effectively if there is a common values base. Values are therefore important both expressively and instrumentally.

How can equity as a value be sustained in complex systems over time? What steps can society take to maintain its core values? There may be incentives or disincentives in a system, for example, that support or damage the upholding of values. Because this task group is about delivery systems and mechanisms, we are keen to identify *practical* steps that can be taken at various levels to maintain values – including the use of evidence to determine where the system is in relation to achieving its equity objectives.

To tackle our remit, we took the Global Commission’s recommendations on delivery systems and mechanisms, and asked what these meant for the UK policy context. Six policy case studies were developed on issues selected for the insights they reveal about how systems in the UK operate to support or undermine equity objectives. Each case study combined a) synthesis of the evidence with b) policy analysis and c) interviews with a small number of key informants, to tell an illuminating story from which suggestions for future action could be generated.

From the case studies we have tried to distil “principles for action” as well as indicating “what does not work” or “areas for disinvestment.

1.2. What is the relationship between delivery systems and health inequalities?

We are asked to consider the role of health services, among other systems, in delivering reductions in health inequalities. Conceptually, access to effective health services can be seen as a social determinant of population health and inadequate access a potential cause of inequalities in health status.

1.2.1. Effective health services as a social determinant of population health

Estimates of the impact of health services on *population health* suggest a valuable, if modest, contribution in terms of reduced mortality and increased life expectancy. Mackenbach, has

estimated, for example, that medical care contributed between 4.7% and 18.5% to the decline in mortality in the Netherlands between 1875 and 1970 (Mackenbach, 1996). In the second half of the 20th century, he estimated that medical care made a greater, though still not the major, contribution to extending life expectancy. In the Netherlands and the United States, for example, more effective health care has been estimated to have added five years to life expectancy at birth in those countries (that is, about 25% of the total improvement) (Mackenbach, 1996). McKee argues that more recent studies demonstrate that access to effective health care has had a measurable impact in many countries in the 1980s and 1990s, in particular through reductions in infant mortality and in deaths in middle and older ages, especially for women (McKee, 2002; Nolte and McKee, 2004). Preventive services have had a larger impact than curative treatments on the marked decline in CVD in industrialised countries over the past thirty years (Capewell et al, 19; Unal et al, 2005).

1.2.2. Effective health services as a human right

The provision of health services to the whole population has an ethical dimension, beyond saving lives. From a *human rights perspective*, a very basic right for people is that of having access to effective health care that ameliorates their suffering when they become sick, that protects them and prevents them from developing disease in the first place, and that helps them maintain their own health when well (Whitehead and Dahlgren, 2007). As Amartya Sen has articulated, without the benefits that access to health services can bring, by improving health and providing freedom from pain and suffering, the ability to take up all other rights as members of society is compromised (Sen, 2000). The arrangements that a country makes to ensure access to effective health care, therefore, becomes a mark of a civilised society.

1.2.3. Inadequate access to effective care as a cause of inequalities in health

Estimates of the impact of medical care on *social inequalities in health* are difficult to make and have to be pieced together from a variety of sources. Analyses of survival from diseases for which there are effective treatments have shown that all socioeconomic groups in high-income European countries have made gains in survival in the 20th century. For such causes of death as tuberculosis, appendicitis and neonatal conditions – amenable to medical treatment/avoidable – mortality rates in England and Wales declined by 70% in the lowest socioeconomic groups and 80% in the highest socioeconomic groups, between 1930 and 1960. This differential decline in mortality rates resulted in a widening in the mortality gap between the groups when measured in relative terms, but the *absolute* differences in death rates narrowed (Mackenbach, Stronks & Kunst, 1989). A narrowing in absolute inequalities in mortality has also been reported for the Netherlands and Sweden for conditions amenable to treatment around birth. Such evidence led Johan Mackenbach to conclude that health care has played an important part in reducing inequalities in health: “*The introduction of effective medical care, aided by perhaps not a perfect but a nonetheless very considerable degree of access to health care for the lower socio-economic groups, has caused mortality differences to narrow, at least in absolute terms*” (Mackenbach, 2003:527).

An analysis of amenable mortality in New Zealand from 1981 to 2004 concluded that trends in amenable causes of death accounted for about one-third of the fall in mortality over the past quarter century for the population as a whole and for all income groups and ethnic groups except Pacific peoples, for whom there was no reduction in amenable mortality. Amenable causes accounted for one quarter of mortality inequalities in 2001-04, indicating further substantial scope for health services to reduce health inequalities (Tobias and Yeh, 2009).

Then there are studies, mainly from the USA where services are not universal, showing that poorer access leads to poorer survival from specific diseases such as cancer (Ward et al,

2008), and that poorer access is experienced by more disadvantaged groups with no or partial health insurance. A long-standing estimate by the US CDC places the contribution that health care deficiencies make to total mortality in the US at about 10% (McGinnis et al, 2002). Several cross-country comparative studies have demonstrated the importance of good access to primary care for life chances (Shi et al, 2002 and 2005; Starfield et al, 2005).

This a growing body of evidence on the trend of out-of-pocket payments for health services causing poverty on a vast scale in middle and low-income countries (Whitehead et al, 2001; McIntyre et al, 2005). Although this is not a major problem in high-income countries with universal health services, there is evidence of hardship caused by rises in co-payments even in welfare systems such as in Sweden (Burstrom, 2009).

1.2.4. Evidence of inequalities in access, uptake and quality of care

While the NHS has improved access across the population, it still has to confront manifestations of the “inverse care law” whereby “the availability of good medical care tends to vary inversely with the need for it in the population served” (Hart, 1971). A system that recognised fully the scale of social inequalities in health would increase health services with increasing levels of deprivation, but that is not always found in reality. A recent systematic review of how close universal health systems have come to matching health services to need concluded that while there was evidence of reasonably equitable access to primary health care by different socioeconomic groups, there was a pro-rich bias in use of specialist hospital services (Hanratty et al, 2007; Dixon et al, 2007). In relation to primary care, though, there are concerns that quality may be poorer in more disadvantaged areas, even if geographic and economic access are good.

1.2.5. So what is the role of the health system in tackling inequalities in social determinants and health outcomes

Even though most of the observed social inequalities in health status are not *caused* by what goes on in health care services, this does not mean that there is no role for the health care system in *reducing* inequalities in health status. Indeed the health system has a potentially pivotal contribution to tackling social inequalities in health on at least four main fronts:

- Putting its own house in order: maintaining an equitable NHS and addressing those inequalities in health *care* that are contributing to the observed inequalities in *health status*.
- Preventing or ameliorating the health damage caused by living and growing in disadvantaged circumstances (i.e. the health damage caused by wider social determinants of health).
- Acting as a champion and facilitator to influence other sectors to take action to reduce inequalities in health.
- Directly influencing other social determinants of health, such as local employment and economies, and acting as a good “corporate citizen” in everything from staffing to catering.

We need to monitor and identify which policies and interventions are making things worse, but also recognise and preserve the equitable systems that we do have, and guard against erosion by countervailing forces.

PART 2:

WHAT ARE THE POLICY OPTIONS FOR THE UK?

In Part 1, the case was made for a key role for the health sector, working in partnership with other sectors, in tackling health inequalities and their social determinants in four main areas:

- Maintaining an equitable NHS and addressing those inequalities in health *care* that are contributing to the observed inequalities in *health status*.
- Preventing or ameliorating the health damage caused by living and growing in disadvantaged circumstances (i.e. the health damage caused by wider social determinants of health).
- Acting as a champion and facilitator to influence other sectors to take action to reduce inequalities in health.
- Directly influencing other social determinants of health, such as local employment and economies, and acting as a good “corporate citizen”.

We examine the options and what helps or hinders delivery in these areas in greater detail here.

2.1. Maintaining an equitable NHS and addressing inequalities in service delivery

The Commission on Social Determinants of Health’s Global Report made several recommendations on building universal health care systems as an essential part of the global strategy to “close the gap in a generation”. These include:

“Build health care systems:

- based on principles of equity, disease prevention, and health promotion;
- based on the principle of universal coverage of quality services, focusing on Primary Health Care;
- ensure that health care systems financing is equitable...focusing on tax-/insurance based funding, ensuring universal coverage of health care regardless of ability to pay, minimising out-of-pocket health spending
- build and strengthen the health workforce, and expand capabilities to act on the social determinants of health”. (CSDH, 2008)

Considering the Global’s Report’s recommendations in the light of the British health policy context, the NHS already embodies the key principles of an equitable system. In fact, we would argue, along with Wanless (2001), that it is possibly the most equitable and efficient system in the world in its conception, even if it falls short of the ideal in its operation. There is no room for complacency, however. The specific challenge for the UK from the CSDH report is to maintain the essential components of the equitable system that the country already has, in the face of potential erosion of the fundamental principles on which it is built. At the same time, the system needs to improve the mechanisms for identifying and rectifying inequalities in delivery of the services and develop further the capability to take a social determinants of health approach.

2.1.1. Safeguarding the equity principles of the NHS

It is worth rehearsing what the equitable components of the British system are. These include:

- Equitable financing of the system: through general taxation, so that contributions towards the financial cost of the NHS are shared across the whole population in a progressive way: in proportion to income and divorced from the need for and use of services. The NHS has one of the progressive funding systems in the OECD (Van Doorslaer et al, 1993). In this way, risk is pooled, so that the burden of payment for health services is shared: the rich support the poor, the healthy support the sick, those of working age support the young and the old.
- Universal entitlement. Everyone included in the scheme as a right, without having to undergo a means test or other test of eligibility.
- Free at the point of use: money should therefore not be a barrier to use of services when sick.
- Comprehensive in range – primary, secondary, prevention and promotion, mental as well as physical health, chronic as well as acute care.
- Comprehensive in terms of geographic spread of services: aided by resource allocation formulae to match resources to differential need of the populations of different administrative areas; national and local planning which takes need into account.
- Based on strong primary care. One of strongest systems in world (Starfield et al, 2005), in which 90% of health-care encounters take place in primary care (Peckham and Exworthy, 2003), but accounts for only 10% of the cost of health-care. Gatekeeper role adds to efficiency.
- Selection on the basis of need for health care, not ability to pay.
- Encouragement of a non-exploitative ethos: public service values, minimising incentives for making profits from patients (minimising fee-for-service transactions, for example), and the principle of offering the same high standard of care to everyone, without discrimination.

A great many reforms and reorganisations have been made to the NHS and other public services since the 1970s for a variety of reasons, mainly in the name of efficiency. There is a sense that we have lost sight of the fundamental principles that maintain an equitable, universal system. Certainly, there is too little assessment of whether the various reforms are meeting even their stated aims, let alone whether they are having a detrimental effect on the values and equity principles of the public sector.

The case study on the Quality and Outcome Framework (QOF) presented in PART 3 illustrates the kinds of assessment that need to be done on system changes and what lessons we can learn from them for maintaining an equitable system and reducing identified inequalities in services. It focuses on the Quality and Outcomes Framework (QOF) introduced as part of the 2003 General Medical Services contract, which introduced financial incentives in an attempt to change the system dynamics. The evaluation identified both positive and negative impacts on health inequalities and discovered that the quality of care was already improving prior to the introduction of the QOF: highlighting the importance of looking at underlying trends. Crucially, this kind of assessment provides pointers on how the system could be improved in the future from an equity perspective. It should also highlight contradictions between the goals of the

particular system innovation being assessed and that of other equitable parts of the system. The QOF, for example, with its focus on secondary prevention, poses a potential threat to the population perspective outlined in recommendation 2.

Key recommendation 1: equity assessments

Equity assessments should be carried out on system changes (planned or implemented) to assess not only whether they are meeting their stated aims, but also whether they are having detrimental effects on the values and equity objectives of the wider system as a whole. There should be provision built into the system for taking action on the findings of these assessments.

2.1.2. Emerging challenges to the principles of an equitable NHS

Two potential threats that need thorough equity assessments are the renewed call to introduce charging for GP consultations as NHS budgets get squeezed, and the piloting of Personal Health Budgets.

Challenges to ‘free at the point of use’ principle

With the recession biting and funding for the NHS likely to be squeezed from 2011, there have been renewed calls to abandon the principle of ‘free at the point of use’ and for charges to be made in primary care for consultations with GPs. Based on evidence from countries where charges have been introduced or increased, this would be a highly inequitable policy. This is because such a policy has the greatest negative impact on low-income groups, who reduce their use of essential services, even though they have the greatest need for services due to their higher prevalence of ill-health. The Wanless Report presented evidence that charges can not only discourage people from seeking treatment, but can also direct people to other parts of the healthcare system that do not make charges or cause them to delay until treatment is more urgent and expensive (Wanless, 2001). As well as a large body of evidence on the harmful effects of user charges in low and middle-income countries (Whitehead et al, 2001; McIntyre et al, 2007), the experiences of New Zealand and Sweden are highly relevant to the UK situation in this respect. In February 1992, user charges were introduced for services provided by public hospitals in New Zealand. There were multiple reasons put forward to justify their introduction, including: to reduce health expenditure, to improve equity of primary care by making higher income people pay more, to discourage free hospital use over primary care, and to encourage health living (Ashton, 1992; Hornblow, 1997). These assumptions proved false: the fees discouraged health care use by low-income people to a greater extent than by higher income people and cost more to administer than was collected in fees, thus proving both inequitable and inefficient. The scheme was abandoned in 1993 (Gauld, 2001).

Even in Sweden, where an originally low fee for a primary care consultation has been increased over the last decade to about 15 euro per visit, there is evidence that this level of fee deters people from low-income groups from seeking care. A recent study in Stockholm County, for example, found that the proportion of people reporting that they had abstained from seeking care in spite of perceived need, due to financial reasons, followed a clear social gradient, with 5% of the general population abstaining compared with 35% of social assistance recipients (Burstrom et al, 2007). The authors concluded that increased reliance on user charges in Sweden is inconsistent with promoting equity of access (Burstrom, 2009). This serves to flag up the dangers for the NHS of going down that route and certainly the need for rigorous system-wide assessment of any proposal to abandon this NHS principle.

Challenges to the principle of pooling risk? Personal health budgets

Personal Health Budgets (PHBs) are part of the UK Government's agenda for empowering patients. They were signalled in Lord Darzi's report, NHS Next Stage Review (Darzi, 2008), and 68 provisional PHB pilot sites, covering 75 PCTs, were announced on 12 May 2009 (DH, 2009a). The idea is to allocate individual patients a (sometimes notional) sum of money to cover the health care that they require for "fairly stable and predictable conditions". The areas of continuing care, end of life, long term conditions, mental health and learning disabilities have been identified as suitable for the pilots (PPF and DH, 2009). The intention is that the budget will be set at the level of need for an individual and will be sufficient to cover all their needs (DH, 2009b). Top-up payments would not be allowed (DH, 2009b), although it is difficult to see how this could be enforced.

While the sentiment of giving patients more control over the management of their condition is laudable, there are inherent dangers in the proposed scheme, not least if it undermines the foundations of the system for financing the NHS in an equitable way. A number of commentators, including the King's Fund, have raised additional concerns (Dixon and Ashton, 2008). What are the main equity concerns?

- A major concern is the undermining of the equitable financing system. The central principle of the NHS system of funding is the so-called 'gift economy', involving cross-subsidy and pooling of risk. Everybody pays into the common 'pot' according to their means, but not everybody needs to use the service to the same extent and at the same period of time – an individual's need for health care is unpredictable. In the NHS, those in need get to use the service free of charge when they need it, subsidised by everyone else. Once you start putting a cash value on NHS services and allocating average amounts to individuals, then it damages the ability of the system as a whole to cross-subsidise in this way.
- What happens if a person's budget runs out but they still need care, or they develop other needs not covered by the budget? The DH says that no one will be denied treatment in such circumstances, but will the patients ration themselves? Is this scheme the thin edge of the wedge, signalling the end of 'free at the point of use' services. The transaction costs involved in judging individual need and supporting patients to make decision on best care are potentially burdensome to the service.
- Will individuals be able to choose treatments that the NHS does not support because they are judged by NICE to be ineffective (Dixon and Ashton, 2008; NHS Confederation, 2009)? If so, the efficiency of the NHS may suffer because the money will have been wasted, and the patient may require additional services if their health deteriorates during the ineffective treatment (Dixon and Ashton, 2008).
- There is a danger that it will create a two-tier health service and exacerbate inequalities in health if more affluent people are able to purchase services over and above those funded by their PHB and poorer people are not (Anon, 2009; McIntosh, 2009; O'Dowd, 2009).

These and other emerging challenges need to be scrutinised for equity impacts with the utmost care, as illustrated in the QOF case study in **Part 3**.

2.2. Sustaining a strong population health perspective within the health system

The Global Report recommends *"expand the health sector policy and programmes in health promotion, disease prevention and health care, to include a social determinant of health approach, with leadership from the Minister of Health"*.

Above all, this requires a system that takes a population health perspective, capable of going beyond the individual needs of registered patients or users of services. The UK system is already oriented towards prevention and health promotion to a greater extent than in many other countries, in that it includes these services within the comprehensive package covered by the NHS. Most importantly, it has had highly developed systems for taking a population health perspective on monitoring needs and delivering appropriate responses, ranging from protection against communicable diseases such as the current swine flu epidemic to environmental control, prevention, promotion and multi-sectoral work on social determinants of health. This population health perspective contrasts with an approach limited to registered patients or users of services, where sections of the population can slip between two stools and only expressed needs for treatment services are addressed.

2.2.1. The Case study on population health and re-organisations in PART 4 maintains that English public health system works well with many positive features. However it has been 'damaged' by recent re-organisations. The case asks key questions including:

- Which re-organisations have 'strengthened' public health and which have 'damaged' it?
- What system aspects have been particularly affected?
- Which mechanisms might be developed to address strengths and shortcomings?

The lessons coming out of this analysis for future on re-organisations include:

- a. Key messages
 - i. Strong evidence that re-organisations have been detrimental to public health despite its re-emergence
 - ii. Public health still appears to be marginal to core activities of PCTs and wider NHS. Progress remains patchy
 - iii. Modest Improvements have been made but on balance, probably not sufficient to make intended in-roads into health inequalities
 - iv. Some areas of health policy (affecting public health) seem non-negotiable (eg. patient registration with GPs as independent contractors)
- b. Recommendations
 - i. The frequency and intensity of structural re-organisation should be limited because of the deleterious effects on the health system and especially public health viz.
 1. Mergers rarely bring expected benefits
 2. Organisational effort deflected for 1-2 years
 3. Public health remains marginalised within broader health system
 - ii. Clearer and more consistent frameworks are required for collaboration especially in performance management

Mini-case-study on re-organisation : Shifting the balance of power

Here we give an example of a mini-case-study on one significant re-organisation: '**Shifting the balance of power**' (2001). This reorganisation addressed the organisational consequences of the NHS Plan (2000). SBOP was the policy which prompted the national implementation of Primary Care Trusts (taking over from Health Authorities) and a reduction in the number of SHAs. (Previously PCTs had been an option (level 4) in the development of Primary Care Groups). Following SBOP, the introduction of 303 PCTs effectively fragmented the public health function; the available leadership was spread thinly with only a handful of staff in each PCT. PCTs did assign a Board level responsibility to public health (through DsPH) but some appointees were not sufficiently competent to operate at Board level. A period (12-18 months) of organisational upheaval followed the SBOP implementation as new structure and processes took time to become established.

Although there were some prior examples of Public Health Networks, SBOP stimulated their further development in order to share intelligence and information and to support 'isolated' public health practitioners. Managed PHNs were effective in providing knowledge exchange but were hampered by the need for DsPH to be "on top of every issue locally."

The 2006 reform of PCTs (which reduced their number from 303 to 152) was widely welcomed for restoring the balance of power between commissioners (PCTs) and providers. (Too many, small PCT had lacked to power to challenge acute providers). The reduction in PCT numbers (and increase in population covered) made a stronger alignment with public health functions, Coterminality (which facilitated joint public health appointments and joint performance management) was achieved in many cases. Coterminality between PCTs and unitary authorities and county councils was welcomed but often at the expense of collaboration with district/borough councils. However, the public health function "collapsed" after 2006 with a decline in morale. Whilst non-medical specialists were increasingly appointed to DPH posts following SBOP, non-medical specialists seem to have "lost out" after the 2006 PCT mergers.

This mini-case-study shows the often unintended consequences of health system reform upon public health. For the most part, the SBOP reforms have had a deleterious effect upon public health though the 'balance sheet shows some (usually short-term) benefits

***Key recommendation 2: ability of system to take population health perspective:
The UK's highly developed system for taking a population health perspective on assessing needs and delivering appropriate public preventive and health promotion services should be safeguarded and enhanced in planned system changes.***

2.2.2. Increasing preventive activity: the pros and cons of NHS Health Checks

Another lever being used to try to encourage the health system towards more preventive activity is *NHS Health Check*. NHS Health Checks were introduced nationwide in April 2009, as an evidence-based intervention for reducing mortality from cardiovascular disease. Some advocates have suggested that this is potentially a great delivery mechanism, if promoted and conducted well, to target and engage more disadvantaged people at a preventive and early intervention stage. The critical issue, however, is how they should be conducted to promote health equity, because they could be counterproductive and increase health inequalities if conducted insensitively. **Box 2.1** gives an example of how the Health Checks are being used in Knowsley in a sensitive way, and as only one part of a wider cardiovascular disease (CVD) prevention programme. If they are used in this way, then they could make a useful contribution to equity of access to preventive health care.

Box 2.1. Incorporating NHS Health Checks into wider CVD prevention work in Knowsley

Prior to the introduction of the NHS Health Checks, NHS Knowsley and Knowsley Council had been developing a programme to reduce cardiovascular disease within the Borough. Within Knowsley, it was seen as important to include cardiovascular risk assessments (health checks) as part of the programme, but that these needed to be undertaken within the context of a whole-systems approach if there was to be long-term reduction of inequalities from cardiovascular disease within the Borough.

Knowsley at Heart is a broad and ambitious programme that is tackling CVD prevention (primary and secondary) on an industrial scale. This is looking at the initiatives which need to be undertaken in the short- medium- and long-term, in order to achieve the overall goal of cardiovascular disease rates which are similar to the national average.

In the short-term, it is seen that there is value in identifying people at risk of cardiovascular disease, through health checks, and helping them to reduce their risk, through improvements in their lifestyles (food, physical activity, smoking, alcohol) and through appropriate medical treatment. The Knowsley programme for vascular risk assessment is making these assessments as accessible as possible for local residents, making them available in local community venues (eg local supermarkets, community centres etc), community pharmacies, as well as in GP surgeries. During these health checks, people are signposted to support from lifestyle trainers, the Activity for Life programme, smoking cessation services, the Community Cooks programme, and many other sources of help. They can also be referred to their GPs for medical help.

To ensure equality of access we have used a social marketing approach to the health checks. to develop better understanding of local people in relation to their aspirations and the way they live, to ensure that the checks are appropriately located, and that they are marketed in a way which communicates with local people.

In the medium term, we are engaging local people as champions who will encourage others to lead a more healthy lifestyle, and help them to understand cardiovascular disease. Currently, there are over 70 people who have signed up as Champions for the programme, and they are receiving training and support as this role is developed.

The training of front-line staff is also being prioritised across the Council and NHS Knowsley, to enable them to have a better understanding of cardiovascular disease, and to empower them to give appropriate advice to the clients they are seeing on a daily basis.

In the longer term, the programme is working on the wider determinants of health within the Borough, as a partnership involving the Council, NHS Knowsley, local businesses, and the third sector. Specific initiatives to improve health are included within the plans for children and young people's services, housing, regeneration and planning, leisure and culture, employment and skills and crime and disorder, as well as health and wellbeing.

While the NHS health checks are based on clinical evidence, there could be the danger of them increasing health inequalities, if they were not conducted with an emphasis on accessibility, equality and diversity. There would be the danger that the people who accessed the health checks were those who were more informed, and who were more able to access the venues. There would also be the risk that the results of the health checks were more readily acted upon by those who had fewer problems.

An emphasis on understanding, and meeting the needs of, the different 'segments' of the target population is very important, to minimise these risks. It is also important to embed the health checks within a comprehensive programme which addresses the wider determinants of health, and which involves and engages the local population. *Diana Forrest, DPH, Knowsley*

2.3. Championing work with other sectors at the local level

The Global Report recommends actions to "*build and strengthen the health work force and expand capabilities to act on the social determinants of health*".

For the UK, this means, among other actions, developing the health system's role in acting as a champion and facilitator to influence other sectors to take action to reduce inequalities in health. **The case study on local multi-sectoral working in PART 5** gives examples of what partnerships have done to tackle to improve housing conditions and make them healthier, and joint work with the education sector to tackle disadvantage and social exclusion. It also synthesises the evidence from attempts by local public sector agencies in the UK to work together over the past two decades on the social determinants of health. This evidence indicates a range of common facilitators and barriers to this kind of working and ways in which

the conditions for effective partnership working can be enhanced in the future, summarised as follows.

2.3.1. Lessons from national area-based initiatives delivered locally

There is a substantial body of literature on what works to aid partnership working of the kind required to tackle the social determinants of health, including from the range of area-based initiatives introduced over the past decade with the aim of reducing inequalities. These include Health Action Zones (HAZs), Health Improvement Programmes, Healthy Living Centres, New Deal for Communities and Sure Start. From this literature barriers and facilitators have been identified:

System barriers

- Heavy external pressures, such as heavy policy overload from central Government, limited the efficacy of partnership and collaboration.
- Local partnerships have been put under pressure from competing priorities between the partner organisations, such as:
 - different accountabilities
 - funding and budget concerns
 - a lack of understanding of each other's roles – for example the health service adhering to a medical model of health that excludes the local authorities
 - a difference between national and local priorities.
- Partnerships can be undermined by rapid turnover of members and organisational changes within the partner agencies.
- New members can bring different goals that are inconsistent with the developed aims of the partnership.
- Inadequate start-up time
- Inadequate time for assessment of impact: It takes time for programmes to become established and generate learning: two years for organisational change to be established [18 months for local learning to be disseminated nationally; when trying to engage with the community it can take 18 months just to build the relationships needed to begin the work.
- Time pressures can discourage flexibility and reflection.
- Constantly changing policy priorities and organisational restructuring had a detrimental impact on partnerships in some cases, through having to re-negotiate the partnership with new or reconfigured agencies, or partnerships suddenly finding themselves faced with a new policy
- Performance monitoring was generally considered overly burdensome, and not representative of the work that was being done, by those providing the information.

System facilitators

- Sufficient time, security and stability to work well
- Having policy options available that fit the vision and values of the political climate.
- Shared values were important public service motivators and public sector workers were motivated by making a difference.
- A partnership based on shared values, embedded within the public sector, can help to disseminate those values out into the public sector organisations and influence the ways of working there.

- Such a values-based approach can enable the transfer of ideas, innovation and new practice, can facilitate ‘mainstreaming’ of services and the building trust between organisations and between communities and organisations, and ultimately can deliver accountability of local government and health.

Messages from the frontline: what helps city-wide and region-wide working

- Joint PCT/city council posts focused on social determinants of health
- Joint operational units
- Co-terminosity of PCT and Local authority boundaries
- Common goals and targets focussed on addressing inequalities in health and wellbeing
- Joint funding mechanisms, e.g. Section 75 funding (which is sustainable)
- A nominated lead on inequalities in each PCT as the commissioning body
- A single regional strategy for regional development that puts health as one of the prime drivers of the strategy

Key recommendation 3: Local leadership on facilitating joint working

Local mechanisms need to be initiated to make multi-sectoral work on social determinants of health both easier and more effective, along the lines set out in the principles for action.

Key recommendation 4: National and local synergy

Government departments need to support rather than undermine local joint working on the social determinants of health and inequalities. This includes demonstrating that this kind of work is valued nationally through the targets and performance management mechanisms that are put in place; through the setting of adequate timeframes for setting up the joint work and evaluating impact.

Key recommendation 5: Workforce development on determinants of health

Government departments and regional workforce development agencies need to expand capability to understand and act on the social determinants of health in the non-specialist, as well as the specialist, workforce. This requires both reaching out to include practitioners in sectors other than health, as well as expanding capacity in educational establishments to carry out this development work.

2.4. Tackling the wider social determinants of health directly

In the debate on what health systems could do address the causes of inequalities in health, the question arises of whether there are direct ways in which the system might influence the wider social determinants, such as reducing poverty, improving employment rates and influencing the local economy of disadvantaged areas. There is evidence of promising initiatives from around the regions on all these issues. **The Case study on direct action in PART 5** details the following:

- **Tackling poverty by boosting incomes of patients.** As part of wider anti-poverty strategies, several health sector agencies, in particular primary care organisations, have been experimenting with offering advice and help with claiming welfare benefits delivered in health care settings. The rationale for this is that there is currently low take-up of benefits for which patients would be eligible, and increasing incomes would improve the standard of living of recipients and in doing so increase the opportunities they have to live a healthy life.

- **Tackling unemployment.** Another way to increase the income of people who are sick is to help them keep or get jobs. The potentially significant contribution of health services in relation to work has been recently reiterated by the government (Black, 2008; DH, 2008). There is particular emphasis on the value of intensifying medical rehabilitation services to help people recover from or manage their health condition to enable a return to employment (Black, 2008). In addition, a major role is being proposed for GPs in switching from their current role of sickness certification (in which an employee is judged to be too sick to work) to one in which they concentrate on assessing the degree of “fitness for work” of a person and prescribing ways of improving that fitness.
- **Boosting the local economy.** Perhaps the most radical way in which the health sector could directly attack poverty and unemployment is to harness the NHS’s purchasing power and position as a major employer. The premise on which the initiative was built is the recognition that the NHS and social care sectors have tremendous economic weight. They spend billions every year on purchasing a wide range of goods and services from laundry services to catering and computers, from beds to building maintenance. The persuasive argument put forward is that if this purchasing power were harnessed to support local businesses in the most hard-pressed communities, then the benefits might extend to greater social inclusion and equity, as well as improving the health of the community it serves:

Key recommendation 6:

Local public agencies should be proactive in assessing how they can confront poverty, unemployment and disadvantage in their communities more directly. This includes using opportunities in health care settings to help patients get the social welfare benefits they are entitled to; contributing to rehabilitation of people with longterm sickness to help them get fit for work; and using their organisation’s employment and purchasing power for the benefit of the local communities that they serve.

2.5. Co-ordinating efforts across the whole of government

The Global Report emphasises the need to ensure that health equity is embedded in all policies, systems and programmes across the whole of government:

“Place responsibility for action on health and health equity at the highest level of government, and ensure its coherent consideration across all policies, including recommending:

- *Parliament and equivalent oversight bodies should adopt a goal of improving health equity through action on the social determinants of health, as a measure of government performance;*
- *Institutionalise the monitoring of social determinants and health equity indicators and the use of health equity impact assessment of all government policies including finance.”* (CSDH, 2008).

What does this mean for the UK? We are not starting with a blank sheet. There is a long tradition of using targets, for example, which have emerged as key drivers of the public policy system in the UK, and have been used to try to achieve improved performance, indeed to measure performance, across a range of government departments and goals. From this UK experience to date, there are lessons to be learnt, both negative and positive, in the use of targets, as **the case study in PART 6** draws out. It is a study of the macro-level issues which relate to the role of targets in planning across the public policy system to achieve outcomes such as reductions in health inequality. In this case study we examine the changes which have taken place in relation to the use of targets in the public policy system. We argue that there have been some long term shifts in the mode of integration used in the public policy system, with a post war era which could be characterised as a complex adaptive system giving way in

around 1979 to a model better described as a vertically-integrated mechanism. We go on to argue that the time is now ripe for a further step change which would reflect the need for a better way of handling complexity, jurisdictional boundaries and the mobilisation of the creative energies of staff right across the public policy system.

This case study first examines the historical contexts within which targets have been used. We then introduce the two alternative modes of integration which form the conceptual backbone of this work. That takes us to the research evidence on the positives and negatives of the use of targets in the experience of the current mode of integration. The next section examines current developments in the policy planning system, notably the creation of new outcome-focused Public Service Agreements and the development of joined up Local Area Agreements. We argue that this approach could be used in a way that transforms a vertically-integrated mechanism into a complex adaptive system. We then focus on some key issues which emerge from our analysis, which we have grouped under the following headings:

- Shifting the balance between top down integration and adaptive mode
- Local adoption of national priorities
- Developing strategic leadership of the whole system
- Measurement and evidence

We then go on to make recommendations which offer specific actions aimed at enhancing systemic capability. We believe that if that were to happen, targets would be the joint expression of common objectives, that there would be incentives to use them to achieve the agreed purpose rather than to game-play, and that this would avoid the tendency which is currently very evident of hitting the target but missing the point.

Key recommendation 7: Developing common view

Policy makers, professionals and service managers across the system need to escape from the blame culture which has emerged during the operation of previous target regimes. They need to harness the considerable scope for developing common ground, and particularly the scope for developing a common view about the key priorities and how they should be tackled. The new generation of Public Service Agreements (PSA) and the creation of the Local Area Agreement (LAA) system provide promising vehicles for developing the desired common ground on values and outcomes.

Key recommendation 8: shared targets on shared objectives

Targets which are based on shared objectives, and driven through relationships based on mutual respect and appreciation of the logics which drive different players, stand every chance of helping to influence the social determinants of health inequalities.

2.6. Considering the global equity impact of UK initiatives

Actions in the UK to tackle inequalities in health services may have a profound effect on the ability of other countries to improve their own health care systems and serve their populations adequately. **The case study in PART 7** highlights in particular issues relating to the possible impacts of any increases in health worker resourcing in England on health inequalities in other countries.

England has long been affected by the global shortage of health professionals, and traditionally relied on importing health professionals to meet the shortfall. Most recently the UK has been

importing doctors and nursing staff from sub-Saharan Africa and the Philippines. The other side of this flow has been that some lesser-developed countries have lost health workers.

For some countries this has produced a source of income and a way to skill-up the health workers that eventually return and has therefore had a potentially positive impact. For other countries, the UK recruitment regime has caused shortages of health workers and stretched health services – leading to increased health inequalities, both within the country and in comparison with developed countries such as England.

In light of these concerns the UK Government has been involved in initiatives to address the issue of the depletion of health workforces in lesser-developed countries. In particular the Department of Health has developed a code of practice around international recruiting that outlines that no recruitment of health workers should take place from less developed countries unless it has been agreed to between the Department of Health and the government of the source country. Furthermore, in 2007 the Government announced its involvement in an International Health Partnership, which aims to improve the health services and capabilities of lesser-developed countries.

Although efforts have been made to address the issues of health worker migrations from less developed countries to England, it is still likely that any increase in the demand for health workers to deliver additional health services and programmes is likely to lead to increased demand for health workers from lesser-developed countries. There are clear implications from this in terms of reducing health inequalities in England in two particular areas if efforts to reduce these health inequalities require significant increases in health workers. The first of these is the potential to export these health inequalities to countries less able to address them by importing health workers from these countries. The second is in terms of the sustainability of these efforts if they rely on the continued supply of health workers from less developed countries. Additionally this may also impact on other Government policies, such as aid and development initiatives to improve health in the countries from where these health workers are being sourced. As such the implications of any increase in resourcing for the health systems need to be considered as part of any effort to address health inequalities in England.

Key recommendation 9: assessment of global impact

Policies which lead to increased health resourcing in England need to be assessed in terms of their impact on health and health equity in other countries.

Key recommendation 10: sustainable workforce development

Expansion of the England's health work force needs to be planned in a sustainable way so that it does not exacerbate the health workforce deficiencies in developing countries.

2. 7. Principles for action and disinvestments

Beyond the general recommendations, the evidence in the detailed case studies in Parts 3 to 8 has generated specific pointers for future action, which we have distilled into 'principles for action' and 'what does not work'. These are collected together and presented in **PART 9**.

PART 3

Case study on an experiment in altering the system dynamic – The Quality and Outcomes Framework (QOF) initiative

Tim Doran

SUMMARY

The Quality and Outcomes Framework (QOF) was introduced as part of the 2003 General Medical Services contract for general practitioners in the UK and links financial incentives to the quality of care provided by practices for a range of chronic conditions. Quality is measured against a set of over 70 clinical activity indicators, with practices rewarded on a sliding scale according to the proportion of eligible patients for whom each target is achieved. Further payments are awarded for aspects of practice organisation and for conducting patient surveys. Practices may exclude ('exception report') patients they deem inappropriate from specific indicators, for reasons including extreme frailty, intolerance of a particular drug, and refusal of treatment.

The QOF was intended to increase the income of general practitioners, to improve overall quality of care for chronic disease and to reduce variation in care between practitioners. There are, however, concerns that the QOF systematically disadvantages some practices and some population groups - particularly those experiencing material deprivation.

Findings of QOF assessment

Most practices reported high levels of achievement for the quality indicators in the first year of the scheme (2004-05), and levels of achievement generally increased in the second and third years, before reaching a plateau for most indicators in the fourth year (2007-08). Levels of achievement are related to the type of activity, baseline achievement pre-QOF and the maximum payment threshold for the activity (i.e. the level of achievement required to earn the maximum payment, which varies from 50% to 90%). In 2007/8 the average practice earned over £120,000 from the QOF, at a total cost to the NHS of £1.1 billion.

The QOF has had some *positive* impacts on health inequalities and their monitoring:

- For the incentivised activities the worst performing practices - concentrated in the most deprived areas - improved at the fastest rate. Gaps in the quality of primary care for conditions including coronary heart disease, asthma and diabetes have therefore quickly narrowed under the QOF scheme. This may have been facilitated by the use of progressive payments which motivate practices with a range of baseline achievements to improve.
- The provision to exception report preserves the clinical autonomy of practitioners, safeguards against inappropriate treatment of patients, and ameliorates perverse incentives to deny care to 'difficult' patients. Practices in deprived areas exception report more patients than practices in more affluent areas, but the difference is marginal and rates of exception reporting have generally been low.
- A comprehensive information technology system was established to support the QOF, and most practices now use computerised patient records. Disease prevalence and quality of care at the practice level can now be monitored and linked to a range of patient and practice characteristics. However, data is not routinely collected at the patient level,

and it is therefore difficult to measure quality of care by patient age, sex and other socio-demographic characteristics.

The QOF may also have had *negative* impacts on health inequalities:

- Prevalence of the QOF conditions recorded by practices is lower than prevalence estimates provided by national surveys – this gap may be greater in more deprived areas. Quality of care for ‘missed’ patients is not known. Some practices also appear to have removed patients who are unlikely to meet a QOF target from the relevant disease registers.
- Improvements in quality of care have not been as rapid for some ethnic minority groups.
- Quality of care was already improving prior to the introduction of the QOF, and for many QOF activities there was only marginal and short-term improvement in quality above the underlying trend. Evidence on whether improvements in QOF scores are associated with improved outcomes for patients is equivocal. Given the level of investment in the scheme, the opportunity costs in terms of interventions foregone need to be considered when analysing the impact of the QOF on health inequalities.
- Quality of care for some non-incentivised activities was improving prior to 2004, but does not appear to have done so after the introduction of the QOF. There is also less training, education and use of guidelines for non-QOF conditions. Gaps in quality care may therefore be developing between patients with QOF conditions and those with non-QOF conditions, particularly in practices which had low baseline achievement for QOF-incentivised activities. Quality of care is more difficult to monitor for non-QOF activities, because data is not routinely collected as it is for QOF activities.
- Primary preventive activities may have been neglected to some extent in favour of the secondary preventive activities prioritised in the QOF.
- The QOF payment system scaled payments according to the square root of disease prevalence, rather than actual prevalence. Practices with high disease prevalence – concentrated in deprived areas – therefore received less remuneration per patient than those with low prevalence. This inequitable payment system was corrected in 2009.
- Although practices achieve the QOF targets corporately, QOF payments are distributed by practice partners - usually the most senior physicians. These payments have not generally been equitably distributed among practice staff.
- Practice staff behaviour and the nature of the relationship between health professional and patient has changed under the QOF, and gathering data for quality targets has become a priority in consultations. The nature of the QOF scheme, and the proportion of practice income that is tied to performance on the QOF indicators, creates a risk that care will become more fragmented, efficiency will be prioritised over genuine quality, and professionalism will be eroded.

In summary

- The QOF costs the NHS over £1 billion per annum, with a substantial proportion of the money it brings into practices invested in senior general practitioner income.
- The QOF was not designed to address health inequalities, but by incentivising higher quality, systematic care for common chronic diseases it has the potential to do so. Its success in this regard is dependent on whether the apparent improvements in the quality and equity of delivered care under the QOF translate into long-term health gains for patients.
- The QOF also has the potential to increase health inequalities by diverting attention away from non-incentivised areas of care, particularly for practices with sicker and more deprived populations which generally have greater difficulty in achieving QOF targets.

- In the first five years of the QOF, payments to practices did not fully reflect the level of morbidity in the practice population. The payment formula was corrected in 2009, so that resources should, in future, be better matched to need.

Specific recommendations to improve equity aspects of QOF

- The ongoing reviews of both existing and potential new QOF indicators – conducted by the National Institute for Health and Clinical Excellence – should include a formal and comprehensive assessment of their impact on health care inequalities.
- Consideration should be given to including more primary preventive activities in the QOF, where these activities are appropriate for general practice and can be operationalised as QOF indicators. However, the QOF should not be viewed as the only vehicle for promoting primary prevention within general practice.
- The provision to ‘exception report’ patients should be retained. Exception reporting allows practitioners to exercise their clinical judgement and patients to opt out of care. It therefore ameliorates some of the perverse incentives of pay-for-performance schemes to coerce or to refuse care to patients.
- Maximum payment thresholds should be revised annually in light of patterns of achievement by practices. The effect of raising thresholds on levels of, and socio-economic gradients in, achievement and exception reporting should be closely monitored.
- Minimum payment thresholds, if raised, should be set at such a level that they continue to provide an incentive to practices with low baseline performance to improve.
- Indicators for which quality of care is generally high and variation in quality is low should be reviewed for possible ‘retirement’, but activity for these indicators should continue to be monitored.
- Activity data for non-QOF conditions should be routinely monitored.
- Data on quality of care should be monitored at the individual patient level, and linked to socioeconomic and demographic characteristics.

3.1. AIMS OF THE STUDY

The aim of this case study is to review the evidence for the impact of the QOF on health inequalities. The specific objectives of the case study are to determine: the objectives of this initiative; the key players; how the QOF was set up to achieve its objectives; the effect of the QOF in terms of quality of services and equity of access to better quality services; the effect of the QOF on practice culture and behaviour; and the lessons for the future in terms of, for example, designing a system to generate greater equity.

3.2 METHODS

3.2.1. Review of the literature

Relevant literature was identified through a search of the Pub-Med databases and relevant UK health service websites, and a further key author search. Secondary and tertiary references were identified from relevant primary and secondary references. Key authors were contacted to identify further research unidentified, in the grey literature or awaiting publication. The initial search was restricted to the years 1998 to 2009 (1998 being the year when modern pay-for-performance schemes were first introduced into health care systems), with appropriate older

references identified from the primary references. The review was restricted to literature written in the English language. Given the focus on the United Kingdom (more specifically England) this was not considered to be a serious limitation to the review.

3.2.2. Interviews

Interviews were conducted with five key people involved in the design and implementation of the original QOF, and in the development of the scheme during its first five years of operation. These informants, anonymised in the report as Informant 1 to Informant 5, represented the British Medical Association, the Department of Health, or NHS Employers in QOF negotiations, or provided academic support to the QOF design and development process. The interviews covered the main themes of the case study and addressed the seven areas outlined in the objectives.

3.2.3. Primary analysis

Limited primary analysis was conducted using two relevant databases:

- The Quality Management and Analysis System (QMAS) database held by the NHS Information Centre contains data extracted automatically from the clinical computing systems of practices participating in the QOF. It contains practice-level data for the years 2004/5 onwards for the conditions and activities included in the QOF, and is used to calculate payments to practices under the framework.
- The General Practice Research Database (GPRD) is a computerised database of longitudinal medical records derived from volunteering primary care practices in England using the *Vision* software package. Data is currently collected for over 450 practices and 13 million patients. Data are available at the patient level for both QOF and non-QOF conditions for the years 1999 onwards.

These databases were used to perform analyses on: the impact of the QOF on quality of care for both incentivised and non-incentivised activities and conditions; variation in quality of care by age, sex, and geographical location of patients; and the extent to which different patient groups are excluded by practices participating in the QOF.

3.3. RESULTS

3.3.1. *The development of the initiative*

Between 2001 and 2003 negotiators for the Department of Health (DH) and the British Medical Association met to revise the national contract for general practitioners. At the time there were several issues facing general practice in the UK: the morale and standing of general practitioners; the quality of care provided to patients; and the inflexibility of the existing national contract. With regard to the first issue, there was a widespread view within the profession that general practice was suffering from low morale and that the pay of general practitioners had fallen behind that of specialist consultants working in secondary care (BMA 2001, Informant 1, Informant 5). On the second issue, clear evidence – both international and national – had emerged during the 1990s that quality of care was highly variable (Institute of Medicine 2001, Seddon et al 2001, Leatherman and Sutherland 2003), and leaders of the medical profession, following years of denial and protectionism by some in the face of the evidence (Collings 1950, BMJ 1986, Petchey 1995), began to accept that improvements were necessary. During this period, improvements in quality measurement methodology and information technology made it possible to measure quality of care more accurately and to compare quality between different providers working in different settings and with different case mixes (Brook et al 1996). On the

third issue, there was consensus in the profession and the Department of Health that a new contract was required that would incentivise doctors to work in general practice and would improve access to high quality care for patients (NAO 2008).

On the Government side, on coming into power in 1997 New Labour made quality of care a priority issue, and also explicitly committed itself to tackling wider health inequalities, implementing a range of social and health-oriented policies (DH 1999, DH 2002). Within the NHS, a comprehensive programme of quality improvement initiatives was introduced – including National Service Frameworks and clinical audit – and several new bodies were created – including the National Institute for Clinical Excellence (later the National Institute for Health and Clinical Excellence), the NHS Modernisation Agency, and the Commission for Health Care Audit and Inspection. This programme was intended to eliminate unacceptable variations in the quality of health care and thereby assist in the fight against health inequalities (DH 2000, DH 2003). In New Labour's second term, following several years of uninterrupted economic growth, there was a substantial increase in spending on the NHS, which created an opportunity to simultaneously increase funding for primary care and to target quality of care. Additional funding for general practice could be incorporated into a new contract in such a way that all practitioners would gain in terms of income, with the amount of gain tied to the quality of delivered care.

The new contract was finally agreed in 2003, to be implemented in April 2004. The contract introduced several changes to general practice, including removing the requirement for practices to provide out of hours care and enhanced services; the introduction of a minimum practice income guarantee; and the implementation of the Quality and Outcomes Framework (QOF). The contract was implemented across all four countries of the UK simultaneously, without any piloting of any element of the contract.

Different objectives of different stakeholders

The two sides in the original negotiations had different objectives for the new contract and its QOF component. Informant 5 saw these objectives as: "Increased remuneration for general practitioners by the BMA [British Medical Association], and reduced variation in quality by the DH [Department of Health]. They were each reasonably happy with the other's agenda." (Informant 5) The Department of Health's main aim was therefore to improve quality of care, and to reduce variation in quality of care, by linking funding to delivered quality of care (NAO 2008, Informant 3). This pay-for-performance element was seen as essential because the existing payment mechanisms – with remuneration largely allocated on a capitation basis – were perceived to disincentivise quality improvement: "Good practices were good practices because they invested money that would otherwise be taken as salary." (Informant 2)

The DH was aware that high quality care was possible and wanted to systematise care, so that best practice could be implemented across all practices, and the QOF was seen as the key driver (Informant 3). The underlying information technology required to support the QOF would also provide the DH with important information on activity in primary care and disease prevalence. Finally, the DH was keen not to be seen to be giving something for nothing, and linking pay to performance would allow it to demonstrate a return on a substantial investment (Informant 2). The objective of the QOF for the British Medical Association was to increase general practitioners' pay, but also to cover the cost of meeting the quality targets (Informant 1).

Whilst the objectives of the DH and the BMA could both be accommodated to some extent by the QOF, the different understandings of the purpose of the initiative have generated conflict and misunderstandings between the two sides in subsequent negotiations. The DH has come to view the payments as an incentive to improve quality of care – which implies that quality has

historically been sub-standard – whilst the BMA views the remuneration as reward for work undertaken and not necessarily an incentive to improve quality of care (Informant 1). These disparate views have consequences for the future development of the QOF, particularly on the issue of retiring indicators which have reached a ceiling in terms of achievement, and replacing them with indicators for which there is greater potential for improvement.

The QOF and health inequalities

In some official statements and documents the QOF has been explicitly linked to health inequalities. John Reid, the Health Secretary at the time the QOF was introduced, stated that the QOF: "...provides a new allocation formula that removes the historical inequalities of the current system of per-doctor payments, which penalised practices in under-doctored areas. Resources will be allocated to practices more fairly based upon patient need, practice workload and costs and not just on the numbers of people on the practice register." (Reid 2005)

However, although it can be argued that an initiative to reduce variation in quality of care is effectively an initiative to reduce health care inequalities, inequality was never mentioned in the original QOF documents and was not addressed in the negotiations. Tackling health inequality was therefore not one of the original aims of the QOF. Indeed, proposals to weight QOF points for deprivation were rejected by negotiators on the basis that that would be double paying, because deprivation was weighted for in capitation payments. (Informant 5)

In its testimony to the Health Select Committee on Health Inequalities, the BMA argued that it did attempt to address health inequalities at the time of the original contract negotiations, but outside the incentive framework: "We argued actually quite strongly [for] significantly less money in QOF and more money into funding what I would call basic services, trying to improve staffing levels in the poorer practices and suchlike, so there was more of a balance." (House of Commons Health Committee 2009, para 227)

There is a wider issue of how to organise primary care to tackle health inequalities, and where responsibility for this lies. Whilst primary care is frequently identified as essential in tackling health inequalities (WHO 1978, DH 2007), the record of primary care in the UK in addressing health inequalities, or even of matching provision to need, has been so poor it has effectively sustained health inequalities (Collings 1950, Tudor Hart 1971, Delamothe 2008, Informant 5). In recent years there has been more awareness of health inequalities – particularly where they affect workload and resources (Informant 2) – and general practitioners are generally committed to treating patients they see equally. The Chairman of the Royal College of General Practitioners has recently stated: "GPs have an important role in reducing health inequalities. With unrivalled access to the heart of communities, we can influence the health inequalities agenda as practitioners, commissioners and community leaders. We have the skills and resources at our disposal to help reduce health inequalities and improve standards of care for our patients." (Field 2008)

Despite this, there remains resistance within the profession, for example: "Is it the doctor's job to improve health inequalities? I don't think it is – obviously I mustn't make it worse, but it's not my job to solve the problem. My job is to solve the patient's problem, not society's problem. What doctors must not do is discriminate... The [health] outcomes of whether you do well or badly related to your poverty... are actually nothing to do with the health service but to do with wider society." (Informant 1) Consequently there are few examples of primary care taking a more community-oriented approach to health care: "Primary care mops up the pieces." (Informant 5)

Therefore, not only was the QOF not primarily intended to address health inequalities, there was at the time of its introduction an underlying reluctance within general practice to fully engage with the issue of health inequalities at the population level. Whether it was ever intended to address health inequalities or not, the QOF touches on a long-standing tension within the profession between maintaining a patient focus and having responsibility for a predominantly geographically-based population. As articulated by one general practitioner: “The profession has essentially been bribed to implement a population-based disease management programme that often conflicts with the individual patient-centred ethos of general practice.” (Lipman 2005)

Issues around the design of the Quality and Outcomes Framework

The framework links additional payments to practices (i.e. in addition to pre-existing capitation and other payments) to performance against a set of 146 quality indicators (Roland 2004). These indicators relate to clinical care for 10 chronic diseases, organization of care, patient experience, and some additional services (**tables A2-4, appendix**). The clinical indicators were mainly concerned with processes – e.g. diagnosing conditions, measuring parameters and giving treatments – with only 10 of the 76 clinical indicators relating to intermediate outcomes, such as controlling blood pressure (**table A2**). The concentration on processes was largely pragmatic – they are generally easier to measure – but processes are also more under the control of physicians. In contrast, achieving an outcome goal relies on additional factors such as patient adherence to treatment and advice, and wider socio-economic factors over which the physician may have little or no control (Watts et al 2008). Outcomes may also take several years to become apparent, and attributing an outcome to the actions of a particular physician or physician group is extremely difficult, particularly with chronic disease. Most QOF clinical indicators have therefore been based on processes for which there is evidence, or at least professional consensus, for effectiveness in terms of improved outcomes.

The QOF is mainly concerned with secondary prevention for existing chronic disease. There are therefore few indicators which relate to primary prevention (10 of the 146 indicators – see **table A4, row 5**). There is therefore a risk that primary preventive activities will be overlooked, although there are incentives outside the QOF for primary preventive activities – such as administering childhood immunisations. The QOF was intended to evolve over time, to reflect the emerging evidence. It has therefore been subject to periodic review, with existing indicators being revised or dropped, new indicators introduced and points allocations and payment thresholds adjusted. In the first major revision, in 2006/7, indicators in seven new areas were introduced (**table A3**), most minimum achievement thresholds were increased from 25% to 40% and maximum achievement thresholds were increased for some indicators.

Allocation of points and payment

Practices earn points – up to a maximum of 1,050 (reduced to 1,000 in 2006/7) – for meeting the targets set out in each indicator. Some targets are dichotomous (for example, maintaining an asthma register earns the practice 7 points) and for others, in the clinical care domain, points are awarded on a sliding scale based on the proportion of eligible patients for whom the target is achieved. For the clinical indicators practices must exceed a minimum achievement threshold of 25% to earn any points (i.e. must achieve the given target for at least 25% of eligible patients) and are then awarded more points with increasing achievement up to a maximum threshold that varies from 50% to 90% depending on the indicator. The maximum thresholds were intended to reflect the maximum practically achievable level to deliver clinical effectiveness, but effectively mean that practices can earn maximum points and remuneration whilst missing the targets for up to 50% of patients (Fleetcroft et al 2008).

The points allocated to each indicator were determined in the negotiations between the DH and the BMA, and were intended to reflect estimated workload for practices rather than population health gain. There is therefore a risk, where there is a mismatch between workload and health gain, that practices will focus on the more profitable, labour intensive activities which have relatively low gains in terms of population health (Fleetcroft and Cookson 2006).

Payment to practices under the QOF is determined according to a basic formula:

$$\text{Base Payment} \times \text{QOF Points Scored} \times \text{Prevalence Adjustment} \times \text{List Size Adjustment}$$

In 2004-5 the base payment was £76, and this was increased to £125 in 2005-6. Practices could therefore earn a basic QOF payment of up to £79,800 in 2004-5 and £131,250 in 2005-6. The basic payment is adjusted for disease prevalence by applying the Adjusted Disease Prevalence Factor (ADPF). This involves:

- Truncation – practices with prevalences of the relevant diseases below the 5th centile are assumed to have the same prevalence as the practice on the 5th centile.
- Transformation – a square root transformation is applied to the truncated prevalence
- Rebasing – each practice's truncated, transformed prevalence is divided by the mean of the truncated, transformed prevalence for all practices.

The final payment to the practice is then determined by multiplying by the relative list size (practice list size divided by the mean list size for all practices). The effect of the ADPF is to reduce variation in payments to practices, so although practices with a higher proportion of patients with the relevant conditions receive more remuneration for a given level of achievement, they receive less per patient.

Protection of patients

With pay-for-performance schemes there is a risk of inappropriate treatment of patients for whom a quality indicator is not appropriate (Yip 1998, Starfield 2001). Risk-adjusting indicators is problematic, as it involves creating very complex indicators (Fisher 2006), and it is not possible to allow for all eventualities. The QOF takes two approaches to this problem. First, maximum achievement thresholds are set below 100%. Second, physicians are permitted to use their clinical judgment to remove inappropriate patients from achievement calculations, a process known as 'exception reporting'. Acceptable reasons for exception reporting are: the patient refuses to attend review, having been invited on at least three occasions during the preceding twelve months; the indicator is not appropriate due to particular circumstances e.g. terminal illness, extreme frailty; the patient is newly diagnosed or recently registered with the practice (measurements should be made within three months and clinical standards delivered within nine months); the patient is on the maximum tolerated dose of medication; the specific medication is not clinically appropriate e.g. due to an allergy, adverse reaction or contraindication; the specific medication is not tolerated; the patient does not agree to an investigation or treatment (informed dissent); the patient has a supervening condition which makes treatment of their condition inappropriate; the specific investigative or secondary care service is unavailable.

There are concerns that exception reporting could permit substandard care, or be exploited for financial gain by practices excluding patients for whom the targets had been missed rather than for a genuine clinical reason (Doran 2008 et al ii). However, exception reporting is seen by

physicians as an essential safeguard against inappropriate treatment. It may also be important from an equity perspective, as it relieves the financial pressure on practices to deny care altogether to patients for whom the targets are not appropriate. In US schemes which do not have an exception reporting provision, physicians can become resentful of non-compliant patients, placing them under additional pressure and even dis-enrolling them (McDonald and Roland 2009). Use of exception reporting by practices under the QOF is reviewed in **section 3**.

Information technology

In order for the QOF to function, practices were required to record patient characteristics and clinical activity using standard definitions on clinical computing systems. Data from these systems were then extracted systematically and collated on a central database. The cost of installing the clinical computing systems in practices which lacked them was met by the DH. The national system for collating the data, the Quality and Management Analysis System (QMAS), has been managed since 2004 by the NHS Information Centre. This system records, for each practice and each QOF indicator: the number of patients deemed appropriate for each indicator, i.e. who were in the subgroup specified by the indicator and were not exception reported by the practice (D_i); the number for whom the indicator was met (N_i); since 2005/6, the number of patients exception reported by the practice (E_i).

The system was primarily designed to support the contract and to calculate payments to practices. It does, however, provide a useful, if limited, epidemiological resource, permitting disease prevalence and quality of care to be monitored for many chronic conditions for the majority of practices in the UK for the first time. QMAS data can be linked at the practice level to other datasets, and quality of care thereby linked to a range of patient and practice characteristics. The QMAS database does not allow quality of care to be monitored at the patient level, but a potential replacement system, the General Practice Extraction Service (IC 2009ii), is planned which will allow analysis at this level.

3.3.2. The effects of the QOF on quality and equity of care

The effects of the QOF, both intended and unintended, are considered together here under the headings of access, quality of care, equity of care and effects on practice behaviour. The intended effects of the QOF are taken to be to improve quality of care generally, and to reduce variation in quality. For the purposes of this review, quality is taken to include access to care and improvements in equity of care. Although these were not explicitly identified as aims of the QOF at the outset, they would be considered important aspects of high quality care by those involved in creating the framework and seen as desirable outcomes.

Case finding and access

In the early years of the QOF, the financial incentives encouraged practice staff to identify patients with the incentivised conditions and record their condition on their clinical computing systems in a systematic way. This is because practices with more patients received more money for achieving the targets. Non-attenders were enthusiastically pursued by some practices, even into their own homes if they wouldn't attend practices (Checkland et al 2007, Campbell et al 2008). However, the prevalence adjustment in the payment formula (**see section 3**) meant that practices with higher prevalence, whilst receiving more remuneration in total, received less per patient. This may have mitigated the incentive to case find, or even actively discouraged case finding. The reality or expectation of unidentified cases in the community being more difficult to engage or treat may have been a further disincentive. It is also possible

that some practices actively removed patients from disease registers if they believed they couldn't achieve the targets for those particular patients (Gravelle et al 2007).

The prevalence of most conditions incentivised under the QOF – as recorded by practices – is below that estimated in national surveys (**table 3.1**). For conditions including diabetes and hypertension, prevalence recorded by practices increased in the first years of the QOF, which may reflect case-finding, improved recording and/or a genuine increase in prevalence. In the case of diabetes, according to the Health Survey for England prevalence increased by over 75% between 1994 and 2003 (Information Centre 2008), and prevalence recorded by practices was increasing prior to the introduction of the QOF (**figure 3.1**). The scheme does not, therefore, appear to have increased case finding above the underlying trend for diabetes.

Table 3.1: Summary prevalence statistics from QOF data (2004/05 and 2005/06), comparison with Health Survey for England data

	QOF National Prevalence		Health Survey for England (2006)	
	2004/05	2005/06	Male	Female
Asthma ^a	5.8%	5.8%	13%	16%
CHD	3.6%	3.6%	6.5%	4.0%
Diabetes	3.3%	3.6%	5.6%	4.2%
Hypertension ^b	11.3%	12.0%	31%	28%
Stroke	1.5%	1.6%	2.4%	2.2%

Source: The Information Centre 2008

a) ever doctor diagnosed, ages 16 and over

b) systolic BP \geq 140mmHg or diastolic BP \geq 90mmHg or taking medication prescribed for high blood pressure

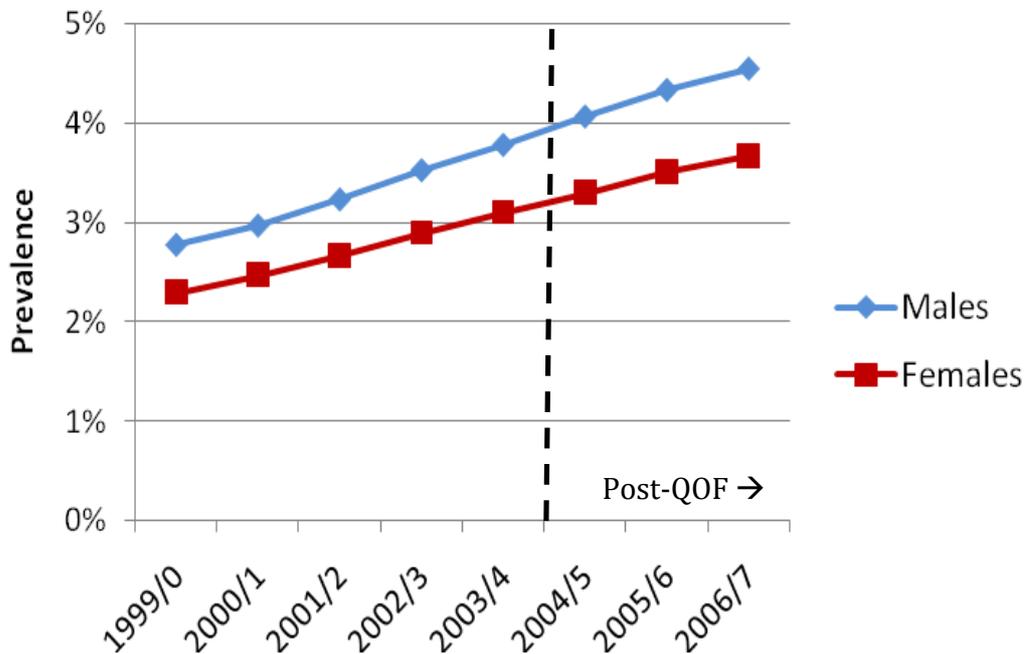
The disincentives to case find in the QOF are stronger in deprived areas where the prevalence of chronic disease is generally greater. This is compounded by patients living in deprived communities being less responsive to invitations to attend appointments and less likely to engage with long-term management of chronic illnesses (Hippisley-Cox et al 2004). In addition, patients can not benefit from the QOF if they are excluded through exception reporting, and those being exception reported may be those who would benefit the most, for example: patients with comorbidities or living in more deprived areas (Heath 2007). In the first three years of the QOF there was a socio-economic gradient in exception reporting, with practices in more deprived areas excluding more patients (Doran et al 2008ii). However, the gradient was very shallow, with practices in the most deprived 20% of areas excluding a median 7.6% of patients from the clinical indicators in 2006/7, compared with practices in the most affluent 20% of areas which excluded 7.2% of patients (Doran et al 2008iii).

The provision to exception report appears to have been used appropriately by the majority of practices, but there is evidence that some practices with low achievement rates may have inappropriately excluded patients in order to gain maximum remuneration (Gravelle et al 2007). Rates of exception reporting have generally been higher for intermediate outcomes activities than for process activities, particularly measuring and recording, and social gradients for outcomes activities may also be steeper (Doran et al 2008ii). Exception rates have also generally been high for influenza vaccinations, and there is a risk that the most vulnerable members of the community who would benefit the most from vaccination are more likely to be

excluded. However, as data for the reasons for exception reporting are not routinely collected, and as data are not available at the patient level, this is difficult to prove either way.

Access to practices was also related to area deprivation, with 90% of practices in the most affluent 20% of areas open for more than 45 hours week, compared with 74% of practices in the most deprived 20% of areas (Ashworth et al 2007i). This may be related to practice size, as smaller practices find it more difficult to provide extended hours, and are more common in deprived areas.

Figure 3.1: Trends in prevalence of diabetes recorded by 150 practices drawn from the General Practice Research Database, 1999/2000 to 2006/7

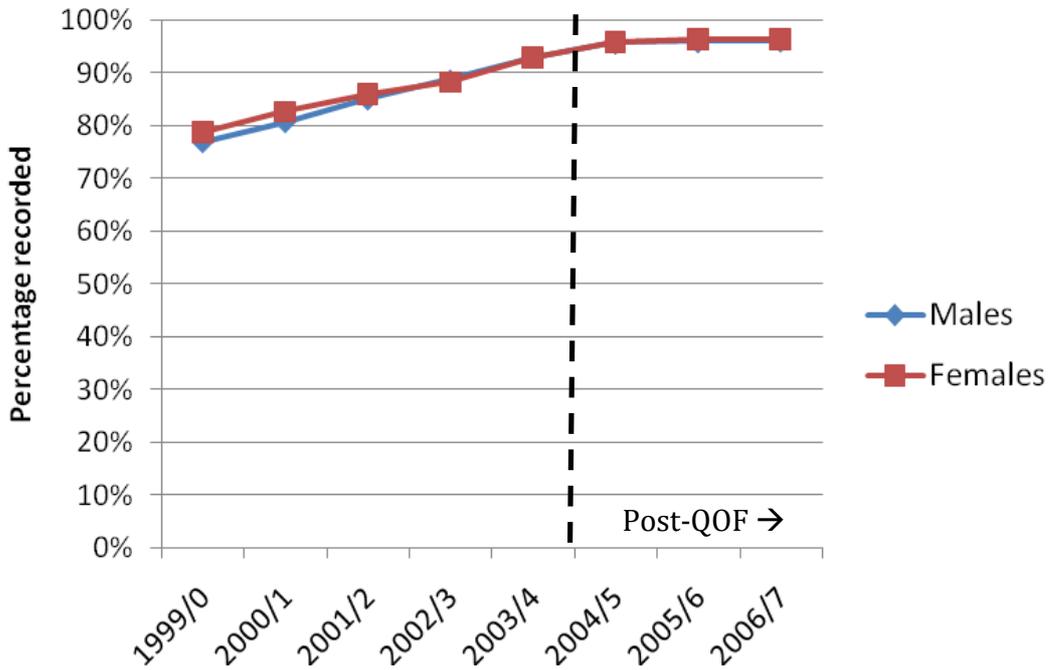


Source: Primary analysis for Marmot Review, NPCRDC 2009i

Quality of primary care under the QOF

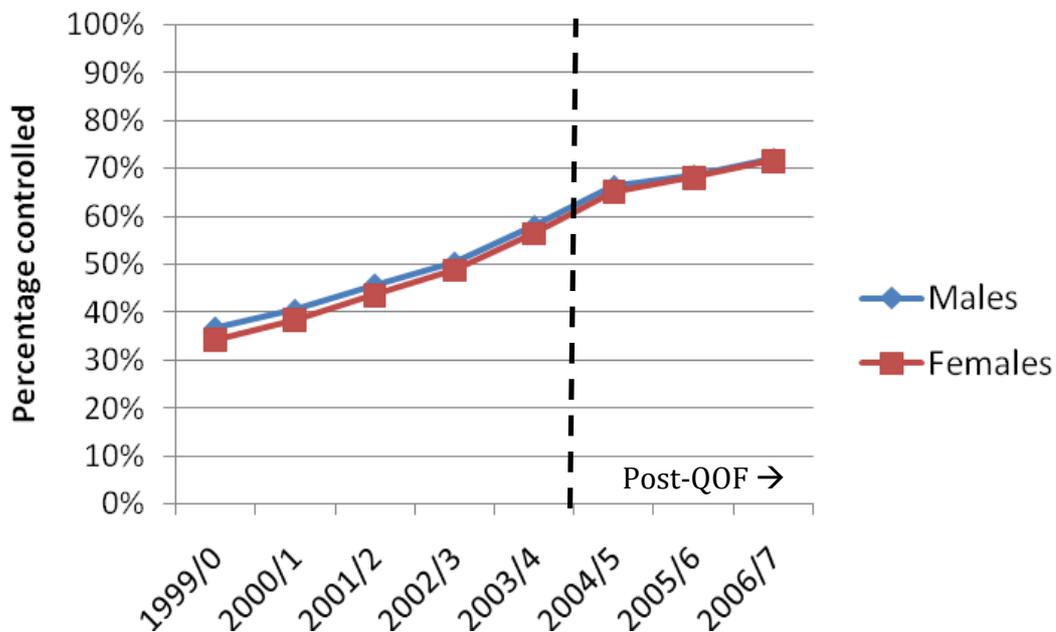
Performance on all the clinical QOF indicators generally improved during the first three years of the scheme (Millett et al 2007i, Doran et al 2008iii, Vaghela et al 2009). It is difficult to establish how much of this improvement was directly attributable to the QOF, as it was introduced uniformly across the country with no piloting, and performance data was only collected routinely from 2004 to support the scheme. However, evidence from representative samples of practices suggests that quality was already improving prior to the introduction of the scheme in 2004/5 (for example, see figures 3.2 and 3.3). Tracker studies have found modest accelerations in improvement in quality of care for diabetes and asthma under the QOF, but not for coronary heart disease (Campbell et al 2007).

Figure 3.2: Proportion of diabetic patients whose blood pressure was recorded by 150 practices drawn from the General Practice Research Database, 1999/2000 to 2006/7



Source: Primary analysis for Marmot Review, NPCRDC 2009i

Figure 3.3: Proportion of diabetic patients with blood pressure $\leq 145/85$ mmHg in 150 practices drawn from the General Practice Research Database, 1999/2000 to 2006/7

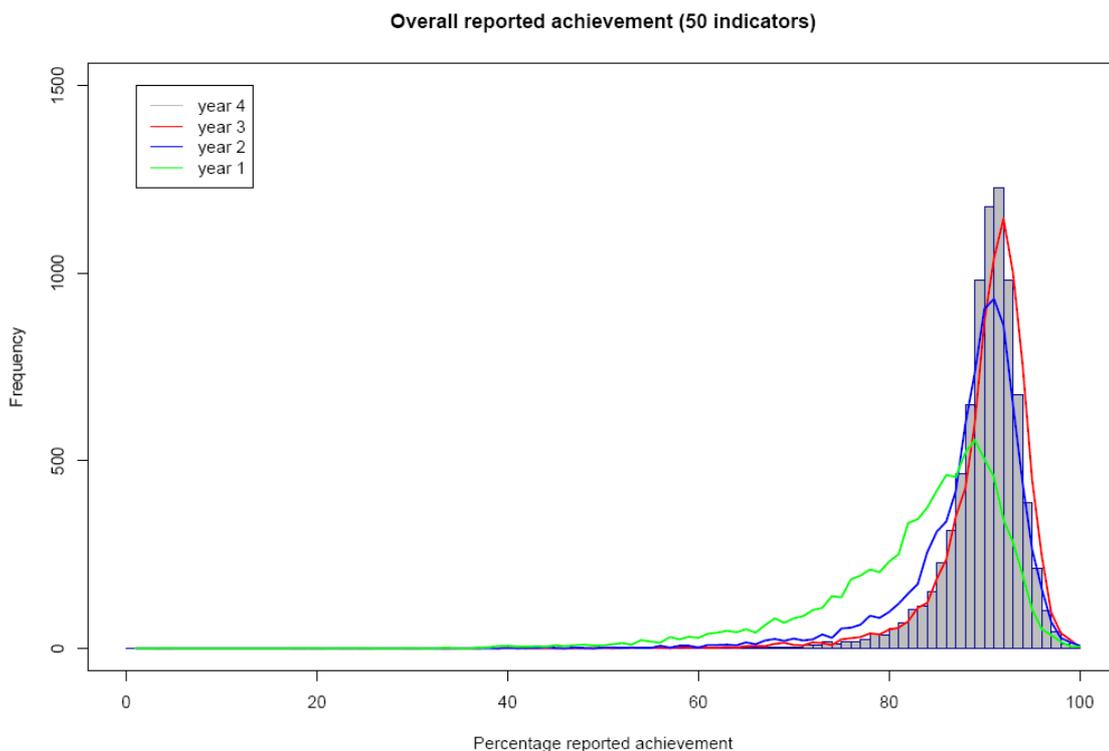


Source: Primary analysis for Marmot Review, NPCRDC 2009i

Greater use of clinical computing systems may have contributed to the apparent upward trend in quality, with practices becoming more systematic over time in the way they recorded their activity. Practices certainly had a strong incentive to record their activities after the introduction of the QOF, in order to qualify for the incentive payments. However, improvements in quality also extended to activities such as control of glycaemia and cholesterol levels, which were recorded by external laboratories and not by the practices, which suggests that at least part of the improvement was genuine. The improvement in quality pre-QOF may be attributable to the many quality improvement schemes implemented over the period, for example clinical governance and National Service Frameworks for the most common chronic diseases, but as with QOF, it is difficult to attribute improvements to any one scheme. Indeed it may have been the combination of activities that was responsible: a common feature of successful health-related quality improvement initiatives is a multi-level approach with supported learning, development of effective teams, clear accountability, and the appropriate use of information technology (Ferlie and Shortell 2001). The QOF not only had the necessary infrastructure in place, it was introduced into practices that had been made repeatedly aware of the need to monitor and improve quality. Improvements in quality of care under the QOF diminished over time, so that the greatest improvements occurred in the first year (2004/5), with very little improvement in the fourth year (2007/8) – see **figure 3.4**. Given the upward trend in quality for most activities pre-QOF, it is feasible that quality of care would have reached its current levels without the QOF, but one or two years later. For many activities, particularly those concerned with measurement processes and those starting from a high baseline performance, a ceiling may now have been reached beyond which little further improvement is possible. For these activities the QOF now serves to maintain performance rather than to improve it, and in terms of population health gain there would be greater benefit in ‘retiring’ the relevant indicators in favour of others with potential for quality improvement (Informant 5).

The deceleration in improvement for most indicators may relate to the maximum achievement thresholds, which for the majority of indicators have been set far below average levels of achievement. For example, for indicator CHD 8 (coronary heart disease patients with cholesterol ≤ 5 mmol/l) the maximum threshold was initially set at 60%, and 84.3% of practices achieved above this level in 2004/5 (**figure 3.5**). Even though the threshold was increased to 70% in 2006/7, by 2007/8, 95.4% of practices were achieving above the maximum threshold. This raises the question of what motivates practices under the QOF, as most do more than is required to secure maximum remuneration under the scheme. Competition and reputation may therefore be more important than money (Campbell et al 2008), as may professionalism. It also suggests that the maximum thresholds – which were intended to reflect what is practically achievable by practices and to stimulate improvement – have been set at too low a level. Increasing the thresholds to a more appropriate level may stimulate further improvement by practices, but these higher standards may be more difficult to achieve for practices serving deprived populations. Higher thresholds may also lead to higher rates of exception reporting, as practices will seek to maintain their income through more diligent identification of patients to whom the indicators do not apply, and will face a greater incentive to inappropriately exclude patients. These pressures may be greater in more deprived areas, and a steeper socio-economic gradient in exception reporting may emerge as a result.

Figure 3.4: Reported achievement on 50 'stable'* clinical QOF indicators for 7.870 practices in England, Year 1 (2004/5) to Year 4 (2007/8)

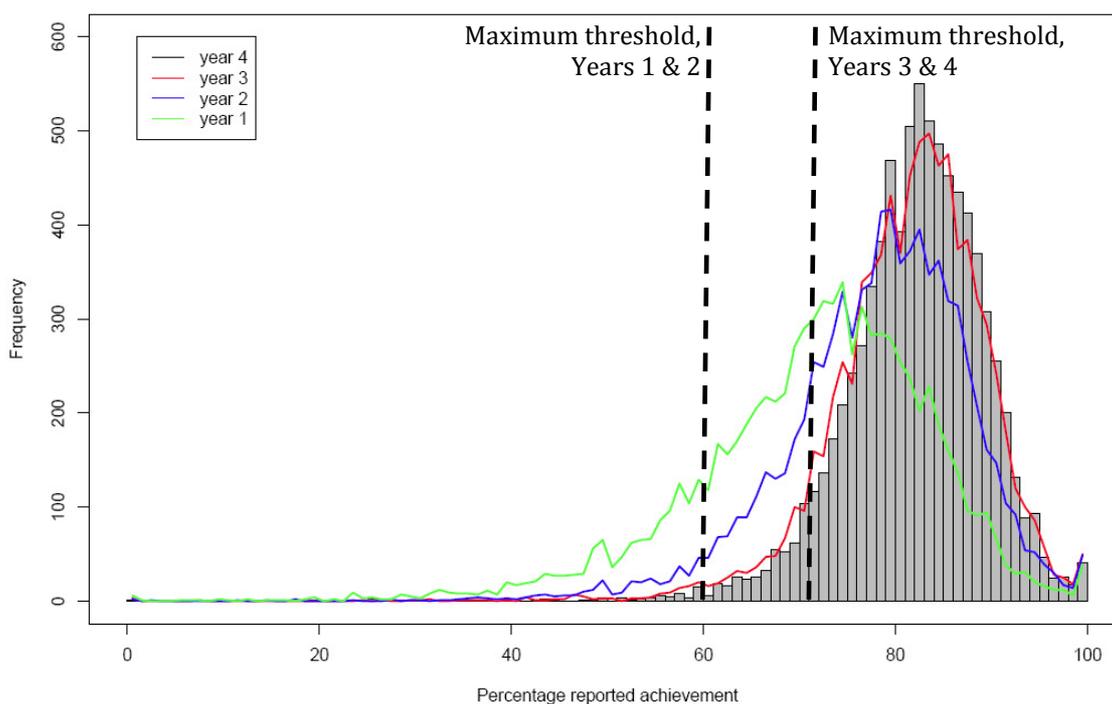


Source: Primary analysis for Marmot Review, NPCRDC 2009ii

*** Stable indicators are those that were unmodified between 2004/5 and 2007/8**

Mean achievement: Year 1 82.3%; Year 2 87.8%; Year 3 89.7%; Year 4 90.0%.

Figure 3.5: Reported achievement on CHD8 (coronary heart disease patients with cholesterol ≤ 5 mmol/l) for 7.870 practices in England, Year 1 (2004/5) to Year 4 (2007/8)

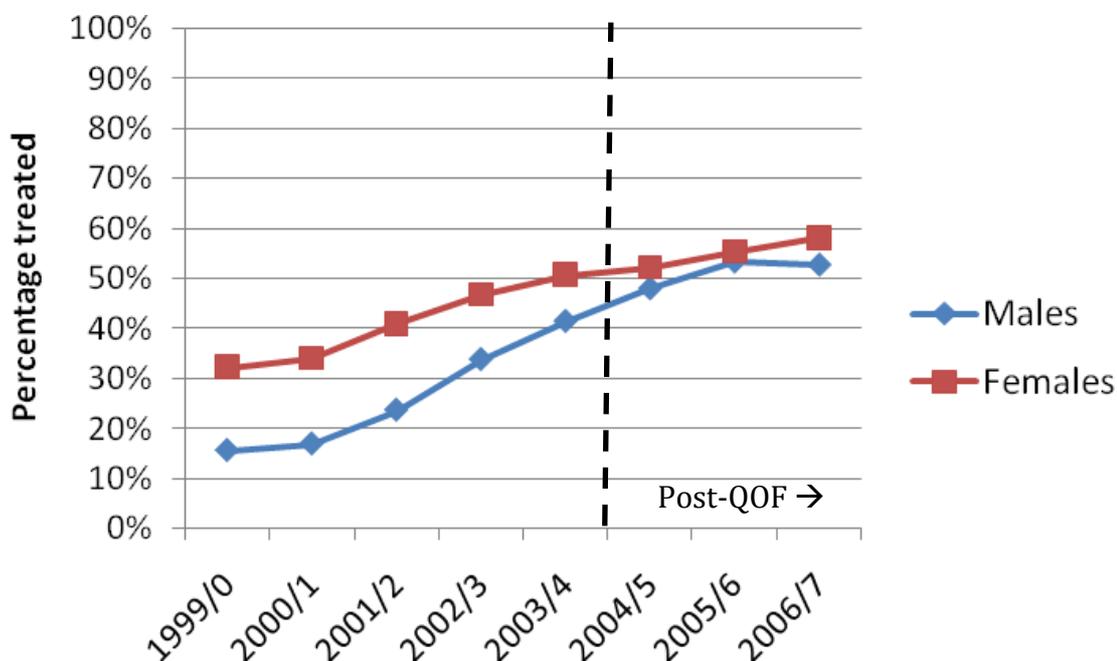


Source: Primary analysis for Marmot Review, NPCRDC 2009ii

The QOF is likely to have had effects beyond the incentivised activities. At the time it was implemented some commentators were concerned that neglect of non-incentivised activities would be an inevitable consequence of a financial incentive programme (Heath 2004), whereas others predicted that specific incentives would lead to overall improvements in quality of care by focusing attention on quality improvement (Lester 2006). The actual effect of the QOF on non-QOF activities is difficult to assess, as data is not routinely collected for all practices. Studies have therefore relied on records from samples of practices and relate to small numbers of practices (e.g. 42 in Campbell et al, 2007; 150 in NPCRDC 2009i) or patients (e.g. 1156 in Steel et al, 2007). These small studies suggest that there is some spill-over to other activities for QOF-incentivised conditions, but not to activities relating to non-QOF conditions. For some of these non-QOF activities, trends in quality do not appear to have been affected at all – for example: trends in prescribing for patients with osteoporosis do not appear to have been affected, positively or negatively, by the introduction of the QOF (**figure 3.6**). For others – for example treatment of depression, prior to its inclusion in the QOF – quality stagnated (Steel et al 2007). In interviews practice staff did not believe that the quality of care they provided for non-incentivised aspects of care had suffered, but neither did they believe it had improved at the same rate as for QOF conditions (Maisey et al 2008).

Whilst the pressure to perform under the QOF is acknowledged by most practitioners, there is disagreement over whether other aspects of care have been neglected as a result, for example according to Informant 1: “I look after patients because they’re patients and they’re ill. I’m not really too fussed about whether I get a QOF point for it or not. I don’t think about QOF in my day-to-day thinking about patients... It’s nonsense to suggest that if it isn’t in QOF it’s not done.” (Informant 1) Whereas Informant 5 maintains: “It makes what is measurable important... I think there is more money in it than there should be – it has focused attention away from other things more that it should have done, or indeed needed to do.” (Informant 5)

Figure 3.6: Proportion of patients with osteoporosis treated with bisphosphonates, selective oestrogen receptor modulator, HRT, parathyroid hormone or calcitonin in 150 practices drawn from the General Practice Research Database, 1999/2000 to 2006/7



Source: Primary analysis for Marmot Review, NPCRDC 2009i

Evidence for improved health outcomes

Most QOF clinical indicators relate to process activities rather than patient outcomes. This raises two issues: whether these processes reflect and encourage best practice, and whether they result in improved outcomes. There has been criticism that some indicators reward what is measurable, rather than what will necessarily improve patient wellbeing (Heath 2007). Practices which have scored highly on the stroke indicators, for example, have been found, on detailed examination, to be providing poorer quality care – in terms of adherence to specialist treatment guidelines – than those with low scores (Williams and de Lusignan 2006), suggesting that there is a mis-alignment between best care and points for some indicators. In this situation, practices with lower baseline performance may concentrate their efforts on scoring points at the expense of providing the highest quality of care.

With respect to improved outcomes, the evidence is mixed. Weak associations at best have been found between practices' scores on the QOF and hospital admission rates for epilepsy, coronary heart disease and diabetes (Shohet et al 2007, Downing et al 2007, Bottle et al 2008i, Bottle et al 2008ii). Other factors, including availability of services and area deprivation, appear to be more strongly related to hospital admissions rates. Research to date has, however, been based on small samples of practices and/or has used a single year of data. Points scored also do not necessarily reflect quality of care provided, because practices can score the maximum number of points without achieving the targets for all patients due to the upper achievement thresholds. There is evidence emerging that improved achievement of targets for glycaemic control – in terms of the proportion of patients

for whom the targets have actually been reached – is associated with modest reductions in emergency hospital admissions for complications of diabetes (Dusheiko 2009). Given that the QOF focuses on chronic conditions, it will be several years before its effects on health outcomes can be fully assessed. In the meantime, the incentives in the QOF to refer patients for specialist assessment and to screen for complications, particularly in the case of chronic kidney disease, coronary heart disease and diabetes, have led to increased workloads in secondary care, which does not benefit from the incentive payments. For a range of reasons, including those discussed above, it is difficult to assess the cost effectiveness of QOF activities: robust cost-effectiveness evidence is only available for a few QOF activities, mainly relating to prescribing; the activities are not performed in isolation, either from other QOF activities or other quality improvement initiatives; and cost-effectiveness depends on baseline activity and the number of points (and hence pounds) allocated to the activities (CHE 2007).

One vital omission in the research evidence to date is the views of patients. The QOF indicators are all clinically determined and framed, and there is evidence that as quality of care as defined by clinical interventions improves patient satisfaction can actually decrease (Weyer et al 2008). Practices are therefore under pressure to hit targets that may not be valued by patients, and some practices have reported being less willing under the QOF to allow patients to decline treatment, despite the provision to exception report (Campbell et al 2008). Patient experiences and outcomes were largely overlooked in the first few years of the QOF, with practices able to collect points relatively easily for administering and reflecting on patient surveys. Nationally in 2007/8 practices achieved 97.2% of the available patient experience points. However, externally administered and collated patient surveys may have a more substantial role on future versions of the QOF. This is essential, because if improvements in quality – as measured by the QOF indicators – do not correlate with improvements in patients' subjective well-being, the system is failing (Doran et al 2008i).

Effect on health care inequalities

In the first year of the QOF scheme practices in more deprived areas made fewer referrals for investigations – possibly due to a lack of access to secondary care services or practice-based equipment (Ashworth et al 2007i) and were less likely to provide certain treatments – for example statins (Ashworth et al 2007ii). They also tended to have lower rates of achievement generally on the QOF indicators (Doran et al 2006, Strong et al 2006, Wright et al 2006), with the greatest differences for: treatment of epilepsy and severe mental health problems (Ashworth et al 2007i); intermediate outcomes – such as control of blood pressure (McLean 2006); and organisational indicators (Wang et al 2006). This did not just affect practices in the most deprived areas, there was a clear socio-economic gradient in achievement across all areas. Well organised and training practices were able to compensate to some extent for patient social disadvantage and achieve high QOF scores (Ashworth et al 2007ii, Gulliford et al 2007). Variation in achievement also increased with area deprivation, with the worst performing practices in the most deprived area having substantially poorer achievement rates than the worst performing practices in the most affluent areas (Doran et al 2008iii).

There are several possible reasons for the gradient in performance. Compared with practices in affluent areas, practices in deprived areas are more likely to be small, have large ethnic minority populations, have a low ratio of GPs to patients, and to have older GPs educated outside the UK (Doran et al 2008ii). All these factors are independently associated with poorer performance on the QOF (Doran et al 2006).

Training practices, which tend to perform well, are also less common in more deprived areas (Ashworth et al 2008).

Practices in deprived areas also generally have to work harder in order to achieve the same level of care as practices in more affluent areas (Hippisley-Cox et al 2004). This immediately places them at a disadvantage with respect to the QOF. This was compounded by the QOF payment formula, which adjusted payments to practices for disease prevalence using the Adjusted Disease Prevalence Factor (ADPF, **see section 2**). This formula applied a square root transformation to disease prevalence and also truncated prevalence in practices with low disease prevalence, treating them as if they had higher prevalence and increasing their remuneration accordingly. As a result practices with higher disease prevalence, particularly smaller practices, received less remuneration per patient than those with low prevalence – in extreme cases up to 30 times less (**table 3.2**). As practices in deprived areas are more likely to be small and to have high disease prevalence, they were systematically disadvantaged by the payment formula, which had the effect of distributing resources away from deprived areas. The ADPF has been scrapped for 2009/10, meaning resources will be more equitably distributed in future, but also that practices with low prevalence of the QOF conditions will have reduced income from the QOF.

Table3. 2: Example of payment to practices under the QOF

	Practice A	Practice B
Number of patients with CHD	30	30
List size	560	23,324
Prevalence of CHD	5.4%	0.13%
CHD points achieved	101	100.5
Payment	£850	£25,063
Payment per patient with CHD	£28.33	£835.33

Source: Guthrie 2006

Despite these disadvantages, practices in deprived areas improved at the fastest rate in the first three years of the QOF. Between 2004/5 and 2006/7 the gap in median achievement between practices in the most affluent and the most deprived 20% of areas in England narrowed from 4.0% to 0.8% for the clinical indicators (Doran et al 2008iii). Improvements in performance were strongly inversely associated with baseline performance but were not significantly associated with area deprivation – i.e. the worse a practice performed in year 1 of the scheme the more it tended to improve, and being located in a deprived area was no impediment to that improvement. This pattern was repeated for the primary preventive QOF activities – for example: by 2006/7 rates of blood pressure screening for the over 45s were 87.9% in the most affluent 20% of areas and 87.7% in the most deprived (Ashworth et al 2008). This narrowing in quality across the social gradient may reflect performance approaching its achievable limit in affluent areas following several years of continuous improvement, both pre- and post-QOF, with practices in more deprived areas lagging some years behind.

Not all population groups may have benefited from the improvements in quality under the QOF to the same extent. Small, local studies suggest that ethnic inequalities have remained for some indicators, with black and south Asians groups less likely to meet intermediate outcome targets for diabetes (HbA1c ≤ 7.4%, blood pressure ≤ 145/85 mmHg, and total cholesterol ≤ 5 mmol/l) than whites (Gray et al 2007, Millett et al 2007, Millett et al 2009).

The very rapid improvement in the worst performing practices may have been in part attributable to the use of a sliding scale for allocating points and payments, which links the level of remuneration directly to the level of improvement. This means that practices with low baseline performance, rather than facing unattainable absolute achievement thresholds, are rewarded for even modest improvements. The use of absolute targets in other pay-for-performance schemes has resulted in only the highest achievers being rewarded, so the money goes to the providers who arguably need it the least (Rosenthal et al 2005).

It is important to note that performance on the QOF indicators is largely self-reported by practices with a financial and a reputational incentive to report high levels of achievement. Achievement scores can be inflated by over-reporting the numbers of patients for whom a target has been achieved or by inappropriately excluding patients for whom the targets have been missed (Gravelle 2007, Doran 2008iii). Unambiguous evidence of fraudulent reporting is difficult to obtain, but can be inferred to some extent from suspicious patterns of achievement. For example, following the introduction of the QOF recorded blood pressure values just above the QOF targets became significantly less frequent and values just below significantly more frequent (Carey et al 2009). As the perverse incentive to over-report achievement is greater for worse performing practices, there is a risk that – if substantial numbers of practices have succumbed to this perverse incentive – the apparent gains in health care equity under the QOF may, in part, be illusory.

If the gains are genuine, the QOF has the potential to make a positive impact on health inequalities. Most of the life expectancy gap between the most and least materially deprived parts of England is attributable to QOF conditions such as cancer, coronary heart disease and chronic obstructive pulmonary disease (DH 2007, Doran et al 2008iii) – although the cancer indicators form a very small part of the scheme. If improved quality of primary care leads to improved outcomes, then more equitable primary care should reduce health inequalities. The overall impact of the QOF on health inequalities will also depend, however, on its effect on equity of non-incentivised aspects of care. Inequalities could have widened for such activities, with practices in deprived areas devoting more of their resources to meeting the QOF targets.

Whether overall positive or negative, there are limits on the impact the QOF can have on health inequalities as it does not address the underlying socio-economic causes – nor would it be expected to – and it focuses on secondary prevention for existing chronic disease, with few elements of primary prevention. It has been argued in some quarters that more QOF points should in future be devoted to primary preventive activities (Praities 2008). It has also been argued that more points should be allocated to treatment and intermediate outcomes activities at the expense of measurement and recording activities, so for example: smoking cessation advice and treatments – and even non-smoking rates – for all patients would be prioritized over simply recording the smoking status of patients with existing chronic diseases (HC Select Committee 2009). To date, such changes have been resisted by BMA negotiators, who – for example – rejected the recommendations of the Expert Review Panel to include cardiovascular screening and prevention indicators in the 2008 version of QOF (Informant 4).

Harnessing the QOF to address health inequalities in general, and to improve primary prevention in particular, makes two basic assumptions: that general practice is responsible for primary prevention; and that the QOF is an appropriate vehicle to improve primary prevention within general practice. The first of these assumptions

has been challenged by some, for example Informant 4: “Primary prevention is not the biggest part of our remit, that’s... public health.”(Informant 4); and Informant 1: “I’m not there to give treatment for lifestyle, I’m there to advise on lifestyle: I can’t make people not smoke, or not eat the wrong food. If you want people to not smoke or eat the wrong food you make it bloody hard to get hold of those things... If you’re serious about stopping people eating burgers, shut down McDonalds.” (Informant 1)

Others have identified a role for general practice in a wider framework if there is evidence for effective interventions: “The issue of primary prevention is difficult, because the evidence on primary prevention is much less clear than the evidence for secondary prevention. It was entirely right in the 1990s that the UK should focus on secondary prevention, because that’s where the greatest health gains were to be made. Because care for chronic disease has improved so much that equation is now changing and the balance now needs to be shifted back towards primary prevention. Sending children to doctors to get thin is not going to be helpful, but they [general practices] need to be part of a strategy, which includes weighing fat kids when they pitch up.” (Informant 5)

If general practice does have a role, the question is then whether it is appropriate to incorporate primary preventive activities within the QOF. Incentives are only fair and effective when the person or organization incentivised has the means to change the relevant parameter (Informant 5). If responsibility for tackling obesity, for example, is shared across general practice and local authorities, how far each is held responsible for different components of a broad strategy or for local outcomes will be difficult to establish. For discrete activities QOF may be well suited to primary preventive activities: “I think it [QOF] is perfectly alright as a vehicle for that [primary prevention]. The best examples we’ve got are population screening for blood pressure over 40... immunization, cervical cytology... basically you’ve got a denominator, and that’s what you need for primary prevention – a denominator and an intervention – and a practice list remains the best denominator... for most things.” (Informant 5)

For other activities, the technical challenges of framing QOF indicators may make it inappropriate: “...It [using QOF to address primary prevention and health inequalities] is being said by people who don’t really understand how you might operationalise an indicator that could... address health inequalities.” (Informant 4) If an indicator can be framed, the QOF negotiators then need to agree to include it in the framework. Failure to reach agreement in the past has resulted in the loss of potentially valuable indicators: “The idea of health check for people with learning disabilities was evidence-based and would most certainly have addressed some of the health inequalities issues for that group. However four nation agreement over its introduction proved impossible.” (Informant 4)

If the QOF is to become more oriented towards addressing health inequalities in the future, there are therefore many obstacles to overcome, both cultural and technical, and it should not be regarded as the only vehicle for addressing health inequalities within general practice.

Effect on practice culture, behavior and earnings

In order to meet the demands of the QOF, practices have had to become more systematic in the way they identify patients, provide care and record activity, and paper-based practices have had to move to computerised notes (Maisey et al 2008). The requirement to achieve centrally-determined clinical targets based on guidelines and standardized treatments was seen by some practitioners as at best a threat to clinical judgement and autonomy (Heath 2007), and at worst unethical (Mangin and Toop 2007). The attachment of financial incentives to the targets raised fears that the

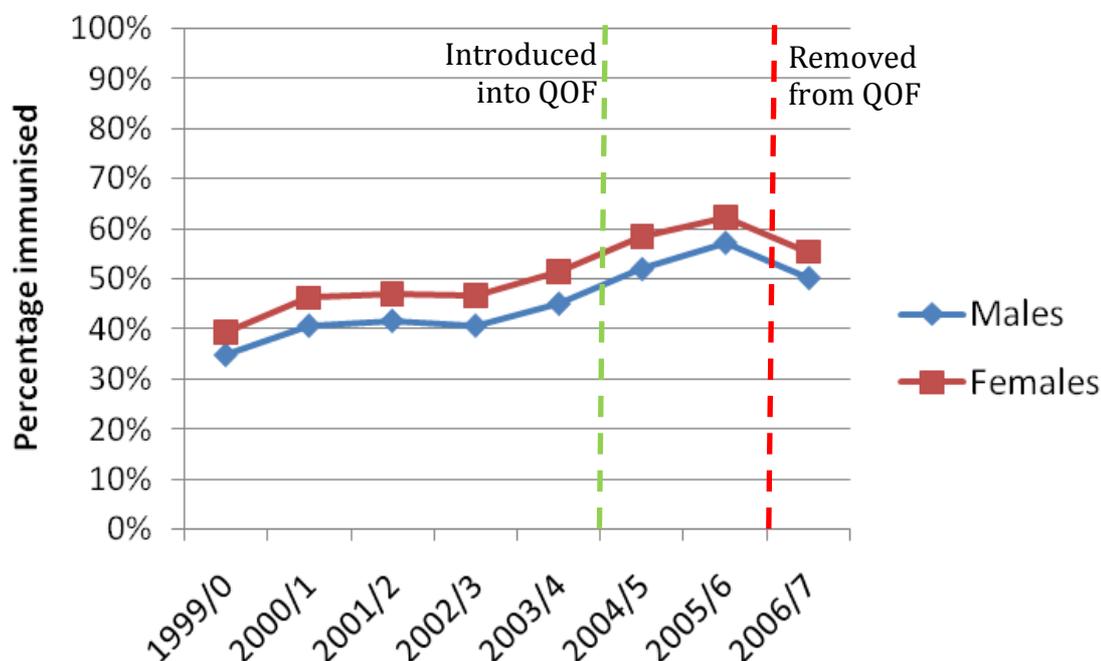
treatment of patients was being broken down into a series of isolated tasks that would have financial rather than clinical value (Wald 2007). This approach undermines the ideal of fiduciary medical professionalism, which places the health of the patient above the economic self-interest of the doctor (Hendrickson 2008). However, all methods of paying medical practitioners carry these risks. For example, capitation payments reward practices with similar populations equally regardless of the quality of care provided. As providing better quality care is generally more expensive, capitation payments carry a perverse incentive to provide poor quality care. Proponents of pay-for-performance would therefore argue that linking remuneration to quality of care aligns physician self-interest with the best interests of the patient in a way that other payment systems fail to do (Hendrickson 2008).

When interviewed, practice staff have been found to pursue incentivised targets whether they believe they uphold professional values or not, but generally have more enthusiasm for those that do (Maisey et al 2008). QOF indicators introduced in 2006/7 for chronic kidney disease, depression and obesity in particular are seen as being less relevant. With regard to patient consultations, there is an aspect of a dual QOF-patient agenda, with the health promotion component of the consultation made explicit by QOF-related computer alerts, which some practitioners find intrusive (McDonald and Roland 2009). Practice staff cite several dangers of the QOF approach: focusing on 'harder' biomedical data at the expense of 'softer' patient-centred information; deskilling of doctors in dealing with chronic disease; lack of training in non-QOF areas of care; decline in continuity of care and the personal relationship between patient and practitioner; encouragement of a pharmaceutical approach to care; and the prioritisation of efficiency over genuine quality (Elwyn et al 2006, Campbell et al 2008, Checkland et al 2007, Maisey et al 2008). Most of those interviewed are confident that they can withstand such dangers and maintain their professionalism, although they worry about others. One of the main concerns with a financial incentive scheme is that intrinsic motivation will be eroded (Deci 1999, McDonald et al 2007). There is conflicting evidence for this effect with respect to the QOF. The over-achievement – relative to the maximum payment thresholds – of most practices on most indicators (for example, see **figure 3.5**) suggests that altruism or professionalism may be a strong factor in practices' performance on the QOF indicators. This may reflect the efforts made in the design of the original indicators to align the financial incentives with professional values (Roland 2004). Conversely, when indicators have been removed from the QOF, as occurred with the indicator for immunising asthmatic patients against influenza, there have been substantial reductions in achievement rates (**figure 3.7**). In 2006/7 practices lost a financial incentive to immunise asthmatics (£1,500 for the average practice) and a reputational incentive, as performance was no longer monitored or publicly reported once the indicator was removed from the framework. This suggests that when extrinsic motivations are withdrawn the activity becomes less important to practices.

In terms of morale, surveys suggest this has improved from a generally low base for general practitioners under the QOF, despite the misgivings noted above, which in part relates to the reduction in hours under the new contract – an average of 4 hours per week – and the increase in pay – an average increase of £19,000 (26%) per year (Whalley et al 2008). There has also been a general increase in satisfaction with the amount of responsibility and job variety provided under the new contract. Many nurses, who often lead on the QOF activities and deliver routine care for the chronic diseases, also state they value the increased responsibility, but there is some resentment that the financial rewards associated with the QOF have not equitably distributed (Elwyn et al 2006, McDonald et al 2007). Whilst practices are judged corporately on their performance against QOF targets, the payments are made to practice partners and the partners decide how the money is distributed – there is no

requirement that payments be invested in facilities, equipment, staff or anything directly relating to patient care.

Figure 3.7: Proportion of asthmatic patients aged 16 and over immunised against influenza in 150 practices drawn from the General Practice Research Database, 1999/2000 to 2006/7



Source: Primary analysis for Marmot Review, NPCRDC 2009i

Following the money trail within QOF is not straightforward. By 2007/8 over £1 billion per annum was being distributed in QOF payments, and between 2004/5 and 2006/7 over 4,000 additional physicians were recruited to general practice, a 15% increase (NAO 2008). Between 2002/3 and 2005/6 the income of principals increased by an average of £41,600 (58%), although this was followed by a slight reduction in the following year when the QOF targets changed. By 2006/7 the average income of a non-salaried GP was £107,000, with 997 GPs (3%) earning in excess of £200,000 (IC 2009). In contrast, between 2002/3 and 2005/6 the income of practice nurses and salaried physicians increased broadly in line with inflation – for salaried GPs this equated to an increase of ~£2,200 pro rata (3%). So the QOF succeeded in closing the gap that had developed between the incomes of non-salaried general practitioners and hospital consultants, but also resulted in a dramatic increase in income inequalities within practices.

3.4. FINDINGS AND LESSONS FOR THE FUTURE

Main findings

- The QOF costs the NHS over £1 billion per annum, with a substantial proportion of the money it brings into practices invested in senior general practitioner income.
- The QOF was not designed to address health inequalities, but by incentivising higher quality, systematic care for common chronic diseases it has the potential to do so. Its success in this regard is dependent on the whether the

apparent improvements in the quality and equity of delivered care under the QOF translate into long-term health gains for patients.

- The QOF also has the potential to increase health inequalities by diverting attention away from non-incentivised areas of care, particularly for practices with sicker and more deprived populations which generally have greater difficulty in achieving QOF targets.
- In the first five years of the QOF, payments to practices did not fully reflect the level of morbidity in the practice population. The payment formula was corrected in 2009, so that resources should, in future, be better matched to need.

Specific recommendations to improve equity aspects of QOF

- The ongoing reviews of both existing and potential new QOF indicators – conducted by the National Institute for Health and Clinical Excellence – should include a formal and comprehensive assessment of their impact on health care inequalities.
- Consideration should be given to including more primary preventive activities in the QOF, where these activities are appropriate for general practice and can be operationalised as QOF indicators. However, the QOF should not be viewed as the only vehicle for promoting primary prevention within general practice.
- The provision to ‘exception report’ patients should be retained. Exception reporting allows practitioners to exercise their clinical judgement and patients to opt out of care. It therefore ameliorates some of the perverse incentives of pay-for-performance schemes to coerce or to refuse care to patients.
- Maximum payment thresholds should be revised annually in light of patterns of achievement by practices. The effect of raising thresholds on levels of, and socio-economic gradients in, achievement and exception reporting should be closely monitored.
- Minimum payment thresholds, if raised, should be set at such a level that they continue to provide an incentive to practices with low baseline performance to improve.
- Indicators for which quality of care is generally high and variation in quality is low should be reviewed for possible ‘retirement’, but activity for these indicators should continue to be monitored.
- Activity data for non-QOF conditions should be routinely monitored.
- Data on quality of care should be monitored at the individual patient level, and linked to socioeconomic and demographic characteristics.

PART 4

Case study on sustaining a strong population health perspective within the health system

Mark Exworthy

4. The Global Report recommends “*expand the health sector policy and programmes in health promotion, disease prevention and health care, to include a social determinant of health approach, with leadership from the Minister of Health*”.

Above all, this requires a system that takes a population health perspective, capable of going beyond the individual needs of registered patients or users of services. The UK system is already oriented towards prevention and health promotion to a greater extent than in many other countries, in that it includes these services within the comprehensive package covered by the NHS. Most importantly, it has had highly developed systems for taking a population health perspective on monitoring needs and delivering appropriate responses, ranging from protection against communicable diseases such as the current swine flu epidemic to environmental control, prevention, promotion and multi-sectoral work on social determinants of health. This population health perspective contrasts with an approach limited to registered patients or users of services, where sections of the population can slip between two stools and only expressed needs for treatment services are addressed.

The English public health system works well with many positive features. However it has been ‘damaged’ by recent re-organisations. Key questions include

- Which re-organisations have ‘strengthened’ public health and which have ‘damaged’ it?
- What system aspects have been particularly affected?
- Which mechanisms might be developed to address strengths and shortcomings?

‘Re-organisation’ is defined as significant changes in health system structure and process. This case study presents results from three analyses:

- Policy analysis (section 4.1)
- Literature review (peer reviewed and grey) and interpretation (section 4.2.)
- Informal interviews with key stakeholders (section 4.3.)

4.1: Re-organisations in past 20 years: selective policy chronology and assessment

Year	Policy / event	Impact on public health system
1988	Acheson report into community medicine	Re-definition of CM to public health medicine (and later to public health) with consequences for PH workforce
1991	NHS internal market	Purchaser/provider system, Trusts, & GPFH. Formation of PH Departments in HAs
1992	Health of the Nation	Public health emphasis welcome but overtaken by health-care concerns. But “Continual organisational turbulence and resulting staff turnover were perceived as frequently disrupting management teams” (<i>HOTN-policy assessed</i> , para.2.10),

		(Hunter/Fulop)
1997	Health Action Zones	Perception that HAZs were not successful due to lack of performance management
1998	Independent Inquiry (Acheson Report)	4 impacts on policy: Climate of opinion / Prompt to new policies / Inequality dimension to current policy / Source book (Exworthy et al, 2003)
1998	Public Service Agreements	Public health objectives set for DH and other central government departments
1998	"Our healthier nation" green paper	Seeks a <i>"third way between the old extremes of individual victim blaming on the one hand and nanny state social engineering on the other."</i> Emphasis on partnerships. Targets in CVD/stroke, accidents, cancer, & mental health (though not equity-focused)
1998	Sure Start	Emerged from 1998 green paper (national child-care strategy)
1999	"Saving lives" white paper	Follow-on from OHN (1998). Emphasis on prevention, with targets. Signs of a new focus on individuals
2000	NHS Plan	Chap. 13 (on HI) but largely about health-care reform. HI targets announced. Whitehead: positive about <i>"the setting of the new overarching resource allocation objective for the NHS: 'to contribute to a reduction in avoidable health inequalities'</i>
2000	Public Health Observatories	Regional centres for collation, interpretation and dissemination of public health data
2000	National Service Frameworks	Creation of national service requirements in 9 high priority conditions but some with <i>'local'</i> implementation
2001	Shifting the balance of power	303 PCTs created. PH function fragmented. Emergence of PH Network
2001	Non-medical specialists	Regional differences in approach (eg. DsPH appointments)
2001	Health Select Committee report on Public health	Strong evidence that re-organisation was a significant impediment. Public health structure was not perfect but further re-organisation not desirable. SBOP announced shortly afterwards
2002	HMT Cross-Cutting Review (HI)	Influenced PSA targets for dH and other departments.
2002	Wanless (I)	"Securing our future health. Taking a long-term view"
2004	Foundation Trusts	Semi-autonomous agencies within the NHS, with regulator (Monitor) <i>'separate'</i> from DH
2004	Healthcare Commission	From CHI/CHAI. Re. public health agenda - recommends that <i>"the drive for delivery is sustained without the distraction of further national policy or structural changes"</i> (2008)
2004	Wanless (II)	"Securing good health for the whole population"
2004	Spearhead PCTs	Evidence of shift to secondary prevention. Geographical overlap with Neighbourhood Renewal. SDH focus but still project-based
2004	Patient Choice ('Choosing health')	Debate on impact in terms of inequality Proper vs Le Grand
2005	Practice Based Commissioning	More decision-making power over NHS resources to general practitioners (GPs), and allow them to design and deliver completely new services or commission others to do so
2004	Local Area	Priorities for a local area agreed between central

	Agreements	government and a local area (the local authority and Local Strategic Partnership) and other key partners at the local level
2004	QOF	Incentives to improve quality of general practice services
2005	NICE	Incorporating public health from former Health development Agency
2006	PCTs re-configured	152 PCTs. 80% of PCTs are coterminous with local authority. Sense that non-medical specialists 'lost out' in merged PCTs. Third of Faculty PH membership now non-medic.
2006	"Our health, our care, our say"	Emphasis on community-based services (cf. acute care) and greater public involvement
2006/07	NHS Operating Framework	Health inequalities included as a priority for NHS organisations
2008	World Class Commissioning	Competencies include inter-sectoral working but little else on health inequalities
2008	Health Select Committee inquiry (health inequalities)	Published March 2009

4. 2: Evidence of the impact of re-organisations on the public health system

The literature search generated 283 references. From reading the abstracts of these references, it was thought that 85 of these references (30%) might be relevant to understand and analyse health care inequalities in the NHS. Of these 85 references, 38 (45%) were of high-moderate relevance, 26 references (31%) were of weak or no relevance and 21 references (29%) could not be retrieved.

There appeared to be nine recurring themes emerging from the 38 references, which are discussed in turn:

- The need for community involvement or community partnerships
- The need for effective multidisciplinary team working
- A 'target culture' causes inequality policies to be given less priority or ignored
- A constantly changing organisational structure (and consequent changes in processes) prevents health practitioners from focussing on health inequalities
- Divides in central and local policy implementation
- Whose responsibility is health care?
- Research issues
- Devolution within the UK (Scotland, Wales, NI) and it's impact on health gaps
- The role of NHS/Social staff in adopting a population health focus

4.2.1. The need for community involvement or community partnerships

"Communities are meant to be at the heart of partnership" (DETR 2001, cited in Brigden 2006:40)

The idea of community involvement has been at the centre of many of New Labours initiatives to reduce health inequalities in the most disadvantaged areas of the UK (Blackman, 2006). Since its landslide victory in 1997 the labour government has called for the "NHS to put more of its effort into the communities with the greatest needs and seeking out the people at risk" (Hewitt 2006:1101) and have insisted that

the “impact on the local economy and local community is taken fully into account” (Hewitt 2006: 1101).

In stressing the role of community in reducing inequalities of health care, the government has implemented several initiatives such as Health Action Zones (HAZ's) in 1997 (Bauld et al) , the New Deal (Hewitt 2006), Wanless II (2004) and “our health, our care, our say” (2006).

Bauld et al (2005) examine and analyse the implementation of HAZ since its conception in 1997. They suggest that, despite its downfall due to “an ever-expanding list of new initiatives to transform public services and promote social justice” (Bauld et al 2005: 427), they should be praised for their emphasis on community involvement which, they believe, did *lead to improved health care in some areas. This is emphasised by Barnes et al (2004) who stated:*

“Community involvement was... a key feature of the new ways of working that were developed and which started to contribute to improved health among engaged HAZ initiatives” (Barnes et al 2004, Cited in Bauld et al 2005)

Bauld et al (2005) conclude that HAZs worked at a local level due to the “experiential knowledge of community members [which] was an important contribution to designing projects and developing strategies” (p.439). They also suggest that the work of HAZ's activities were also able to “[push] health inequalities as a priority up the local agenda and made them more visible” (see also Smith et al 2009), which often improved the health of excluded groups such as travellers, prostitutes and street drinkers that were often ignored by other policies and also were able to establish health promotion at a local level.

Hewitt (2006) has also praised community involvement initiatives for improving local health inequalities and looks particularly at small neighbourhood (Braunstone) in Leicester which had benefited from a “New Deal” scheme with the local residence winning extra funding for a new sports centre to be built to improve the fitness levels of the local community. She concludes that “the impact of regeneration is significant...the NHS should be on the side of poor communities every time” (p.1101).

However, whilst Bauld et al and Hewitt have noted some positive aspects to community initiatives, the majority of community schemes have been approached with much caution and criticisms have been made surrounding the lack of or abandonment of community involvement despite advocating a “community centred approach” (Shaw 2006, Tenbensen 2008, Wise 2008, Willis 2008, Dixon 2007).

In research conducted in New Zealand, Tenbensen et al (2008) highlighted how involving the local community in governmental initiatives to reduce health inequalities can be very difficult despite the implementation of community groups, scheduled meetings and consultation/discussion groups. The main problems cited by Tenbensen et al are very much aligned with the problems experienced with UK initiatives.

First, there was a difference in the level and nature of community engagements within districts as well as between them. This was particularly noted by Willis (2008) who analysed area-based initiatives such as “New Deal for communities” and “Sure Start” that attempted to break cycles of deprivation. Milne (2009) who looked at the health qualities among older people in rural England, discovered that rural populations were less engaged or absent from the implementation of policy at a national level.

Dixon et al (2007) also noted the difference in community engagement between areas, notably between the more affluent and poorer populations and their engagements with their GP's. They state that access to specialist services are controlled by GP's and therefore different members of the community will be entitled to different services due to an ability to communicate symptoms and needs more effectively, education and home resources such as the internet, which enables them to be more aware of the services that they are entitled to. They state "a major reason for the inequality in use of specialist care within the NHS may be that the better off have a louder voice than those less well off". It is therefore the need for policy makers to make sure that all voices are heard in addressing new policies.

Second Tenbensen et al (2008) discovered that, while initiatives did increase community consultation, they had little impact on strategic planning. They stated "Maori groups...acknowledged the DHBs [district health boards] had made efforts to consult them, but had doubts about the degree to which Maori views were taken into account in local planning" (p.1147). This was also discovered by Wise 2008 in her research in Australia. These points have parallels with community involvement and planning in the UK.

In contrast to Tenbensen et al, Shaw et al (2006) studied the relationships needed to improve health inequalities in the UK. They noted that, despite the advocacy for community participation in primary health planning, "those participating in the study did not discuss relationships with their local communities in...depth" (p.85). They therefore assert that local authorities need to "build closer relationships with local communities" (p.85)

In conclusion, the literature concentrating on the UK and elsewhere (New Zealand and Australia) has emphasised that there is significant "recognition of the need to work with and for communities to ameliorate the effects of material, social and political disadvantage and more positively to redistribute material resources, information and political power more equitably" (Vinson 2004, cited in Wise 2008). However, more needs to be done to establish and continue these relationships to sustain an equitable future and reduce health inequalities for the most disadvantaged communities. As Crowley emphasises, "public health will only regain its core purpose by forging partnerships with local communities" (p.265)

4.2.2. The need for effective multidisciplinary team working

In addressing health inequalities through national and local initiatives, effective multidisciplinary team working, partnerships and "joined-up thinking" are deemed essential (Hewitt 2006; Bauld et al 2005; Smith et al 2009; Exworthy and Peckham 1998; Exworthy et al 2006; Hunter and Sengupta 2004; Hunter 2008; Callaghan et al 2000). In emphasising partnership working, Hewitt (2006) draws on the development of the white paper "our health, our care, our say" to demonstrate how New Labour are committed to "stronger partnership working" (p.1100). Additionally, the NHSE (1998) claims "Successful [partnerships] will be those that can harness the range of skills necessary to learn and work together for an effective partnership which will improve patient care" (NHSE 1998 cited in Callaghan 2000:20)

Bauld et al (2005) highlight the need for collaborative and partnership working to reduce health inequalities through her examination and analysis of HAZ's. She states the only way for HAZs to be successful was through the partnerships that were

created in different areas such as “Sure Start”, “New Deal for Communities”. This is emphasised by:

“The HAZ initiative was intended to be a partnership-based programme, and HAZ’s were best understood as a collection of agencies, groups and individuals rather than as organisations in their own right. Whatever was achieved by HAZs was achieved through collaboration across organisational and sectorial boundaries” at the local level.” (Bauld et al 2005: 438)

Drawing on the work of Wilkinson and Applebee (1999), Bauld (2005) concludes that the HAZs demonstrate that “cross-sectorial partnerships are easier to establish within localities than across broader geographical areas” (Wilkinson and Applebee 1999 cited in Bauld 2005:437) and that complications in communication often arise at the local-national boundary which puts a strain on collaborative and partnership working due to different priorities and agendas. This is emphasised by Huxham (1996) who states “difficulties in making collaboration work...centre on differences in aims, language, procedures, cultures and perceived power” (cited in Callaghan et al 2000:19).

Exworthy et al (1998) suggests that partnership working can be improved by understanding and examining the coincidence of geographical boundaries between partnerships, known as coterminosity. They suggest that there are three main benefits; communication, responsibility and common approach between services which can improve partnership working and joint purchasing in health and social care.

In contrast to the positivity surrounding partnership or multidisciplinary working, Smith et al (2009) emphasis the assumption amongst English policy makers that partnerships are a good thing and suggests that this assumption is never questioned but it believed to be essential in achieving positive public health outcomes. In the paper, they question the efficiency of partnership by suggesting that partnerships are costly and that the impact on health incomes are not clear because focus is usually on the processes of partnership rather than the outcomes.

Also in this paper Smith et al (2009) focus their attention on the partnership working in HAZs and conclude that partnerships do not create direct health improvements. They suggest three main reasons for this; first partnership working was rarely defined and partnerships were often regarded as successful if they were supportive rather than the achieving health outcomes. Second, it was difficult to attribute health outcomes with partnership working (see also Exworthy et al 2006) and third partnerships often shifted or changed over time periods and therefore clear partnership working could not be tracked.

In his editorial “Building multidisciplinary public health”, David Hunter (2004) suggests that the productivity of multidisciplinary team working between medical and non-medical professionals for reducing the health gap is unknown. He states “certainly it remains uncertain how far the commitment to developing a multidisciplinary public health workforce in the UK will go and at what pace”. He looks particularly at the implementation of “shifting balance of power” in 2002 and how it fragmented public health into regional government offices, strategic health authorities and Primary Care Trusts (PCT’s), which has resulted in mounting demands on public health resources in PCT’s and therefore is not conducive to addressing health inequalities. Hunter suggests that in order to get these multidisciplinary teams working together they need to define and clarify their individual tasks so that they are not duplicated or neglected.

At a national level, partnership working has also been heavily promoted by the Labour government under the title 'joined-up government' (Health Select Committee, 2009) This is evident, *inter alia*, in the designation of health inequalities as the subject of a Cross-Cutting Review by HM Treasury in 2002 and the introduction of Public Service Agreements across ministries. This emphasis on joined-up government represents a shift from vertical, service delivery to horizontal, collaborative government (Peters, 1998). Whilst there has been some progress in embedding joined-up government (Health Select Committee, 2009), enduring challenges remain (which bear a striking resemblance to previous efforts). These include the dominance of ministries (as centres of power for ministers and civil servants) and a lack of a powerful counterweight to ministries (Exworthy, 2009).

4.2.3. A 'target culture' causes inequality policies to be given less priority or ignored

It has been noted that the increasing pressure on the health service due to government targets or a 'target culture' has led to policies relating to inequalities of health to be given less priority and sometimes 'diverted' due to other targets, which are viewed as more important (Bevan and Hood 2006; Crowley 2005; Evans 2004; Tenbenschel 2008; Graham 2004). Therefore progress to address health inequalities has been slow. This is emphasised by Crowley (2005) who states "the health inequalities picture in Britain has been well reported over many years, yet action to tackle these inequalities, despite the setting of national targets, remains unimpressive" (p.265; emphasis added).

Exworthy et al (2006) argue that targets are only way in which to measure the progress of policies to tackle health inequalities. Targets are not in and of themselves a 'problem'; indeed, many public health practitioners called for 'health inequality' targets following the publication of the Acheson Inquiry report (1998) which did not recommend them (Exworthy et al, 2002a). However, the incentive regime comprising targets (for health inequalities vis-a-vis other policy imperatives) is crucial to the achievement of their objective.

Evans (2004) demonstrates that inequalities in health priorities are often 'diverted' due to being "swamped by targets". In struggling to balance health care targets policies relating to inequalities are often pushed to the end of the agenda and therefore given less priority, this is particularly so at a local level. Evans (2004) writes:

"[A]t a local level PCT's and their partners struggled to balance the very specific and challenging targets set by the PPF, especially the politically sensitive ones to reduce NHS waiting times, with the much broader requirements in the cross cutting review to break the cycle of inequalities and strengthen disadvantaged communities" (p.70)

Evans (2004) emphasises that policies relating to inequalities of health were able to be given less priority because chief executives and other managers were not held accountable for failing to meet objectives in inequalities. However, failure to meet other targets such as the reduction waiting times did have serious consequences for chief executives such as redundancy (see also Exworthy et al (2002b)). Therefore other health priorities were deemed as more important due to tougher consequences.

However, it is not just the lack of accountability that is preventing inequalities from being addressed. Hunter (2008) states that there is a lack of "policy coherence" and

clarity (policies being too vague), which has caused frustrations and confusion in those trying to implement policy (see also Graham 2004). Hunter states “there is widespread suspicion and frustration that government policy pushes and pulls in opposing directions, for example widening inequality gaps in one direction...while prioritising them in another”. He continues that target benchmarks are also shifting due to changing policy focus such as government control over health to that of individual control over one’s own lifestyle which makes addressing inequalities very difficult.

Bauld et al (2005) also examines the problems of targeting in addressing health inequalities through the implementation of HAZs. They suggest that HAZs appeared to fail because they were not given enough time to flourish (see also Tenbensel et al 2008) and that targets often had tight deadlines and concentrated on the need for early wins rather than longer term considerations that are helpful in addressing inequalities.

Despite the negativity surrounding the ‘target culture’, Bacon et al (2007) and O’Dowd (2008) suggests that “targets provide a useful starting point” (Bacon et al 2007:152) in addressing health inequalities because they “focus attention on addressing inequalities. O’Dowd emphasises this point by stating;

“The important thing about target is that there can be no messing about. It focuses your mind. By focusing on shorter term objectives to start with we will be paving the way for the things that help towards longer term objectives” (O’Dowd 2008:2)

Despite these positive additions, the majority of the literature has suggested that a ‘target culture’ has been detrimental or counter productive to the priorities of health inequalities. This is emphasised by Graham (2004);

“Targeting disadvantage will not deliver the relative improvements needed among those in the middle tiers of the socioeconomic structure to reduce health inequality across the population” (Graham 2004:126)

The Health Select Committee (2009) noted data problems in designing and implementing the targets for health inequality in England.

4.3.4. Frequent changes in organisational structure and processes prevent health practitioners from focussing on health inequalities

Much has been written about the difficulties and problems in addressing health inequalities due to shifting policy, changing structures of health organisations and changed partnership working at both the local and national level (Killoran and Kelly 2004; Evans, 2002; Evans 2004; Hunter 2008; Graham 2004).

Hunter (2008) has highlighted how restructuring the public health system at the centre has “hampered” the health system at the local level. He points to incoherence at the centre in regards to policy and resources that has prevented inequalities from being addressed at the local level. He surmises;

“If the notion of a public health system lacks coherence at the centre, it is not surprising that those working in the ‘system’ at a sub national level struggle to make sense of conflicting policies, resource deficits and a workforce that is fragmented, and in some areas under strength” (Hunter 2008:1044).

The lack of coherence and clarity of policy goals during organisational restructuring of shifting policy emphasis is also noted by Fotaki (2007), who suggests that addressing health issues productively was “impeded by the lack of clarity in formulating policy goals” (p.330, see also Cameron et al 2008 and Graham 2004).

Highlighting that consistency is beneficial to addressing health inequalities, Hunter (2008) implies that initiatives such as HAZs and healthy living centres did go “some way towards indicating the potential for healthy public policies and showing what a public health system could achieve” (p.1045). However, it is clear that they did not go far enough due to shifting partnerships and targeting thus emphasising the negative effects of constant change and reorganisation to health care policies.

Fotaki (2007) also looks at the problems of organisational change on health care policy and suggests that mergers are particularly hazardous to addressing inequalities in health care (see also Blakely 2009). During this time staff become over-stretched and stressed during this period with managerial tasks and therefore will not be able to focus on other tasks and policies. To explain this point she draws on the work of Wilkin et al (2001):

“[PCT’s] may be overwhelmed by managerial demands and a heavy workload arising from organisational changes associated with mergers and transitions to trust status, and will therefore not be able to devote adequate resources to changes that will produce health improvements” (Wilkinson et al 2001, cited in Fotaki 2007:313)

Also, constant restructuring and shifting policies are causing confusion amongst health professionals as they struggle to keep pace with governmental changes. Professionals struggle to know who is responsible for implementing goals and who might be accountable if these policies fail. Hunter (2008) has also suggested that due to policy changes professionals feel that they no longer have “a sense of ownership” over health policy as it is taken away from them at the national level (see also Exworthy et al, 2002).

It has been suggested however that change and restructuring might not be detrimental in addressing health inequalities or other policies if the government could learn from the mistakes of previous policy implementations (Exworthy and Powell 2000; Kiloran and Kelly 2004; Evans 2004; Freeman 2007). However it is clear that “government has yet to learn from previous policy failure on inequalities” (Exworthy and Powell 2000 cited in Evans 2004) and therefore change and restructuring is only problematic to addressing inequalities in health.

In conclusion it is evident that shifting policies and organisational restructuring has caused achievements in health inequalities to be “modest and fragile” and therefore detrimental to the reduction in health gaps.

4.2.5. *Divides in central and local policy implementation*

Throughout the literature, it has been noted that there has often been a divide between the policies implemented centrally to reduce health inequality and the implementation of these policies at a local level. (This mirrors wider debates at inter-governmental relations). This has caused a debate as to where are interventions best targeted and whether this divide has helped or hindered the cause for reducing health inequalities. It is clear from the literature that they majority of writers believe that the divide between local and national policy implementation has caused friction and complications for improving health equity. However, much rests on the assumptions about the causes of health inequality (Exworthy and Powell, 2004). If it

is assumed that health inequality is derived from income inequality, then fiscal measures at a national level would be suitable whereas if the assumption concerns a lack of social capital locally, then local interventions would be sensible. Currently, central and local interventions are pursued but it is unclear what the balance between these should be (ie. the relative contribution in reducing inequality). (See section 6 below)

Much of the literature has suggested that although health inequalities are being addressed at the national level, the implementation of policies are often “patchy” at the local level (Exworthy et al 2002; Brigen 2006; Tenbenschel 2008; Blackman 2006; Hunter 2005; Bauld 2005; Graham 2004; Wills 2008). This is emphasised by Exworthy et al who state; “once issues are on agenda, an ‘implementation gap’ between national objectives and local action is likely” (Exworthy et al 2002:80; Lipsky 1980; Hill 1997).

Many reasons have been given for inciting the ‘implementation gap’. First, targets were seen to cause an implementation gap because “targets were left to local discretion” (Exworthy et al 2002:82). Targets have hampered the implementation of health inequalities at a local level because they have been “pushed off the local agenda by the overwhelming number of other national imperatives” (Exworthy et al 2002: 86; Brigen 2006; Evans 2004). Evans (2004) illustrated how local PCTs struggled to implement health inequality targets at a local level due to other national health policies and priorities. Bauld et al (2005) also highlighted that partnerships between local and central hampered the work of HAZ. They state “overly pragmatic approach to delivering change places an emphasis on top-down change processes that are at the detriment of lateral, cross agency working” (Bauld et al 2005:437)

In alignment with the targets and the number of health policies and priorities, Tenbenschel (2008) looks at the problems of addressing health inequalities in New Zealand. Similarly to evidence in the UK, Tenbenschel found that whilst overall he felt that central government had been successful in reducing health inequalities, implementing policies was often patchy and some areas were better at implementing changes to reduce health gaps. He states “achievement of progress [in some areas lagged] behind their own and government expectations” (Tenbenschel 2008:1148). This emphasises a quotation made by Pressman and Wildavsky (1973), which states “great expectations in Westminster may be dashed locally” (cited in Exworthy 2002:83).

Second, due to policy the “state has been hollowed out” (Jessop 1994, cited in Exworthy 2002:83) and therefore the connections between local and centre are increasingly complex (Exworthy and Powell, 2004). There are multiple centres and localities which means that “central government is...less able to steer these networks that have been created in the differentiated polity” (Rhodes 1997, cited in Exworthy 2002:83). To explain how the threads between the centre and local operate Exworthy et al draws on Kingdon’s model (1995) which looks at policy streams and how they can remain separate until government or policy entrepreneurs place them together. With the policy streams separated inequalities in health can not be addressed adequately. However, “when both national and local windows are aligned, greater opportunities for policy may thus be created” (Exworthy et al 2000, cited in Exworthy et al 2002:83) and therefore inequality gaps can be reduced. Further complexity has been added by the internationalisation of health inequalities within some public health competencies being ceded to supra-national organisations such as the EU.

Third, connected to policy streaming and the lack of central thread between central and local agencies is the lack of communication, clarity of policy and support

between the two levels. These lacunae have left local bodies confused about which policies should have priority, how to implement them locally and how national targets might be different from local initiatives already in place (Graham 2004; Bauld et al 2005; Hunter 2004, 2008; Blackman 2006; Exworthy et al 2002). Demonstrating this notion through the implementation of national targets at the local level Blackman writes;

“[Confusion] at local level about how to express a national target as a target for specific local authority area, to frustration that there has been little support for local bodies with developing plausible models of how their interventions will achieve targets within the timeframes envisaged” (Blackman 2006: 76)

Exworthy et al (2002) also note that some national policies are not greatly different from local initiatives and therefore they were “rebranding” or “rebadging what agencies were already doing” highlighting communication problems between the national and local levels.

Set in contrast to the negative aspects of the divide between local and central agencies Klein suggests that the divide has been beneficial to addressing health inequalities at the local level because it gives local agencies autonomy, a sense of achievement and “more space for decision making” which is able to address equity problems that are central to the disadvantaged areas. However, it is clear that the majority of the literature has criticised the divide between central and local levels for not being productive in addressing health inequalities.

4.2.6. Whose responsibility is health care?

Since New Labour came into power in 1997 different policies have been implemented to reduce inequalities. In alignment with policy changes, ideas regarding who is responsible for health care and reducing health gaps have also shifted. At the start, central government was deemed responsible for the population’s health and reducing health inequalities (Hunter 2008; Hewitt 2006). However, over time, these ideas shifted and central government placed greater responsibility in the hands of the public. They decided that inequalities in health should be reduced by communities and the individual, and that they would support individual lifestyles changes through health care promotion (Hunter 2008; Macintyre, Hewitt 2006; Willis 2008; Crowley; Hunter 2005). Such shifts were redolent of the debates around ‘Health of the Nation’ (1992).

Hunter (2008) demonstrates how New Labour’s vision for reducing health inequalities was embedded in a “whole system approach” and for government to take responsibility for the public’s health rather than allowing individuals or “small scale interventions” to take responsibility for reducing health inequalities (see also Bridgen 2006). He emphasises this by stating that “policies aimed at individuals would be inadequate...or small scale interventions will not be sufficient” to reduce the health gap (Hunter 2008:1044). Therefore government needs to take responsibility for the public’s health at a national and local level. Yet, others claim that the first term of office (1997-2001) was marked by a series of marginal initiatives which failed to ‘bend’ the mainstream (Exworthy et al, 2003).

In a similar vein to Hunter, Hewitt (2006) demonstrates how government at local and national levels should take responsibility for the public’s health. However, she states that the government should not take full responsibility for reducing health gaps but that a partnership between the community and government should be established so

that they share the responsibility for reducing inequalities. Hewitt suggests that government should support the public's access to health care and healthy lifestyles by offering better education and information about healthy eating and provide them with help and better services for exercise and provide them with capacity to have a healthy lifestyle. The public should be encouraged by prevention programmes (smoking and obesity) set up by the government and learn to take responsibility for their own health (see also Crowley and Hunter 2005).

In 1999 New Labour began to shift the responsibility of health to the individual with the publication of the white paper "Saving lives: our healthier nation" (DoH 1999, cited in Wills et al 2008). By the time "Choosing health: making healthier choices easier" (DoH 2004) was published, the transition of responsibility from government to individual was in motion. Klein (2006) has criticised this move suggesting that it has caused healthy living to become "commoditised" and that it has caused outbreaks of moral panics regarding obesity and teenage pregnancies. However, Willis et al (2008) has praised the success of initiatives such as smoking prevention but suggests that banning smoking in public places does indicate that the government is still continuing to take some control and responsibility over the public's health choices.

Macintyre (2000) highlights how the emphasis on responsibility has shifted from central government to the public through health promotion and action teams which have been implemented to reduce health inequalities by helping individuals to improve their lifestyles. She states the remit of action teams were "to persuade more people to play their part in achieving better health by adopting a healthier lifestyle" (2000:1399). In order to achieve this action teams had to look at the causes of poor lifestyle, not only by looking at the individuals health choices but a more holistic view looking at the social and physical environment in which individuals live and promote health prevention schemes. Macintyre advocates action teams by stating;

"If we seriously want to try and reduce inequalities in health we should try to reduce the structured social inequalities which create them, rather than focusing on the immediate short term risks that are manifestations of an unequal society" (Macintyre 2000:1400)

Sheiham (2000) agrees with Macintyre (2000) that other factors need to be considered in addressing inequalities but disagrees with the idea that individuals should be solely responsible for their health, as some people are unable to make healthier choices. She states "By focussing attention on individual choices, the behavioural approach leaves unchallenged most of the structural causes of disease. Victim-blaming implies that individuals freely choose these health damaging behaviours and that they are responsible for the consequent diseases. Thus the health implications of social and economic aspects of society remain unhidden" (Sheiham 2000:353; see also Dixon et al 2006).

In conclusion, responsibility for health has shifted over time from being solely the responsibility of the government to a more collaborative or shared responsibility for taking control of health to the current remit which aims to give individuals responsibility for their own health care through health promotion schemes and better information and education on healthy living and lifestyle changes.

4.2.7. Evidence into practice?

The majority of the articles were based on literature or policy review (50%), in comparison very few were based on 'field' research (qualitative (18%) and quantitative (14%) and 14% used a combined Qualitative and Quantitative research design). Further, 4% of the literature did not clarify their methodology. It is therefore ironic that an overwhelming proportion of the literature calls for a greater engagement with evidence-based research which measures policy implementation and the outcomes of policy especially in regard to inequalities so that governing bodies can learn from the positive and negative ramifications of past policy implementation (Wills 2008; Evans 2004; Exworthy and Powell 2000; Exworthy 2002, 2006; Shaw et al 2000). Macintyre (2000) highlights the need for evidence based policy by suggesting that evidence-based medicine is well established in the UK, however very little attention has currently been given to evidence-based policy. Summarising the arguments put forward by much of the literature she states;

"It is important that robust methods are developed for evaluating the impact of policies, programmes and projects on the health of the population and of different subgroups" (Macintyre 2000:1400)

Shaw et al (2000) also adds that understanding and having knowledge of historical policy is also important in aiding the implementation and predicting outcomes of new policies. This idea is shared by Wise (2008) whose methodology involved policy review. Wise states in her introduction "health promotion theory, policy and practice have been instrumental in guiding the actions that have resulted in these significant outcomes" (Wise 2008:497 see also Blakely for discussion on how policy review can influence policy implementation)

However, despite the call for greater evidence-based policy making and the use of "robust methods" to guide policy implementation, Exworthy et al (2006) have noted the difficulties of using evidence-based policy ideals for addressing inequalities of health and have sighted seven main reasons for this.

First, there is very little evidence ready for policy makers to use when addressing inequalities. They state "policy makers have wanted to intervene but did not know how" (2006:81). The lack of or weak evidence base has been due to the fact that there is very little evidence to show that policies have worked (see Wise 2008 for discussion on lack of evidence to prove that policy had worked for reducing inequalities in Australia), because policies have either not been implemented for very long and or the policy was changed soon after it was implemented (see Evans 2004 for discussion on the implementation and measurement of HAZs), or because they did not know how to measure if the interventions worked (Exworthy 2002; Brigden 2006; Graham 2004).

The difficulty in measuring whether interventions had worked leads to the second point. Policy makers had trouble knowing whether policies addressing inequalities had worked due to the complex causes of health inequalities. There were also several definitions and examples of what was perceived as a success in reducing health inequalities, which makes measuring the outcomes problematic; several studies found inconclusive results to the effectiveness of some policies (Graham 2004, Shaw et al 2000, Smith et al 2009, Killoran and Kelly 2004). This is illustrated by Killoran and Kelly who state;

“There is little agreement either a priori or post hoc to what changes in inequalities would be regarded as a success or what effect sizes of interventions would be regarded as desirable” (Killoran and Kelly 2004:11)

Due to the difficulties in knowing what to measure, several writers noted the difficulties in finding a connection between outcomes and policies, with many suggesting that addressing outcomes is often not possible. This is emphasised by Smith et al (2009) in their discussions on the implementation of HAZs. They state “it is impossible to conclude to what extent partnership working contributed (or not) to the differences in health outcomes observed in these studies” (2009:8; see also Evans 2004; Dowling et al 2004). Outcomes were also difficult to measure because some groups had previously not been studied in regards to inequalities, for example people living in rural areas (Wills 2008; Milne 2007).

Fourth, inequalities could not be addressed sufficiently because the majority of data and outcomes were measured for their short term or “quick win” status and therefore the long term benefits were not measured or were constrained by government’s preoccupation with short term goals or targets (Tenbensel et al 2008; Bridgen 2006; Graham 2004; Fotaki 2007). Studying the use of community projects (which take longer to be established and work effectively) to reduce inequalities, Bridgen states;

“The development of health policy models that involve, and attempt to empower the public continue to be constrained by the competing requirement of quick wins” (Bridgen 2006:43)

Continuing from the idea of targets, the fifth difficulty for evidence-based policy is the problem of securing accountability for the failures or positive implementation of policy and knowing what was the key to the policies success. In addressing inequalities, it is often easy to shift blame amongst partnerships or hold no-one accountable for failing to meet inequality targets. The lack of accountability in failing to address inequalities has flourished due to pressures of other targets such as waiting times, which are perceived by many as being more important due to the heavier consequences such as redundancy (Evans 2004)

Sixth, there is a debate as to what data should be collected for evidence-based policy that addresses health inequalities. Quantitative data (survey, questionnaire and census) is often favoured over qualitative data (interviews and focus groups) (see Killoran and Kelly 2004; Fotaki 2007; Cameron 2008 for discussions on qualitative and quantitative data). However, Cameron asserts that both qualitative and quantitative data sets should be used in conjunction with each other to address the whole spectrum of health inequality issues;

“Qualitative data let in light often distorting the haze of quantitative health measurement. Qualitative data need to be sought and valued together, in developing measures of health influences, across a whole spectrum of health concepts” (Cameron 2008:231)

4.2. 8. Devolution within the UK and its impact on health inequality

The literature review indicated that the majority of writers did not consider the devolution since the late 1990s when addressing the reduction of health inequalities. Only one article wrote extensively about the differences in the address of inequalities in health care between England, Wales and Scotland (Blackman 2006). In contrast, in the overwhelming majority of articles, the author(s) wrote about how inequalities of care were being addressed in the UK as a whole and therefore did not analyse how

inequalities might have been approached, implemented and might have produced positive or negative outcomes within different parts of the UK. No authors found in the literature search referenced Northern Ireland. Smith (2007) examines the translation of ideas into policy regarding health inequality but this examination does not explicitly draw comparisons between national approaches.

Post-devolution, England, Wales, Scotland (and Northern Ireland) have been characterised by “different policy communities existing in the three countries”. Political devolution did not take place in England but it has been affected by devolution as it has prompted a re-examination of its regional approach and can thus be set in contrast to other nations; see Exworthy 1998. Greer (2006) summarises this difference. The “English approach” is based on a “markets and management” idea that involves a regulated market system where professionals are not typically trusted to run their own affairs of health services. The Scottish approach, in his opinion, is based on “professionalism”, whereby professionals are not challenged by political parties. The “Welsh approach” is characterised by “localism” where health services are run by small local councils and have local representation” (Greer 2006, cited in Blackman et al 2006:74-75). Coterminosity in Wales has been achieved in all Local Health Boards whereas only 8-% of English PCTs enjoy coterminosity with local government.

Exworthy (2002) notes that in Scotland, Wales and England the emphasis on addressing inequalities was varied with Scotland (and Wales) placing greater emphasis on targeting inequalities (eg. Scottish public health white paper, 1999). This was highlighted by House of Commons which stated “the Scottish and Welsh NHS plans accorded higher prominence to the public health agenda” (House of Commons 2001, para 4, cited in Exworthy et al 2002: 82).

Blackman et al (2006) compares England’s target culture with the lack of policy management and target culture in Wales and Scotland to analyse the different impact on health inequalities at the local level within each country. They highlight that many of England’s health policies are measured and compared using target and performance indicators which lead to “positive impacts” (2006:68) due to a “sharper focus on priorities” (2006:67). England has also placed much more emphasis on ‘choice’ as a mechanism for improvement (Clews, 2009). However, in contrast, Scotland and Wales have tended to take a pessimistic view of targeting suggesting that they produce “negative effects” (2006:68). This is a view shared by Hunter (2003) who argues that targets and performance management do not address inequalities of care because they “focus on what can be measured rather than what might be more important” (Hunter 2003, cited in Blackman et al 2006:68, see also Bevan and Hood 2006).

Blackman et al (2006) questions whether the lack of targets for addressing inequalities might be disadvantageous to the Scottish and Welsh population as it will not be given priority. The question that follows helps to frame their paper, they ask;

“Scotland and Wales may be adopting a wise position in not seeking to incorporate this complexity within performance management, but will this mean that the issue has less status in Scottish and Welsh discourses?” (Blackman et al 2006:70)

In answering this question, Blackman et al address key issues such as accountability, responsibility, policy implementation at the local level and “best value” regimes, conflicts between central and local policy requirements and the budget.

In analysing who should be accountable and responsible for addressing inequalities, Blackman et al draw on the work of England's "audit and inspection systems" stating that they assess the performance of health services at the local government and local health trusts to make sure that they are addressing inequalities of care priorities set at the national level. They suggest that all levels (local and national) are "expected to share responsibility for national health inequality targets" and that audits will hope to measure their success and outcomes across England. Blackman highlights that both Scotland and Wales have not begun measuring inequalities in health but suggests that in the near future both countries might turn towards approaches of "performance assessment" due to "frustrations of audit bodies ...about the lack of comparative performance data" (2006:72). However, despite this frustration, the converging of audit and inspection systems might be hampered by "strong political imperatives in both countries to treat local government as a means of expressing and acting on their different local priorities, rather than being dominated by the requirements to implement national targets locally, which is what is regarded as what happens in England" (Blackman et al 2006:72).

Examining the target culture in England, Blackman et al (2006) highlights the difficulties that England has encountered including confusion over how to translate national targets to the local level and the lack of support given to local areas by national bodies. However, despite this criticism, they praise the target culture for focusing goals and allowing outcomes to be measured. They conclude that the lack of measurable is a problem for Scotland and Wales and therefore "performance management in Wales and Scotland is being tightened" (2006:76). Moreover, the "best-value" regime in Scotland and Wales has not had the positive outcomes that England has witnessed

Despite this criticism of Scotland and Wales' "best-value regime", Blackman et al comments that the locally lead health system allows them to have "more autonomy in how they run their services" (Blackman et al 2006:77) and does appear to cause less conflict when working with partnerships. They use a quotation from the DoH to illustrate this point;

"[T]he integrated systems in Wales and Scotland imply an ability to plan and align services with priority such as reducing health inequalities" (Department of health 2006, cited in Blackman et al 2006:77)

However, continuing the quotation, it is clear that the DoH feels that England's approach to addressing inequalities might be more responsive to reducing health gaps in certain areas. The quotation continues;

"[The] English system has the potential to use the market to respond health inequalities, such as tendering primary care services in under-served areas" (Department of health 2006, cited in Blackman et al 2006:77)

Finally, Blackman et al looks at the local government expenditure across the three countries in 2002/2003 and notes that it was much higher per person in Scotland (16%) and Wales (9%) than it is in England. However, this increased expenditure did not reflect "higher levels of activity, such as outpatient and inpatient cases, or shorter waiting time" (Blackman et al 2006:78). They suggest that "the higher spending in Wales and Scotland may be having an ameliorative effect...but tackling their health inequalities is going to take more than the current focus on NHS and secondary prevention" (Blackman et al 2006:78).

Blackman et al 2006 do not come to a conclusion about which nation's approach is more beneficial to reducing health inequality. The tone in which the piece is written suggests that Blackman et al might be advocates of the English system which hopes to "see the benefits of performance assessment...extending to health inequalities, encouraging improvement, achieving greater accountability and enabling lessons to be learnt" (Blackman et al 2006:78).

Whilst some comment devolution has allowed greater responsiveness to local needs (and hence elevate the needs of previously marginalised groups), others have noted the potential for greater variations within the UK/NHS to be evident. Thus, whilst intra-group/area equity might be enhanced by devolution, this might be at the expense of inter-group/area equity (Exworthy and Powell, 2004). Wills (2008) also focuses on the differences in strategies within different territories, concentrating particularly on regions within England. She suggests that health inequalities still persist in poor areas because affluent areas have the means (education and resources) for acquiring appropriate health care for their needs. Such changes raise the perennial question of whether the UK has one NHS or four (Powell, 1998).

Blackman et al (2006: 75) provide a summary of three nations' approach to tackling health inequalities

Devolution and the Emergence of National Policy Discourses		
England	Scotland	Wales
'Markets and management'. Distrust of professionals. New Labour choice agenda.	Traditionally strong professions and nationalist imperative of 'Scottishness' in public policy.	Strong role for local government in policy development and organisation.
Performance management of an NHS now with health inequalities as one of its six priorities.	Professionalism and partnership ethos in the NHS with a health improvement focus.	A 'wider-determinants of health' framework but with weak incentives and sanctions.
Performance management of local councils now with health inequalities as a 'shared priority'.	Performance management of local government but with less targets and often weak engagement with health.	Performance management of local government but with less targets and often weak engagement with health.

At this stage of political devolution in the UK (10 years post-implementation), there remains signs that divergence in policy has developed and been sustained, not least because devolved territories have sought to strike a different 'path' from Whitehall. This is not simply explained by different legislative or tax-raising powers. Over time, isomorphic pressures might suggest greater convergence, though contextual factors (such as health needs, governance and policy communities) might indicate otherwise.

4.2.9. The role of health and social care staff in adopting a population health focus

To produce a population health focus which reduces health inequalities, health and social care staff need to be supportive of their local community and provide them with the appropriate education and information to improve their lifestyles and health conditions (Sheiham 2000; Dixon 2007; Malone et al 1998; Russell et al 2008). In the literature, the main professional groups which are seen as crucial to implementing and sustaining a population health focus are: General Practitioners (GP's) or Clinicians (Dixon 2006, Malone et al 1998; Russell et al 2008) and Dentists and Hygienists (Sheiham 2000).

Russell et al (2008) noted that recently the role of the GP in population health and health prevention has increased dramatically and this has had some benefits to reducing inequalities in health. They state that "most clinical encounters should include prevention support" (Russell et al 2008:716) and that there is evidence to suggest that support during consultation can aid some individuals to make health changes that reduce high-risk health behaviour such as excessive alcohol consumption, smoking, obesity and lack of physical activity. However, writing from an Australian perspective, Russell et al have noted some Australian specific difficulties in or barriers to GP's delivering this service and support to their patients such as the cost of "Medicare payments", which means that those less affluent patients will not be able to afford the service. Although the cost of visiting the GP does not apply to the service in the UK, less affluent patients might not be able to visit the GP due to transportation costs or the ability to take time off work to visit the GP.

Russell et al (2008) also note some other barriers to the role of GPs in supporting population health that are relevant to the UK such as the lack of time that GP's have with each patient, long waiting lists (see also Dixon and Grand 2006; Malone et al 1998; Kumar and Exworthy, under review), not having the appropriate communication skills to translate support and information in layman's terms and finally GPs will have to overcome the obstacle that those needing the treatment often don't perceive themselves as needing the treatment and therefore do not visit the GP Surgery, which means that they do not receive the adequate care and support that they need and thus widening the health gap.

In a similar vein to Russell et al, Dixon and le Grand (2006) also look at the long waiting lists to patients wanting to receive this health care and support, and suggests that long waiting lists often cause GPs to "choose to treat patients who are easier and/or cheaper to treat if they have the opportunity to do so", a practice known as "cream skimming" (Dixon and Grand 2006:164) or "cherry-picking" (Beretta 1996). Dixon and Le Grand suggest that GPs often choose which patient's to treat based on their own "values and prejudices about the worth of treating some patients over others". They state that in the USA "treatment decisions" are likely to be made positively over patients who are able to speak eloquently and that are from more affluent areas. Whilst the arguments put forward in this article draw on experiences in the USA, GPs in the UK may also place such judgements on their own patients and therefore such thinking is likely to increase health gaps by "leaving the most vulnerable groups with limited access to health care (Malone et al 1998:328; see also Spinks 1994; Bradshaw and Bradshaw 1995).

Such ideas are highlighted by Malone et al who studies that rationing of healthcare in the UK and highlights how clinicians are able to act as "gatekeepers of health care" only granting certain people access to resources and care, for example fertility treatment (often by postcode). Malone et al state;

“Traditionally rationing of health care has been the province of the medical profession through their clinical discretion and use of waiting lists. Clinicians could use their clinical discretion to deny services, implying they would have no benefit for the individual patient, or place people on waiting lists which itself could be used a means of controlling demand and denying access” (Malone et al 1998:327)

In analysing access to health care, Malone et al study the difference between GPs providing health care to the individual or to the population and suggests that sometimes it is better to deliver health care that will benefit the whole population but it means that the population will have to “accept a lower level of overall health care” (Malone et al 1998:327)

Sheiham (2000) also looks at the differences of providing population centred health or individual health care from an oral health perspective and concludes that a “population approach directed at changing conditions for all is more likely to decrease inequalities in oral health” (2000:358) and suggests that in order for dentists to achieve this they will have to work with the community (through education) and in partnerships with other health care professionals. He states:

“A whole population...approach and integrating oral health with general health policies, policies to promote oral health should become more effective and efficient....oral health with cease to be marginalised. Dentists must become team players in advocacy and education, working with other organisations , including public-sector and community organisations” (Sheiham 2000:360)

Sheiham advocates population health approaches and suggests that with the support and education and information provided by dentists and other oral health professionals individuals and communities will be able to “increase control over, and to improve, their health and well being” (2000:359) therefore reducing health inequalities.

4.3. Lessons for future on re-organisations

c. Key messages

- i. Strong evidence that re-organisations have been detrimental to public health despite its re-emergence
- ii. Public health still appears to be marginal to core activities of PCTs and wider NHS. Progress remains patchy
- iii. Modest Improvements have been made but on balance, probably not sufficient to make intended in-roads into health inequalities
- iv. Some areas of health policy (affecting public health) seem non-negotiable (eg. patient registration with GPs as independent contractors)

d. Recommendations

- i. The frequency and intensity of structural re-organisation should be limited because of the deleterious effects on the health system and especially public health viz.
 1. Mergers rarely bring expected benefits
 2. Organisational effort deflected for 1-2 years
 3. Public health remains marginalised within broader health system
- ii. Clearer and more consistent frameworks are required for collaboration especially in performance management

- iii. Greater variation on service (quality and type), associated with greater devolution and associated incentives (eg. QOF and FT), must be monitored for impacts on equity

Principles for action:

- **Completing the jigsaw.** Strategies that rely just on local interventions will be insufficient to make a lasting and profound difference to the patterns of inequality across the country. Action at all levels of government and active engagement with civil society and the business sector is required over a sustained period of time (probably a decade or longer).
- **Recognise existing contributions.** Much of the NHS and other welfare services make a remarkable contribution to reducing (health) inequality and addressing SDH. Without them, the situation would be far worse. Specific areas of note here are primary health care, universal benefits, and open access (free at the point of delivery)
- **Resist regular re-organisation.** Health reform should take full account of the wider effects/impacts including the anticipated consequences (positive and negative) upon health equity and the social determinants of health. Formal re-organisation and `natural evolution' of local organisational forms disrupt local partnership working and create planning blight over a period of 18-24 months.
- **Secure local accountability.** Accountability for action and inaction (to reduce health inequality and address SDH) should be more explicit and transparent at the local level, not just to national reporting mechanisms. Such accountability mechanisms would be enhanced by much closer working (and possibly, integration) between welfare agencies at the local level. Recent thinking on systems approaches point toward the benefits of this approach. One implication of local accountability will run the risk of greater inter-area/group variation even though intra-area/group equity will be enhanced. This trade-off should be made more explicit and justified.
- **Create a culture of equity.** Reducing health inequality and addressing the SDH should not be seen as additional activities or objectives but integral to the conduct of a well-functioning health system (in the widest sense of the term). It should become as much as part of the culture of an organisation as quality improvement, for example.
- **Equity starts at home.** The NHS and local government should take greater recognition of their potential to influence patterns of inequality locally through their decision-making (such as employment practices, procurement strategies and internal management of organisations). Inevitably, the extent of reliance of locally-inspired, developed and implemented policies will create the potential for wider variations between areas. This approach should be clearly justified as a response to local needs.

What does not work/areas for disinvestment

The evidence-based movement has placed significant emphasis on the transfer of evidence into practice. This has been captured under the rubric of “what counts is

what works.” This rubric fails on two counts in the field of health equity and social determinants of health:

First, the research evidence on what does not work has become more unequivocal, including:

- Top-down implementation on its own
- Strategies that rely solely on behaviour change
- Strategies that ignore the role of context as a mediating factor

Second, the emphasis on counting is double-edged. ‘Counting’ refers to a largely quantitative measure. Targets based on measurable aspects have their place and should not be ignored. However, there is scope for greater qualitative input, reflecting the degree to which local context shapes and is shaped by interventions. ‘Counting’ also refers to the degree to which the issue matters. In this case, health equity, the potential number of stakeholders involved is significant. Local voices are invariably lost in determining ‘what counts.’ Stronger efforts should be made in this regard, a point which is supported by a greater emphasis on local accountability.

PART 5

Case study on championing partnership work at the local level

Margaret Whitehead, Sue Povall and Don Matheson

The Global Report recommends actions to “*build and strengthen the health work force and expand capabilities to act on the social determinants of health*”.

For the UK, this means, among other actions, developing the health system’s role in acting as a champion and facilitator to influence other sectors to take action to reduce inequalities in health. The case study on local multi-sectoral working synthesises the evidence from attempts by local public sector agencies in the UK to work together over the past two decades on the social determinants of health. First, we ask: what does effective multisectoral work actually entail? To answer this question, we give examples from around the country of this kind of working. Second, we summarise what the extensive literature says about what helps or hinders this kind of joint working by local agencies. Third we focus on the current PCT and local authority context in which frontline staff are operating to ask: what specific mechanisms help or hinder their efforts to work on the social determinants of health? The whole leads to principles for action.

5.1. What does effective multisectoral work look like?

The following examples from Liverpool and Belfast illustrate what is involved in local partnership work on the wider social determinants of health.

5.1.1. Liverpool *Healthy Homes* initiative

Paula Grey, Director of Public Health for Liverpool PCT and City Council, in the following example, explains the ongoing *Liverpool Health Homes* initiative for tackling housing and living conditions as important determinants of health. Liverpool is a post-industrial city in the North West region of England with a population of approximately 500,000. Poor housing conditions are believed to cause up to 500 deaths and around 5000 illnesses requiring medical attention in Liverpool each year. Of further concern is the fact that Liverpool has one of the highest rates of excess winter deaths in the UK which means that 250 of the most vulnerable residents die in the winter months each year, the majority of whom have poor housing conditions, which is a key contributor to these deaths. Poor quality housing affects physical, social and emotional wellbeing and causes illness and death through excess cold; increased infection; asthma and other respiratory illnesses. Homes can also be dangerous with injuries to vulnerable and older people arising through falls (in 2007 there were 522 hip fractures in older people in Liverpool); electrocutions; fire and other accidents. The wellbeing impact of poor housing conditions ranges from depression to social exclusion.

It is widely acknowledged in Liverpool that a significant proportion of properties within the private rented sector are sub standard, increasing the chance of occupants suffering preventable ill health, and also contributing to health inequality. One operational problem, however, has been a critical lack of resource to effectively tackle this issue, which generally only allows intervention on a reactive basis, when complaints are received from residents. A new *Healthy Homes* Initiative was devised to address with lack of resource and effort.

A partnership of local public and voluntary organisations has been formed to tackle unhealthy housing conditions in Liverpool. The partnership involves Liverpool NHS Primary Care Trust (PCT) linking up with Liverpool City Council, Merseyside Fire and Rescue service and local voluntary agencies for vulnerable groups such as elderly people (e.g. Age Concern). The aim of the partnership's *Healthy Homes* Programme is to reduce preventable death and ill health due to poor quality housing conditions in the Liverpool private rented sector (including Registered Social Landlords). It aims to do so through a comprehensive approach which combines action on the physical condition of property with attention to the specific health needs of every occupant living in the worst rented properties across Liverpool. Whilst the predominant focus is on the private rented sector, it also helps people in need living in owner occupied property when they are identified during the course of the programme's work.

Over a three year period from 2008 – 2011, as part of the programme:

- Every privately rented property in Liverpool will be visited and intelligence gathered about both the occupants and property condition. Approximately 30,000 properties will have been visited by the end of 2011.
- As a consequence of the visit, the PCT co-ordinates a health needs assessment of all prioritised occupants, and provides advice on home accident prevention and health promotion. Where appropriate, referrals to relevant agencies are also made.
- The worst 5500 private rented homes will be prioritised for full health and safety inspection by Environmental Health Officers and plan of action for improvement.
- Improvements will be secured to the worst 5500 private rented homes in Liverpool to control the most significant and life threatening hazards in these homes particularly to people in the most vulnerable circumstances. This will include the removal of serious health hazards from the homes identified by the Environmental Health inspection, the provision and installation of carbon monoxide detectors to vulnerable households by the Fire and Rescue service, engagement with social landlords to ensure that the improvement of housing stock is dealt with on a priority basis and legal requirements are met, and linkage with the City Council's programmes on energy efficiency and making public spaces cleaner and healthier.

A prospective health impact assessment has estimated that, over the length of the programme, the project could remove the exposure of 11745 residents at risk to 7457 hazards under the Housing Health and Safety Rating System. Through the removal of hazard exposure, the 3 year programme could save in the region of 200 lives when fully implemented, provided that the improvements are sustained. It is also estimated to reduce GP consultations and hospital admissions by over 2000 cases. In terms of PCT priorities, the project will contribute to reducing cardiovascular and respiratory mortality and morbidity from excess cold; reducing mortality and morbidity from damp and mould affected dwellings and from falls and accidents in the home; a reduction in health inequalities; including improvement in housing and control of hazards (influencing housing conditions as a social determinant of health).

Commentary

The amount of time and effort to set up such a programme with multiple partners is considerable and would typically involve five or six officers meeting regularly and taking the case to the various committees for approval over the course of six months to a year. Once up and running the Healthy Homes initiative involves 27 staff from the participating NHS and local government services over 3 years, with associated

capital investment. As such, it requires major commitment and leadership to carry the programme through.

5.1.2. Education sector partnership in Belfast Health Action Zone

Mary Black, Belfast HAZ, provides this commentary on the multi-agency partnership with the education sector to tackle disadvantage and social exclusion. Although the Health Action Zones were established nationwide when the Labour government came to power in 1997, their development in Northern Ireland was significantly different than other parts of the UK. Although initiated by the Department of Health, Social Services and Public Safety, there was no discreet budget (simply modest infrastructure costs) which meant that the model developed in Northern Ireland relied heavily on partners' agreement to focus on common priorities and more effective use of existing resources. In addition further resources have been levered as a result of the partnership. It also meant that they were not overly directed by a Department focused on Health Service targets which proved to be difficult for some HAZs in England. In Belfast the HAZ was led by the local Health and Social Care Trust and from the outset placed emphasis on developing a broad approach to tackling social exclusion, based on creating collaborative advantage and engaging widely with partners from government departments and their delivery organisations, local communities and the community, voluntary and private sectors. Unlike its English counterparts, the Belfast HAZ continues today and is now part of the Northern Ireland Executive's cross-sectoral strategy 'Investing For Health' which aims to place inequalities in health at the centre of government policy.

Formal partners include-Health and Social Care Trust and Commissioner, Education, Housing, City Council, Further Education, Universities, Department for Social Development, Department for Employment and Learning, Business in the Community and the Area partnerships (community area based regeneration partnerships in Belfast). The aim is to work together to tackle inequalities in health and broader social exclusion. The primary focus until recently has been in north and west Belfast - an area characterised by profound patterns of disadvantage reflected in poor educational performance, poverty, high levels of economic inactivity, and health inequalities . It is also the area that suffered most during the conflict with a concentration of deaths, injuries and social disturbance. The aftermath of the conflict casts a long shadow and is manifested with strong lines of spatial segregation, intimidation and at times increased tension, if not outright violence. It is within this context that the Health Action Zone has been working over the past ten years. It has sought to concentrate the energy and resources of partners in certain key areas (developmental pathways) to build and support change. The HAZ functions by:

- Developing effective practice
- Influencing and changing 'mainstream practice'
- Creating links and using practice to influence government policy

HAZ uses a broad social model of health based on the twin pillars of partnership and participation. This work recognises that the major determinants of health inequality lie outside the provision of formal health and social care systems and can only be addressed by working in partnership with communities and with those who can have an impact on the wider determinants of health status. HAZ has also worked hard to develop a sense of coherence among the plethora of policy initiatives as they effect north and west Belfast, seeking to add value and synergy of action wherever possible.

Work with the education sector

One area of development has been the effective work with schools, communities and health and other sectors working together to improve the health and wellbeing of school children and those populations served by the school, with the school acting as a hub for development. Work began in 2000 with 6 post primary schools and demonstrated significant progress with pupil performance, parent and pupil engagement, cross sectoral support and engagement with the school and the development of specific services to meet the need of more vulnerable pupils. This work subsequently informed the development of a much larger government programme, *Extended Schools*, and was also used as the model to address the particular needs of children experiencing trauma as a result of interface violence. Further development has led to the establishment of a *Full Service Schools* model where partners are extending their efforts to support the school through a wide range of interventions. This work has included programmes such as:

- Breakfast Clubs;
- Fresh Fruit;
- After School activities;
- support for children with particular difficulties e.g. counselling,
- use of English as a second language;
- developing links with Sure Start, nursery school provision and transition points to post primary school;
- programmes for parents such as understanding maths, drug misuse, Keep-Fit; health and social care involvement in school programmes;
- engaging actively with local community organisations;
- much greater use of the school building to offer programmes on for example music, cross-community understanding, mental health and wellbeing.

Significantly, this work is now being aligned with another HAZ programme aimed at integrating services for children and young people where communities, health and social care and education authorities seek to redesign service models to deliver improved outcomes for children. It is interesting to note that in this instance funding came as a result of an 'employability task force' for the area. HAZ successfully argued that interventions were needed earlier in order to address the problem of employability. Other programmes have successfully demonstrated how to engage parents in their children's education, acting effectively as another means of community participation and engaging those who are often termed 'hard to reach'. What has been happening over time is a consistent effort on the part of partners to 'join up' their action more effectively.

Commentary

The frustrations of this work are many. It is not systematic and HAZ strives to work across multiple boundaries of organisation, geography, and culture- not to mention individual organisation's goals, priorities and funding timeframes. It is an unending struggle to secure funding for key aspects of work, whilst at the same time some of the thinking has become more mainstreamed. It seems that government still finds it impossible to join up departmental funding streams and to do it consistently over a long timeframe to create the level of change required.

5.2. What helps or hinders this kind of multi-sectoral work? Evidence from the literature

There is a substantial body of literature on what works to aid partnership working of the kind required to tackle the social determinants of health. We conducted a rapid

review of this literature to identify barriers to, and facilitators of, multisectoral action, together with evidence from evaluations of national area-based initiatives with a high public health involvement: Health Action Zones, Sure Start, New Deal for Communities, Local Strategic Partnerships, City Challenge. A total of 59 papers were included in this rapid review.

Terminology to describe collaborative action varies (joint-working, partnership, collaboration, multi-sectoral action, networks and so on) and each of these terms may be understood differently by different people, professions and organisations (Wildridge *et al*, 2004; Berkeley and Springett, 2006a). In this review the terms 'joint-working', 'collaboration', 'partnership', 'multisectoral action' and 'Health for All initiatives' are used interchangeably to refer to the deliberate action of public sector organisations coming together to address the socioeconomic and environmental conditions in a locality that would influence population health.

5.2.1. System barriers and constraints

External pressures and vertical processes that undermine collaboration

- Heavy external pressures can limit the efficacy of partnership and collaboration (Bevir and O'Brien, 2001; Painter and Clarence, 2001; Crawshaw and Simpson, 2002; Barnes *et al*, 2003; Hunter 2003a; Gray, 2004; Newman *et al*, 2004; Povall, 2005).
- Incompatibility of national and local agendas (EIUA *et al*, 2006; Povall, 2005). Constant re-organisation within the core partner agencies is destabilising (Povall, 2005), weakens support for the partnership/collaboration and fosters mistrust (LGA, 2000; Cameron and Lart, 2003; Glendinning *et al*, 2005; Berkeley and Springett, 2006a; Russell, 2007), or at least temporarily distracts leaders and champions from the collaborative process (Evans and Killoran, 2000; Povall, 2005). For example, the reorganisations of core partner agencies undermined Health Action Zone partnerships in England (Barnes *et al*, 2004; Povall, 2005).
- Strong central control and a rapidly changing policy context can reduce the flexibility of programmes and limit opportunities for innovation (Maddock, 2002; NRU, 2002; Barnes *et al*, 2003; Hunter 2003a; Glass, 2005; Povall, 2005).
- Conflicting policies that promote partnerships on the one hand, while requiring competition between the partner agencies on the other hand (Glendinning *et al*, 2005).
- Opportunities for mainstreaming successful projects are limited when funding is under pressure due to reorganisations – especially when health inequalities are perceived as a low priority (Povall, 2005).
- Top-down targets and performance management forces a focus on national priorities rather than local needs (Wildridge *et al*, 2004; Glendinning *et al*, 2005; Povall, 2005) and limits the capacity to learn from the initiative at the regional or country level (Berkeley and Springett, 2006a). Conflict between centrally determined performance management systems and locally developed systems creates burdensome bureaucracy (EIUA *et al*, 2006; NESS, 2005; Povall, 2005), and restrict the capacity for innovation (Barnes *et al*, 2004; Povall, 2005).

- In addition this top-down agenda limits the capacity of local partnerships to mainstream their work by making it part of the strategic work of partner organisations (Povall, 2005; EIUA *et al*, 2006; Russell, 2007; Davies, 2009)
- As this top-down performance management agenda is based around particular services or the remits of individual organisations, even where work has been achieved collaboratively it has to be reported separately (Glendinning *et al*, 2005)

Inadequate time

- Inadequate start-up time is a common problem (Pratt *et al*, 1998; Maddock, 2002; Matka *et al*, 2002; NRU, 2002; Bauld *et al*, 2005; Povall, 2005). It takes time before processes have an impact on spend and then more time before that spend shows effects in population outcomes (Beatty *et al*, 2008). Inadequate start-up time may have ramifications for the way funding is allocated and the programme is developed.
- Inadequate time for assessment of impact. When external targets relate to work that can be measured quantitatively in the short term, insufficient attention may be given to the 'soft' outcomes related to wellbeing and the impact of social determinants of health on health outcomes in the long term (Glendinning *et al*, 2005; Russell, 2007).

Internal pressures and differences

- Partnerships can be put under pressure internally when there are competing priorities between the partner organisations, such as:
 - Different cultures (Callaghan *et al*, 2000; Evans and Killoran, 2000; Wildridge *et al*, 2004; Berkeley and Springett, 2006a; Emslie and Gordon, 2008)
 - Different agendas and interests (Cameron and Lart, 2003; Bailey, 2007) and aims (Callaghan *et al*, 2000; NESS, 2005)
 - Different values, constraints and demands on the organisations lead to different priorities (Callaghan *et al*, 2000; Davies, 2009) and these different priorities may limit the ability of the partners to work together (Evans and Killoran, 2000; UW *et al*, 2005).
 - Different organisational structures (Evans and Killoran, 2000; Callaghan *et al*, 2000; Wildridge *et al*, 2004)
 - Different planning processes and cycles within the partner organisations can make it difficult to synchronise them for the partnership in order to develop joint strategic plans (Cameron and Lart 2003; UW *et al* 2005).
 - Different accountabilities (Exworthy *et al*, 2002; Exworthy, Blane and Marmot, 2003; Wildridge *et al*, 2004; NESS, 2005);
 - A lack of understanding of each other's roles – for example the health service adhering to a medical model of health that excludes the local authorities (LGA, 2000);
 - Differences in beliefs about how best to act on the aims and objectives. For example, should the focus be on reduction in disease or improvement in wellbeing, which is much less easy to measure and requires 'upstream' interventions? Davies (2009) shows that some partners find the 'softer' approach of focusing on wellbeing is difficult to

achieve because it necessitates agreement across many organisations, each with its own priorities and accountabilities.

- Financial uncertainty can make it difficult to foster trust, commitment and good working relationships (LGA, 2000; Cameron and Lart, 2003; UW *et al*, 2005; Berkeley and Springett, 2006b). Lack of adequate resources to recruit, train and retain high calibre staff can limit the effectiveness of partnerships (Beatty *et al*, 2008; DETR, 2000).
- The staff turnover resulting from reorganisations and the resulting loss of confidence in the partnership, and the loss of knowledge and experience can be disruptive (Cameron and Lart, 2003; Berkeley and Springett, 2006b); the loss of key personnel can be disastrous (Bailey, 2007; Cameron and Lart, 2003), it can create instability and the slow recruitment of replacements is associated with reduced spending (Beatty *et al*, 2008).
- New members can bring different goals that are inconsistent with the developed aims of the partnership (Pratt *et al*, 1998; LGA, 2000; Povall, 2005).
- Imbalances of power (Wildridge *et al*, 2004) between the different levels of the partnership, especially when some partners do not have authority over resource allocation (Davies 2009), between the level of authority the partnership members have within their own organisations (Callaghan *et al*, 2000; Berkeley and Springett, 2006b), and where one partner organisation is dominant within the structure – such as GPs in Primary Care Groups (Callaghan *et al*, 2000) or local authorities within Local Strategic Partnerships (UW *et al*, 2005; EIUA *et al*, 2006).
- Although a history of partnership working may facilitate a quick start to a new partnership, if it replicates previous poor relationships it will lead to dissatisfaction amongst the less powerful partners (Raco *et al*, 2006) and can inhibit trust between organisations when there has been a perceived imbalance in power and/or distribution of the resources (Barnes *et al*, 2004).
- A lack of organisational commitment to the partnership (Russell, 2007), this can result from competing claims of populations within the partnership area and also from the disillusionment within those populations resulting from a succession of area-based initiatives that have left before their work was completed (Russell, 2007).
- Differing professional values and working practices, such as the level of individual discretion and accountability, can lead to conflict between different professional groups (Cameron and Lart, 2003; Berkeley and Springett 2006a; Bailey, 2007).
- Preservation and protection of territorial boundaries can limit collaboration. This is true at the central government level (Emslie and Gordon, 2008) as well as in localities (Wildridge *et al*, 2004)
- Poor communication systems both between the partner members (Cameron and Lart, 2003; Emslie and Gordon, 2008) and between the members and their home organisations (Callaghan *et al*, 2000) will limit the success of the collaboration and may foster disillusionment with the process.
- The structure of the partnership can influence its likely success. Davies (2009) argues that the “hub and spoke” model commonly used within Local Strategic Partnerships (a strategic partnership board with thematic sub-partnerships) reinforces the delivery of services and initiatives in vertical

'silos', because the different themed sub-partnerships do not work together and there is insufficient joined-up strategic thinking.

- Commitment to partnership working may reduce willingness to address deep political differences between the partnership members, but reluctance to do so may undermine the ability to work collaboratively and result in shallow working relationships (EIUA *et al* 2006; Davies, 2009).

5.2.2. System facilitators

From the literature, a number of common facilitators can be identified, which improve the likelihood of productive and more sustainable outcomes.

Champions and strong leadership

A key facilitator is strong leadership from individuals (Barnes *et al*, 2004; EIUA *et al*, 2006; NESS, 2005; Povall, 2005) – elected members, senior officers and middle managers in partner agencies – and organisations (Barnes *et al*, 2004).

Partnerships and collaborations are greatly helped by having champions involved:

- who can provide effective leadership (Barnes *et al*, 2004; Cole, 2003; Evans and Killoran, 2004; Hunter and Killoran, 2004; Myers *et al*, 2004; Wildridge *et al*, 2004; NESS, 2005; Povall, 2005),
- who can champion the process and act as 'boundary spanners', bringing different organisations together (Callaghan *et al*, 2000; Cameron and Lart 2003; Barnes *et al*, 2004; Evans and Killoran, 2004; Newman *et al*, 2004; Wildridge *et al*, 2004; NESS, 2005; Povall, 2005; Russell, 2007; Emslie and Gordon, 2008),
- who can lead the successful implementation of policy locally (Johnson and Baum, 2001; Exworthy *et al*, 2002; Gillies *et al*, 2003; Evans and Killoran, 2004; Povall, 2005).

Co-terminosity of organisational boundaries

Collaboration has been helped by co-terminosity of organisational boundaries (Callaghan *et al*, 2000; Cameron and Lart, 2003; Wildridge *et al*, 2004; UW *et al*, 2005; EIUA *et al*, 2006). Exworthy and Peckham (1998; 1999) conclude that co-terminosity makes a small but positive contribution to collaboration.

History of joint working

Having a history of good collaboration within an area provides a good foundation for new partnerships (Callaghan *et al*, 2000; LGA, 2000; Cameron and Lart, 2003; Evans and Killoran, 2004; NESS, 2005; EIUA *et al*, 2006). Where experience in partnership working is lacking, commitment of key individuals to the new collaboration can facilitate to initiative (Callaghan *et al*, 2000). **Local political stability** can create a positive context for collaboration (Berkeley and Springett, 2006a; EIUA *et al*, 2006).

Adequate time and resources

Time is needed at the beginning of the partnership to build relationships and develop trust (DETR, 2000; Povall, 2005; PHAC/WHO, 2008); to build capacity in local individuals and organisations so that they can be part of the planning process (Beatty, 2008; DETR, 2000; Wildridge *et al*, 2004; UW *et al*, 2005; Povall, 2005; Raco *et al*, 2006; Povall *et al*, 2008); to develop policies and procedures and programme monitoring and evaluation (DETR, 2000). Glendinning *et al* (2005, p.376) point out that "integration costs before it starts to pay".

It also takes time for programmes to become established and generate learning: two years for organisational change to be established (Povall, 2005), 18 months for local learning to be disseminated nationally (Schofield, 2004). The rate of change in terms of programme impact may diminish over time when the more easily addressed issues have been tackled. (Beatty *et al*, 2008).]

Partnerships and collaborations need sufficient resources for administration support (Cameron and Lart, 2003; Wildridge *et al*, 2004; Povall, 2005; UW *et al*, 2005; EIUA *et al*, 2006; Raco *et al*, 2006) . Investment in resources for managing the partnership (Povall, 2005; EIUA *et al*, 2006; PHAC/WHO, 2008) and working collaboratively (Cameron and Lart, 2003) contributes to the success of the partnership.

Trust, respect and shared values

Trust between individuals and trust between organisations is an important facilitator for partnership working (Barnes *et al*, 2004; NESS, 2005). There is a need to spend time building trust and respect between the partners (Evans and Killoran, 2000; Cameron and Lart, 2003; Wildridge *et al*, 2004; Glendinning *et al*, 2005; EIUA *et al*, 2006; Russell, 2007). Flexibility within the delivery system and support can help build trust and generate enthusiasm (Povall, 2005). A broad vision for the partnership to start with enables people to engage, then refine the aims and objectives (NESS, 2005; PHAC/WHO, 2008), including the development of a strong case for intersectoral action (PHAC/WHO, 2008). Individuals are more prepared to engage with collaborative working when it fits with their professional role and development and personal preferences (Barnes *et al*, 2004). Organisations are more prepared to engage with collaboration when it fits with their organisational values (Barnes *et al*, 2004). Shared vision / aims and objectives (Callaghan *et al*, 2000; LGA, 2000; Matka *et al*, 2002; Cameron and Lart, 2003; Evans and Killoran, 2004; Myers *et al*, 2004; Wildridge *et al*, 2004; Baker, 2005; Glendinning *et al*, 2005; Povall, 2005)

Strong commitment to the process, including from the front-line staff (Cameron and Lart 2003; NESS, 2004), strategic commitment (LGA, 2000; Gillies *et al*, 2003; Myers *et al*, 2004; Evans and Killoran, 2004; Wildridge *et al*, 2004; Povall, 2005; Russell, 2007) and broad-based political support (Povall *et al*, 2008).

Joint finances and managing change

Having systems to facilitate joint financing (e.g. Health Act 1999) have been helpful and can help facilitate joint working (Wildridge *et al*, 2004; Glendinning *et al*, 2005; Povall, 2005). Mechanisms for managing change are essential for partnerships to succeed (Evans and Killoran, 2000). Strong partnerships can provide some stability in times of organisational change within the host organisations (Wildridge *et al*, 2004; Povall, 2005; Bailey, 2007). Evaluation and audit processes built into the partnership work can facilitate the process of collaboration (Cameron and Lart, 2003; EIUA *et al*, 2006; Russell, 2007)), enable the demonstration of added value (Povall, 2005; EIUA *et al*, 2006), and facilitate learning within the partnership and partner organisations (Wildridge *et al*, 2004; Povall, 2005).

Support and supportive environments

- A locally delivered, supportive programme is valued by those involved with it (Povall, 2005) Supportive environments build trust (Gilson, 2003; Povall, 2005), empower frontline workers and generate the space for innovation (Monks and Ong, 2002; Povall, 2005).
- There is evidence that people want to and value the opportunity to work collaboratively (Povall, 2005). The lack of supportive structures limit their capacity to do so, both in central government (Povall, 2005; Emslie and Gordon, 2008) and in localities (Davies, 2009).

- Clearly defined roles and responsibilities supported by formal policies and procedures (Cameron and Lart, 2003; Barnes *et al*, 2004; Wildridge *et al*, 2004; Glendinning *et al* 2005; NESS, 2005; Bailey, 2007)
- Co-location of core partnership staff – in the same office or the same building (Cameron and Lart, 2003).
- Equity in participation and accountability (Evans and Killoran, 2000); Shared decision making (Povall, 2005; PHAC/WHO, 2008)
- Joint training and team building (Callaghan *et al*, 2000; Monks and Ong, 2002; Evans and Killoran, 2004; Cameron and Lart, 2003; Gillies *et al*, 2003; Myers *et al*, 2004; Wildridge *et al*, 2004; Povall, 2005)

5.3. Voices from the frontline: what helps city-wide and region-wide working

In the current climate, we asked people involved in the day-to-day efforts to work in partnership at local level on the social determinants of health: what helps? Their experience suggested:

- Joint PCT/city council posts focused on social determinants of health
- Joint operational units
- Co-terminosity of PCT and local authority boundaries
- Common goals and targets focussed on addressing inequalities in health and wellbeing
- Joint funding mechanisms, e.g. Section 75 funding (which is sustainable)
- A nominated lead on inequalities in each PCT as the commissioning body
- A single regional strategy for regional development that puts health as one of the prime drivers of the strategy

Box 5.1. presents some of these thoughts in the words of a joint Director of Public Health (DPH), while **Box 5.2** presents ideas from the regional level.

Box 5.1. Voices from the frontline: NHS/LA city-wide partnerships

Has having a joint PCT/Council post improved the situation?

“Oh yes, yes. Well the fact that you are there at all actually. It’s not just the function of the joint DPH that has made the difference, it is partly because I sit on the board for both and for the discussions. And partly because, with the Local Area Agreement, the fact that most of the performance indicators and management things are starting to come together, so instead of having totally separate targets and indicators, we have now a set which are virtually the same for both organisations.

There is Local Area Agreements, there is this new corporate area assessment which is coming in, which again is meant to be inclusive of all the agencies not just the City Council. So, that makes a big difference actually because you can quote a target in the PCT which is important to people here, but you can go down to the City Council and it’s also important to them. So they can actually see how, if you are saying you want to do something, how that actually has some meaning. So because things like teenage pregnancy now are very important to the City Council and we are all measuring the same thing, that is quite powerful really.

Then there is quite a big push as well around partnership to move to these ‘Section 75s’ [joint NHS/LA funding mechanism] so there is this kind of pooled budgets, but as well as the pooled budget we are talking about more integrated commissioning as well, so that’s another push towards more joined up working.

So it’s a step in the right direction?

Oh yes, it’s 100 times better than it would have been say in 2000 and much better than it would have been even in 2005.”

Box 5.2. Voices from the frontline: Regional partnerships

The need for clear leadership:

“This came out of the review the audit commission did in Manchester, of why Manchester were doing so badly on health inequalities was that you had all the players in a sense keen and active, with a reasonable understanding of the challenge, but you had a black hole at the centre which was that no one was pulling together, and calling to account the various partners in terms of the specific actions they would be required to take, either at a scale or pace that would make the difference, and so I think the analysis seems to be that one of the things that would make a difference around delivery in the English system is that we need a nominated lead in each PCT as the commissioning body to understand and describe and champion and lead the inequalities work and that one of the rolls the regions and the centre can play is to feed them with the information, the actions, the research, often in various specific ways”

Opportunities in a single regional strategy

“Each region in England now has to do a single regional strategy [by 2010], and we are working with the regional development agency to define what the content and process might be. Every region will be trying to put health as one of the primary drivers of the single regional strategy. It will put all the other sectoral strategies into one framework document and it could be quite high level but the opportunities are significant because you have got the social housing budget that goes to local authorities to come through the regions and is allocated according to the regional housing strategy, the regional spatial strategy defining the legal context for local development frameworks which is basically your planning guidance at local level. So you have got an enormous opportunity if you say ‘reducing inequalities and improving health and wellbeing is one of our goals’, to put markers in there that will allow challenge to some major structural determinants of both inequalities and health status

generally. And you know that is what all regions will be doing that work, now with their regional development agencies”.

“One of the interesting challenges when I first took the health inequalities strategy to the directors of the government office in the [region] - 14 government departments sat round a table - I went through all the determinants of health, looked at what people were dying from in the [region] and said: we need collaboration on a regional health inequalities strategy. This was about 18 months ago. One of the very interesting things they said to me was, well if it's all these wider social and economic determinants that are generating health inequalities, why are you asking us to have a health inequalities strategy? Surely what we need is an inequalities strategy of which a reduction in health inequalities is one of the outcomes. But actually reductions in housing inequality, educational inequality and other inequalities would also be outcomes, it doesn't make sense to have an educational inequalities programme and a health inequalities programme”.

5.4. Expanding capability to act on social determinants of health

As the Global Report recommends, an expansion of capabilities is required throughout the health work force if delivery systems are going to be more sensitive to, and act upon, the social determinants of health. How might this be done in the UK context? **Box 5.3.** outlines a Scottish initiative, set up in 2006, which acts on two complementary fronts. First, it encourages practitioners in a range of services to be more sensitive in the ways in which they respond to the socioeconomic circumstances of an individual patient or member of the public. Second, it attempts to raise awareness of the way in which practitioners can act on the social determinants of health more directly in their own sphere of influence, for example acting as advocates for economic and social policy that will improve the lives of the local communities that they serve.

Box 5.4. outlines work led by the West Midlands Teaching Public Health Network along twin tracks: development of not just the specialist, but also the non-specialist workforce, ranging from teachers and built environment planners to other local authority and voluntary sector staff; and development of the capacity within the higher education institutions in the Region to deliver the required programmes.

Box 5.3. Expanding capability: NHS Greater Glasgow and Clyde's Inequalities Sensitive Practice Initiative

[http://www.equalitiesinhealth.org/inequalities_sensitive_practice_initiative.html]

The Scottish Government has made tackling inequalities in health through a social model a priority since 1999 (ISPI, 2008). The NHS Greater Glasgow and Clyde's Inequalities Sensitive Practice Initiative (ISPI) was launched in 2006 and was funded by the Scottish Government's Multiple and Complex Needs Initiative. Facilitated by a mainstream Corporate Inequalities Team (CIT), its aim is to maximise its efforts in tackling the causes and health effects of different types of inequality and discrimination (ISPI, 2008). The initiative was based on the social model of health and was founded on the evidence that discrimination on the grounds of low income, social class, gender, ethnicity, disability, age and sexual orientation led to poor health and low social status (CIT, 2007). ISPI piloted an approach to changing frontline practice so that practitioners reflected not only on **what** they did but also **how** they did it (Avanté Consulting, 2009). The aim was to make practitioners aware of any unconscious bias in their dealings with patients and service users that might result in different groups being discriminated against.

ISPI encouraged staff to question the ways in which they respond to an individual's circumstances, to examine personal attitudes and beliefs, and to consider how their current practice and behaviour might not be appropriate in every situation. (Avanté Consulting, 2009, p.5)

The approach goes further and attempts to raise awareness among practitioners of the health service's role in society. It promotes the notion that an Inequalities Sensitive Health Service is one that procures its goods and services to contribute to the reduction of health and social inequalities, and one that advocates for, and helps implement economic and social policy that addresses inequality across society (CIT, 2007).

The pilot ran in four systems: Maternity Services, Integrated Children's Services, Addiction Services and Primary Care Mental Health Services (ISPI, 2008; CIT PPG, 2009; Avanté Consulting, 2009). Each of these areas had already adopted a model of health and social care that went beyond the traditional medical model (Avanté Consulting, 2009). The pilot focused on inequalities resulting from gender and socio-economic status, but the aim was to generate learning that would be applicable across all settings and for all forms of inequality (CIT PPG, 2009). ISPI was intended as a vehicle for identifying what is needed to improve frontline practice, what planning and policy arrangements would be needed to sustain the service improvements, national learning and policy development (CIT PPG, 2009).

ISPI has identified the need for policy, performance management and planning mechanisms to be developed that will more effectively support inequalities sensitive practice across all entry and throughput points of the NHS system. This requires the appropriate resourcing of a workforce development and organisational change process, which will shift the organisation from a position where 'practice supports the system' to one where 'the system supports practice'. (Corporate Inequalities Team for the NHS GGC Policy, Planning and Performance Group (CIT PPG), 2009, p.2/3)

The next stage is to move ISP into mainstream services. A set of ongoing challenges to the mainstreaming process have nevertheless been identified, including: conceptual (the pervasiveness of the medical model); professional (the power of vested clinical interests); organisational (the difficulties of transforming large and complex organisations); and attitudinal (health service staff reflect the prejudices that exist in the wider society). (*Corporate Inequalities Team: Personal communication*)

Box 5.4. Workforce Development on social determinants: West Midlands Teaching Public Health Network

(Based on information provided by Ginder Narle, WMTPHN Manager)

The Department of Health (DH) established nine regional Teaching Public Health Networks (TPHNs) to raise awareness within the wider workforce of how they can contribute to improving the public's health. Each of the Networks has a different focus, depending on local priorities. The West Midlands TPHN has the national lead on Inter-Professional Learning in Public Health, Engaging Partners and Ethnic Minority Health. It encompasses development of not just the specialist, but also the non-specialist workforce, ranging from teachers and built environment planners to other local authority and voluntary sector staff. Strengthening their capacity and competence to support health improvement is an important step to addressing regional public health priorities. A key feature of the Network's approach is interdisciplinary learning with a problem solving focus, e.g. building joint learning between public health and planning professionals around social determinants of health issues. Examples of development work done through the West Midlands TPHN include:

Development of the wider public health workforce for the social determinants for health agenda

The West Midlands TPHN has brought together organisations such as local authorities, PCTs, the Strategic Health Authority, the Improvement and Development Agency for local government (IDeA), the West Midlands Regional Improvement and Efficiency Partnership, and the West Midlands Local Government Association to identify how they can contribute to the regional requirements for reducing health inequalities through delivering on their priorities, for example within Local Area Agreements, the Community Strategy and as determined by the Joint Strategic Needs Assessment. Reducing health inequalities by 2010 is the main

priority for the Regional Health and Wellbeing Strategy. The West Midlands TPHN has mapped this strategy against the Regional Spatial Strategy to identify areas where these strategies reinforce each other or where there may be areas of conflict between them. The aim is ultimately to develop and support a consistent approach towards delivering policy, programmes and services in disadvantaged areas. To this end, the West Midlands TPHN and IDeA will host a new Health Inequalities Network with a focus on sharing best practice, promoting partnership working and maximising opportunities to tackle health inequalities with local authorities through their 'Communities for Health' work.

Development of capacity within higher education institutions

The WM TPHN is working with regional higher education institutions to identify ways in which capacity for public health training might be increased. Considerations have included increasing the number of people who qualify with a Masters in Public Health, providing a flexible credit accumulation scheme, and the possibility of developing a West Midlands Public Health Diploma. The "Regional Health and Wellbeing Strategy" reinforces that health is influenced by a wide range of determinants, for example, education and transport as well as the availability of and access to health care.

References:PHRU (2007) *Teaching Public Health Networks* [online]. Oxford: Public Health Resource Unit. Available at <http://www.phru.nhs.uk/pages/phd/TPHN.html>.
WMTPHN (2007) "The West Midlands Teaching Public Health Network...". *The Circular*, Issue 1. Available online at <http://www.wmpho.org.uk/westmidstphn/Docs/Issue1August2007.pdf>.

5.5 Recommendations and principles for action

Key recommendation 3: Local leadership on facilitating joint working

Local mechanisms need to be initiated to make multi-sectoral work on social determinants of health both easier and more effective, along the lines set out in the principles for action.

Key recommendation 4: National and local synergy

Government departments need to support rather than undermine local joint working on the social determinants of health and inequalities. This includes demonstrating that this kind of work is valued nationally through the targets and performance management mechanisms that are put in place; through the setting of adequate timeframes for setting up the joint work and evaluating impact.

Key recommendation 5: Workforce development on determinants of health

Government departments and regional workforce development agencies need to expand capability to understand and act on the social determinants of health in the non-specialist, as well as the specialist, workforce. This requires both reaching out to include practitioners in sectors other than health, as well as expanding capacity in educational establishments to carry out this development work.

Principles for action on working with other sectors on social determinants

The recommendations can be re-framed as principles for action as follows:

- Local mechanisms should to be initiated to make multi-sectoral work on social determinants of health both easier and more effective. These include:

- agreement on common goals and targets between agencies focused on addressing inequalities in health and wellbeing;
 - the setting up of joint appointments and joint operational units;
 - the increasing use of joint funding mechanisms which are sustainable (moving away from reliance on short-term project funding); and
 - the provision of long-term timescales for the processes of setting up and maintaining partnerships.
- Health and local authority leaders should demonstrate the legitimacy and priority given to this kind of work by committing their organisations to the above action.
 - Government departments should support rather than undermine local joint working on the social determinants of health and inequalities. This includes:
 - demonstrating that this kind of work is valued nationally through the targets and performance management mechanisms that are put in place and
 - the setting of adequate timeframes for initiating such work and assessing impact.
 - Workforce development should include development of understanding of social determinants of health among a wide range of practitioners and the promotion of inequalities sensitive practice.

PART 6

Case study on tackling the wider social determinants of health directly Margaret Whitehead

In the debate on what health systems could do address the causes of inequalities in health, the question arises of whether there are direct ways in which the system might influence the wider social determinants, such as reducing poverty, improving employment rates and influencing the local economy of disadvantaged areas. There is evidence of promising initiatives from around the regions on all of the above.

6.1. Tackling poverty by boosting incomes of patients

As part of wider anti-poverty strategies, several health sector agencies, in particular primary care organisations, have been experimenting with offering advice and help with claiming welfare benefits delivered in health care settings. The rationale for this is that there is currently low take-up of benefits for which patients would be eligible, and increasing incomes would improve the standard of living of recipients and in doing so increase the opportunities they have to live a healthy life. A systematic review of the effects of such advice delivered in healthcare settings found that they led to worthwhile financial benefits. The evaluated initiatives gained a mean of £194 lump sum plus £832 per year in recurring benefits per client seen, giving a total of £1026 per client seen in the first year following the advice (Adams et al, 2006). As the authors point out, this equated to about 9% of average individual gross income in the UK in 1999-2001, so represented a sizable gain. There was little evidence that the advice resulted in measurable health or other social benefits, though this was due to a lack of good quality evaluations, rather than any evidence of lack of effect. Randomised controlled trials have been set up to test the best ways of delivering such advice and to measure health outcomes more robustly.

6.2. Tackling unemployment

Another way to increase the income of people who are sick is to help them keep or get jobs. One adverse consequence of having a chronic illness is decline in employment – found to be more severe for more disadvantaged occupational groups (Burstrom et al, 2000 and 2003), generating further inequalities in health in a downward spiral. The potentially significant contribution of health services in relation to work has been recently reiterated by the government (Black, 2008; DH, 2008). There is particular emphasis on the value of intensifying medical rehabilitation services to help people recover from or manage their health condition to enable a return to employment (Black, 2008). The newly introduced *Condition Management Programme*, for example, commissioned jointly by PCTs and the Department of Work and Pensions and delivered through Jobcentre Plus and primary care, is experimenting with different ways of offering rehabilitation services to people on incapacity benefit. Claimants with mental health, cardiovascular and musculoskeletal problems are offered co-ordinated programmes of psychological, occupational and physiotherapies, the impact of which is currently being evaluated (Barnes and Hudson, 2006).

In addition, a major role is being proposed for GPs in switching from their current role of sickness certification (in which an employee is judged to be too sick to work) to one in which they concentrate on assessing the degree of “fitness for work” of a person and prescribing ways of improving that fitness (Black, 2008). This relies, of

course, on the relevant services being there to support this re-orientation, as well as employers being receptive to a phased, supported return to work for employees on sick leave, as has been widely adopted in the Nordic countries (Whitehead et al, 2009). In this current economic climate, the success of this strategy is also dependent on there being jobs for people to go to.

6.3. Boosting the local economy

Perhaps the most radical way in which the health sector could directly attack poverty and unemployment is to harness the NHS's purchasing power and position as a major employer. The NHS is large enough in its own right to stimulate employment and boost local economies, as advocated in the King's Fund report *Claiming the Health Dividend* (Coote, 2002). As an example, the North West Region of England is one where these ideas have been taken furthest.

The premise on which the initiative was built is the recognition that the National Health Service (NHS) and social care sectors have tremendous economic weight. They spend billions every year on purchasing a wide range of goods and services from laundry services to catering and computers, from beds to building maintenance. The persuasive argument put forward is that if this purchasing power were harnessed to support local businesses in the most hard-pressed communities, then the benefits might extend to greater social inclusion and equity, as well as improving the health of the community it serves:

“Purchasing has direct social, environmental and economic impacts, and presents an ideal opportunity to reduce the risk of health inequalities that can result from a degraded environment, unemployment, poverty and social exclusion” (Groundwork EBS – Merseyside, 2009).

6.3.1. Example of the North West NHS Supplies Bureau

With a population of 6.7 million, The North West is the poorest of the nine English regions and is an unemployment hotspot and has some of the worst health and deprivation indicators in England. The health and social care sector together contribute 6.7 per cent of regional GDP. In the financial year 2000-1 the total revenue expenditure for the health and social care sector was £6 billion: £4 billion on labour and £2 billion on goods and services. The health and social care sector is also one of the largest employers in the local and regional economies, employing nearly 200,000 staff or about 7 per cent of the economically active population. When indirect and induced employment are taken into consideration the sector supported nearly 15 per cent of jobs in the region. How can this economic and employment power be harnessed for local regeneration? NHS agencies linked with the North West Regional Development Agency to develop integrated sustainable development and regeneration plans for the most disadvantaged areas. Locally, the NHS looked to recruit and train people from disadvantaged areas to fill vacancies in the NHS; and also the NHS aimed to purchase goods locally and to use local services to help boost local economies (North West Regional Assembly, 2003; North West Public Health Team, 2003). There are significant obstacles to overcome in implementing such a strategy, but the potential is enormous and yet to be exploited.

One example of the harnessing of NHS purchasing power to boost the local economy is the **North West NHS Supplies Bureau**, developed by Groundwork EBS in Merseyside, with the aim of supporting small and medical-sized local businesses to improve their chances of securing NHS contracts. This aim was to be achieved by

improving the quality and delivery of their businesses and helping them achieve the high standards required of NHS suppliers in terms of health, safety and environment.

Key components of the initiative

The initiative involved working on both the suppliers and the NHS purchasing sides. All 300 small and medium-sized businesses in the designated area were provided with the opportunity to participate in:

- A free business development training programme on how to engage effectively and tender more successfully with the NHS on a local, regional and national basis which included:
 - Health, safety and environmental support and training;
 - NHS tendering procedures
 - EU tendering rules;
- Skills training for participating businesses in information technology and internet trading;
- Entry onto an online database, which was shared with all NHS bodies and other public sector organisations in the area;
- Procurement Clinics for one-to-one support for suppliers with their specific difficulties.

At the same time, the initiative engaged with the NHS and other public sector bodies to influence how the procurement process operated, including:

- Work with NHS Trusts to influence their procurement processes and develop their sustainable policies and to support a sustainable supply chain;
- Working at higher levels, including regional hubs, to integrate sustainability and local economic factors into the procurement process;
- Supporting the NHS to become a “Good Corporate Citizen” (i.e. to contribute to sustainable development).

The initiative was funded for three years, from 2004 to early 2007 by the Regional Development Agency and EC Objective One funding, and supported by broad representation from NHS agencies, government bodies concerned with occupational training, safety and health and business links.

Impacts in relation to targets

An evaluation of the work of North West NHS Supplies Bureau identified impacts on several fronts (Jon Dawson Associates, 2007). The results in Table 6.1 indicate that the Bureau had considerable success in generating new business for suppliers to the NHS and in safeguarding existing business for suppliers to the NHS and to other public sector purchasers. A key target set by the funding agencies was for the Bureau to generate £750,000 of turnover growth amongst North West businesses accessing the Bureau’s services. In practice, this target was exceeded significantly with the value of turnover growth estimated at £18.3 million. In addition, the target set for NHS business safeguarded for North West enterprises was also exceeded.

On the employment front, an estimated 387 jobs were safeguarded and 63 new jobs created amongst the 51 firms that responded to the survey. The Bureau has achieved a national profile (including awards and has influenced changes to procurement practices in the NHS).

Table 6.1: Targets and results for the NW NHS Supplies Bureau

Indicator /Target	NWDA target	Bureau achievement	% of target achieved
Value of turnover growth	£750,000	£18,300,000	2440%
NHS business safeguarded	£3,000,000	£7,736,200	258%
Other public sector business safeguarded	no target set	£20,789,177	n/a
Non-public sector business secured	no target set	£155,471	n/a
Jobs created	69	63.5	92%
Jobs safeguarded	310	387.5	125%

Source: Adapted from Table page 24 or John Dawson Associates (2007)

Commentary

It is important to be clear that the Supplies Bureau strategy is not about protectionism, but about helping local suppliers raise their standards of health and safety and other requirements that are needed to be able to compete for NHS contracts. As such, it complies with both the spirit and letter of the law. There are, however, national developments pushing in the opposite direction. The Public Sector Efficiency Review, for example, recommended aggregation and centralisation of contracts, which operates against the encouragement of local suppliers. There are also continually changing EU regulations on tendering. Currently, the Bureau advises on how to comply with EU regulations, but there are new ones coming along all the time that might challenge the process. This means that an initiative that has won national awards for innovation is still in a rather precarious situation.

See also the Report of the *Sustainable Development Task Group*, which provides detailed commentaries and recommendations on the NHS as Good Corporate Citizen.

6.3.2. Linking the NHS regionally to Europe and the rest of the world

In seeking to act on the social determinants of health more directly, there is a need to link to what is happening in Europe and beyond. **Box 6.1** gives an example from the English regions of an initiative to facilitate such collaboration, which provide one mechanism to take this line of action forward.

Box 6.1. Example: UK Regional Social Determinants of Health Network (Based on information provided by Mike McHugh, Project Leader, UK Regional SDH Network)

The UK Department of Health (DH) has launched a special programme for international collaboration on social determinants of health (SDH). This is a portfolio of projects to build capacity for international collaboration on SDH within the UK, following the WHO CSDH Report recommendation for improved global collaboration on these issues. The UK Regional Network to address health inequalities (HI) and SDH through international collaboration is one of those projects, being managed by the Public Health Directorate East Midlands (PHDEM).

The network is still in its infancy. The PHDEM have conducted research to scope the current level of collaboration by UK regions in European and Global work to address HI/SDH. The results suggested that there is limited, but beneficial, current collaboration with international partners. Following this scoping exercise, PHDEM hosted a workshop in London on 23 April 2009 at which it was agreed to develop the regional network, with the following objectives over the next 12 months:

1. Influence the development of health policy through: monitoring and responding to international HI/SDH policy developments and programmes; developing the collective capacity of people within the network to contribute to national and international HI/SDH policy development; influencing the Marmot Review through direct consultation.

2. Share best practice, for example by distilling and disseminating key recommendations from the WHO CSDH report and the English Marmot Review to regional partners; identifying people within the UK regions who can provide technical assistance in addressing HI/SDH, both nationally and internationally; exploring opportunities to share information on, and best practice in addressing, HI/SDH within UK regions and with international partners; strengthening collaboration between sectors, between UK regions and with international partners; disseminating learning from the National Support Team for Tackling Health Inequalities (NSTHI) on practices that will have an impact on HI in the medium and long term (beyond 2010). For example the NSTHI are running diagnostic workshops around issues such as maximising income and reducing debt. The NSTHI are creating a directory of effective practice and these lessons could be disseminated through the Regional HI/SDH network; identify funding for projects and research; improving the connections between the UK regions and their Brussels offices.

PHDEM are planning a formal launch of the UK Regional Network on HI/SDH in September 2009, addressed by Robert Madelin, Director General of DG SANCO (EU Directorate General for Health and Consumer Affairs).

Commentary

The potential benefits of such a Regional Network include: sharing learning, practice and experience on HI/SDH with UK, EU and global partners, leading to better informed planning and action regionally and locally; opportunities to influence national, European and global policy development; improved collaboration to address HI/SDH nationally and internationally. The network would provide a conduit for a two-way sharing of learning and of influence on policy and practice. Although one of the main focuses is on strengthening links with the UK regional offices in Brussels and with enhancing relations with European partners, the network will also facilitate collaboration further afield. For example, there may be opportunities for the network to engage, with other UK players e.g. the Faculty of Public Health which is currently working to develop public health capacity in developing countries.

NHS World Class Commissioning and the NHS Next Stage Review (Darzi, 2008) both advocate international benchmarking. The DH is keen to create an infrastructure that will support connections between the UK regions and international partners, and this network is part of that process.

Commitment amongst English regions to the network is variable at present. The regions have limited spare capacity and some have expressed concern about the time commitment that will be needed to engage with the work. Although they are willing to learn from others, those lessons must lead to practical pragmatic solutions and actions regionally and locally.

Key recommendation 7:

Local public agencies should be proactive in assessing how they can confront poverty, unemployment and disadvantage in their communities more directly. This includes using opportunities in health care settings to help patients get the social welfare benefits they are entitled to; contributing to rehabilitation of people with longterm sickness to help them get fit for work; and using their organisation's employment and purchasing power for the benefit of the local communities that they serve.

PART 7

Case study on co-ordination efforts across the whole of government: targets as a planning mechanism

Sue Richards

This is a study of the macro-level issues which relate to the role of targets in planning across the public policy system to achieve outcomes such as reductions in health inequality.

In this case study we examine the changes which have taken place in relation to the use of targets in the public policy system. We argue that there have been some long term shifts in the mode of integration used in the public policy system, with a post war era which could be characterised as a complex adaptive system giving way in around 1979 to a model better described as a vertically-integrated mechanism. We go on to argue that the time is now ripe for a further step change which would reflect the need for a better way of handling complexity, jurisdictional boundaries and the mobilisation of the creative energies of staff right across the public policy system.

We have been aided in coming to these conclusions by other researchers, whose work is quoted, by a number of senior officials who gave us their time to be interviewed, and by some impressive local achievers of better health outcomes, who shared their practice with us and shared their wisdom about operating within the public policy system.

This case study first examines the historical contexts within which targets have been used. We then introduce the two alternative modes of integration which form the conceptual backbone of this work. That takes us to the research evidence on the positives and negatives of the use of targets in the experience of the current mode of integration. The next section examines current developments in the policy planning system, notably the creation of new outcome-focused Public Service Agreements and the development of joined up Local Area Agreements. We argue that this approach could be used in a way that transforms a vertically-integrated mechanism into a complex adaptive system. We then focus on some key issues which emerge from our analysis, which we have grouped under the following headings:

- Shifting the balance between top down integration and adaptive mode
- Local adoption of national priorities
- Developing strategic leadership of the whole system
- Measurement and evidence

We then go on to make recommendations which offer specific actions aimed at enhancing systemic capability. We believe that if that were to happen, targets would be the joint expression of common objectives, that there would be incentives to use them to achieve the agreed purpose rather than to game-play, and that this would avoid the tendency which is currently very evident of hitting the target but missing the point.

7.1. Targets - making sense of the historical context

This case study concerns the use of targets as a means of achieving changed outcomes in relation to health inequalities. The Commission is working at a time of some transition in the use of targets, and it is worth reflecting on the context, or perhaps contexts, within which the term is used.

At the risk of appearing over-simplistic, it would be fair to say that the period of 30 years following WW2 could be characterised as a time of professional dominance in public service in the UK. While resource decisions and overall direction were set by ministers in government, the significant decisions about how the system operated and its operational priorities were set within professional communities across national and local levels of public service. (Richards et al, 1999) Professional networks provided the linkages between the system's organisational units. The election of 1979 marked the end of that era and the development of an approach to priority-setting and achieving results which was far more centralised. As with most major shifts in government direction, this sprang from popular consensus at the time that things needed to change.

It would be fair to describe the era which ended as having many of the characteristics of a complex adaptive system, and of the era which was about to be formed as a vertically integrated mechanism (Begun, Zimmerman and Dooley, 2003). The public choice ideology which was espoused by the governments of the 1980s made it imperative for them in any case to escape from the producer capture implied by professional dominance, but a commitment to efficiency and improved service standards put those governments on course to centralisation or vertical integration.

Centralisation was sometimes achieved by constitutional changes, such as the removal from local authorities of some functions and their transfer to ministerially appointed 'quangoes' (Stewart, 1994), or removing from professional bodies the practice of setting standards of service, or the removal of locally elected representatives from health authority boards and their replacement by appointees. But often it was achieved via the route of setting targets for local bodies, with rewards and sanctions associated with their achievement. Along with this went systems of performance measurement which were essential to centralised performance management. So without government actually creating new multi-level organisations, the conditions for vertical integration and setting strategies and priorities from the top for the whole system were created. The table below sets out more detail about these two constructs.

7.2. Two alternative modes for system integration

The comparison below is drawn, with adaptation, from the work of (Bourgon, 2009). It sets out the key elements that differentiate a complex adaptive system from a vertically integrated mechanism.

Complex adaptive system	Vertically integrated mechanism
Holistic – focus on the whole	Reductionist – focus on the parts
Interpretive observation	Objective / positivist observation
Mutual causation	Linear causation
Cross-boundary relationship as unit of analysis	Organizational entity as unit of analysis
Like a living organism	Like a machine
A learning culture	Learning through formal feedback
Adaptation and evolution	Episodic re-design of mechanism

Models in action are often not as clear cut as a priori models, and in practice some examples of complex adaptive system working continued during the whole of the period since 1979 in some policy contexts. For example, it was widely accepted even in the 1980s that economic and social area-based regeneration could only be achieved through collaborative relationships across organisational boundaries and through a tight/loose approach to specifying the ‘what’ and the ‘how’ of regeneration. And there was a flowering of complex adaptive system approaches in the period after the election of 1997. The period saw a proliferation of new policies – national service frameworks in health, SureStart, the National Strategy for Neighbourhood Renewal, the various ‘zone’ initiatives. All of these initiatives reflected significant elements of the model outlined above.

However, this was followed after the election of 2001 by a reversion to the alternative approach, led by the Prime Minister’s Delivery Unit with the targets for service improvement that it drove (Barber, 2007). Despite the above exceptions, the vertically integrated mechanism has been the dominant mode of system integration of the last thirty years. This approach frames the experience of targets of public service actors, and it is no secret that there is significant opposition to this approach from local public service practitioners in particular. .

However, there is some evidence that central government is moving towards adopting a different approach. A change in the nature of the key planning mechanism, the Public Service Agreements, and two reports recently produced by the Cabinet Office (Excellence and fairness: Achieving world class public services, 2008 and Working Together - Public Services On Your Side, 2009) suggest that the narrative from the centre on these matters is shifting. These reports, produced in 2008 and 2009, call for a different approach to the relationship between the centre of government and front line professionals, with central government developing a strategic leadership role for itself to replace micro management, and making a commitment to listen to front-line professionals.

These documents make the intellectual case for a shift away from an approach based on the vertically –integrated mechanism and propose something that approximates to a complex adaptive system, but what also needs to be factored in at this stage of the game is the amount of time and change resource needed to move

from an approach as deeply embedded as the top down, vertically integrated mechanism approach has been . It is hoped that the work done for the Commission will contribute to the development of new thinking, followed by new behaviour, about how best system outcomes can be produced.

7.3. Targets under the two models

While the experience of targets of public service practitioners has been predominantly through their use in a vertically integrated mechanism, it does not follow that there is no role for targets in a complex adaptive system (See Whitehead et al, 1998). But they will obviously be differently constituted. As conceived during the 1980s, they were a means of asserting radically new political direction into public service, aiming at change which could not possibly have been achieved through more consensual approaches because of the interests involved. The upside of this was that an elected government was able to achieve change for which it had a democratic mandate. The downside of that was that access to the professional knowledge, situational experience and mobilised energy of public service practitioners was diminished.

It may be that there is now more common ground of agreement on what needs to be achieved, and also widespread disappointment in what has been achieved through vertically integrated mechanistic targets (Gash, 2008). A third factor now looming on the horizon is the cut in public expenditure which is now clearly coming, which will reduce the capacity of the centre to pay for compliance, (Department of Health, 2009). These three factors together pave the way for using targets in a different way. In our own fieldwork, detailed below, we believe we saw practitioners creating the conditions within which commonly developed targets would act to prioritise and frame collective endeavour in pursuit of purpose, redefining in doing so what people commonly understand by 'targets'.

7.4. Evidence on the impact of targets at the micro level

7.4.1. Output and outcome targets

A key step on the way to understanding the impact of targets is to distinguish between those targets which relate to service outputs and those relating to policy outcomes. Much of the public and professional disaffection with targets relates to how vertical integration was used in the context of service outputs, and here it needs to be said that the evidence suggests some success, as well as a negative side which can be attributed to gaming and other practices.

In relation to service outputs, there were some clear gains as a result of this approach. In healthcare, Propper et al. found that, with some caveats, when compared to Scotland "*the target regime in England led to a significant reduction in the percentage of patients waiting*" (Propper et al, 2007). In a comparison with Wales, Hauck and Street found that the "*stronger performance management regime operating in England appears to have contributed to higher levels of performance on service outputs in the English Hospitals*" (Hauck and Street, 2007). Similar headline successes have also been found for NHS Trust performance (Bevan and Hood, 2006), ambulance response times and hospital waiting times (Bevan, 2009).

However, there is also a growing literature on the unforeseen negative consequences of target setting. For example on how targets can devalue individuals and their experiences by only focussing on crude and arbitrary numbers (Gubb, 2009), ignoring whole customer-journeys through public service systems. This can lead to narrow short-term behaviours rather than learning from lessons to achieve long term improvements.

Targets can also be manipulated, encouraging gaming responses from different players in the system. The three most commonly cited responses to targets are the ratchet effect, threshold effect and output distortion (Hood, 2006; Brown, Miller and Thornton, 1994). For examples of the latter within the NHS, waiting time targets can be met through the use of *“clinical decision units, making patients wait in ambulances, admitting patients unnecessarily, discharging people too early, and miscoding data”* (Gubb, 2009). These types of issues are often summed up as *‘hitting the target but missing the point’*.

According to some, the use of targets during this period was exacerbated further by a central management system that put insufficient *“resources into checking performance data, took reported performance gains at face value, and had no coherent anti-gaming strategy”* (Hood, 2006).

While much of the attention devoted to targets in government relates to service output targets such as waiting times, of equal if not greater significance are the policy outcomes which set out the difference that government wishes to make in the real world. Service performance certainly has an impact on health inequalities, but the critical changes in outcomes come from changes in population behaviour which government might seek to influence. It is possible – although not easy – to control performance to achieve service output targets – but changes in population behaviour can only be influenced by adopting a different approach. In practice, the research we have conducted for this report suggests that the best performance on health inequality outcome targets comes from those actors who operate as though they were in a complex adaptive system. They adopt targets as though they were their own rather than reluctantly complying, they work in partnership with others and persuade them to share their commitment, they measure and evaluate the impact of their actions and adapt according to the evidence, and they build sustainability into programmes of work over time since such outcomes rarely come from quick wins.

7.4.2. Health inequality outcome targets

This section outlines the targets on health inequalities which are currently in force. A number of public service agreements (see below) are pertinent to tackling health inequality however it falls specifically under the remit of PSA 18:

“Promoting better health and wellbeing for all” (HM Treasury, 2007)

This is to be achieved by tackling the major killers of cardiovascular disease, cancer, smoking and suicide. Within this, the Government has outlined a number of commitments. One focuses particularly on reducing disparities in health across the population and aims at:

“Reducing health inequalities by 10 per cent by 2010 as measured by infant mortality and life expectancy at birth.”

'Tackling Health Inequalities: A Programme for Action' is an earlier cross governmental strategy document set out in 2003 which outlines how this aim is to be achieved (Department of Health, 2003). The government acknowledges that by these measures health inequality has been increasing. Those two outcome targets – improvements in infant mortality and life expectancy at birth – are aimed in two specific ways:

“Starting with children under one year, by 2010 to reduce by at least 10 per cent the gap in mortality between routine and manual groups and the population as a whole”

“Starting with local authorities, by 2010 to reduce by at least 10 per cent the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole”

These objectives are to be achieved by working in four broad themes:

- *supporting families, mothers and children*
- *engaging communities and individuals* – including areas of deprivation and socially excluded groups
- *preventing illness and providing effective treatment and care* – by tackling smoking, CHD and cancer
- *addressing the underlying determinants of health* – across Government departments

In the final status update on the strategy the Government reported on the progress made so far (Department of Health, 2007). Unfortunately, although there have been increases across groups in terms of improved health and mortality, there has been less progress in narrowing the gap between groups. Although there has been a slight narrowing in the gap in infant mortality, there has been little change in the gap in male life expectancy and inequalities in female life expectancy have actually increased.

Indeed, only 8 of the 62 spearhead local authorities are on target for meeting the aim of narrowing the gap or both male and female life expectancy by 10% by 2010. Meeting the target is regarded under a vertically integrated system as crucial, and during our research we came across a further current illustration of game playing in order to hit the target, while missing the point for which the target stands as proxy. Much effort is apparently currently going on to use care services to prolong late life in order to improve life expectancy to meet the 2010 target. While we do not object at all to efforts to improve the life expectancy of the very elderly, it does appear that this is a tactical response to targets rather than a strategic approach to health inequalities, and thus reinforces the cynicism that practitioners may have about targets (Interview).

7.5. New developments in planning at the macro level

Public Service Agreements originated in 1998 (Brown, 2001) during the early years of the new Labour government and as originally conceived they were consistent with contemporary efforts to achieving policy outcomes through adaptive approaches. They were originally described as a contract between the Treasury and Government Departments for the few specified outcomes that were set out, and indicated a willingness by the Treasury not to impose a centralist performance management

framework underneath them. It was all about keeping eyes on the big picture, setting a high level template and then leaving people free to operate within that template. (Interview with former Treasury official) It fitted well with the then overwhelming sense of common purpose after a landslide election to achieve better public service outcomes.

PSAs, however, provide an interesting example of the way in which attempts to change the public service system are themselves often undermined by the established norms and patterns of behaviour which they are seeking to change (March and Olsen, 1989; Richards, Newman and Smith, 1997; Lowndes, 1998) while clearly being designed by top officials and ministers in the Treasury to focus the system on outcomes, the interpretation of them applied by departments was in fact within the vertically integrated mechanism model, which a whole generation of people had come to believe was the only way to operate. So PSAs were enacted in ways which led in the short term to ever more detailed top-down planning, with a mushrooming of performance indicators and measurement systems.

This centralist interpretation was then reinforced during the second term. The Prime Minister set out his view that 'delivery' would be the key word to describe this second term. The architect of this change in direction, Professor Michael Barber, who became head of the Prime Minister's Delivery Unit, justifies it as necessary to move public services quickly from 'awful to adequate' (Barber, 2006; Maddock and Richards, 2006). However he concedes that leaving service delivery staff without real discretion would not allow performance to progress beyond adequate and would certainly not encourage innovation (Barber, 2007). The second term Labour Government pushed a strong service improvement agenda to accompany the flow of higher resourcing into key areas of public service.

It is a moot question whether a less 'micro-managed' approach would have led to better results in the medium term, but it is without question that it led to the alienation of front line service professionals which resulted from the use of a vertically integrated mechanism model, and that members of the public interacting with the professionals were influenced in turn by their attitude (Nicholls, 2008). Despite real improvements in the quality of public services, it seems the public was unwilling to give credit to the government for this change, so there were few political rewards for the effort involved.

The PSA trajectory has recently been outlined by the government, as summed up by Cabinet Minister Andy Burnham in his July 2007 PSA Reform speech:

"our approach has continued to evolve. We moved from over 600 targets in 1998, to 160 in the 2000 Spending Round, and 110 in 2004. And we've shifted towards outcome-based PSAs ... and this year, we will move from the 600 targets that we had in 1998, to a streamlined set of just 30 outcome-focussed PSAs" (Burnham, 2007)

If nothing else the sheer volume of performance measurement information generated from so many PSAs overloaded the system. The quality of this data is often poor with the NAO reporting that only 30% of PSA data systems were fit for purpose (NAO, 2006). In its 2003 report the Public Administration Select Committee also noted that the bureaucratic burden of collecting, responding to and validating all that information was exacerbated further by tensions within the system.

"The lack of proper integration between the building of an organisation's capacity through what we call 'the performance culture' and tracking

quantitative achievement in the public services through the 'measurement culture.' (Public Administration Select Committee, 2003)

A strong coalition of local public policy interests has been mobilised over the last few years to fight back against what they regarded as an over-centralised system (Lyons, 2006). Key players in this coalition have been local authority leaders, both political and managerial, and the Local Government Association (Bruce-Lockhart, 2006). This coalition of local players was influential in creating the circumstances for a limited number of common priorities in Local Area Agreements, focusing on up to 35 local priorities agreed by stakeholders in Local Strategic Partnerships. The nature of these agreements is negotiated with central government under the leadership of the department for Communities and Local Government. The central government negotiating position is informed by the PSAs, thus creating a loose alignment between central and local levels, although not one which is so tightly coupled that it represents a vertically integrated mechanism.

All of this reinforces the notion of *place* as a key arena within which the integration of different streams of government action needs to be achieved in support of the local population. The Department for Communities and Local Government takes the lead on the place agenda in Whitehall, using the Government Offices in the regions to provide the middle ground, and negotiates on behalf of Whitehall the limited number of local targets in Local Area Agreements, drawing on the Local Strategic Partnership to integrate the local stakeholders in the place, the sub-region or the region.

The new framework for Public Service Agreements came into affect in April 2008. Together with further refinements in the system for Local Area Agreements these changes in the way central government is saying it wishes to work with service and outcome deliverers may mark a significant break from the past.

7.6. Emerging issues on the operation of the planning system

Our examination of the role of targets in achieving improvements in health inequalities has led us to observe a policy planning system which is in the process of changing, pulling back from a vertically integrated mechanistic model and perhaps on the verge of becoming an adaptive system, almost certainly a better way of handling the complex issues involved. In this section we comment on a number of relevant emerging issues.

7.6.1. Shifting the balance in planning

With some exceptions, the targets in the early rounds of PSAs were set to fit within the Whitehall silo system. 90% of the 600 targets set in 1998 were still process (input or output) targets which allowed micro-management of delivery. Indeed, an effect of the first regime of PSAs was to make departments more inward looking (Walker, 2008). The multiplicity of targets made departments focus on meeting their own, rather than considering how theirs related to others' targets. Furthermore, targets of different types and for different departments conflicted with each other, making it very unlikely that they would assist each other in the joint accomplishment of targets.

Even targets for which there was a long established joint responsibility were not easy to achieve. For example, the DCMS, DH and the then DfES joined in 2004 to lead on

tackling childhood obesity and appointed a single manager for the PSA. However, the results were disappointing, not because those within the departments did not recognise the importance of the target but because it had different relative priorities within each department. (Walker, 2008)

While the PSA system has been progressively modified to focus on the key priorities of government, it has been more difficult to make it the only planning mechanism that links central and locality levels. It exists in tandem with a multitude of other policy drivers for each department and hence as one of many priorities.

“All public sector agencies have targets set or imposed outside of the PSA framework. These have a powerful influence on where management attention is focused (e.g. reducing waiting lists) and will impact on the otherwise laudable intention to encourage a ‘self-organising’ response to the public service agreement (PSA) targets by the various agencies.” (Chesterman and Horne, 2002)

Overall there is an unresolved tension between the cross-departmental outcome objectives and the streams of action which flow from Whitehall into their separate delivery networks. How this tension is managed in future years will be important in reducing the costs of friction and gaining greater overall coherence. (Exworthy, forthcoming)

7.6.2. Local adoption of national priorities – the need for local flexibility

Another issue critical to the success of PSA targets is their implementation on the local level. Some people have raised concerns that there was a lack of awareness of PSAs at the local level and that local government indicators were not aligned with PSAs (National School of Government, 2008). Implied in this concern is a failure to recognise that implementation under an adaptive approach is done differently from implementation under a vertically integrated approach.

One of the senior leaders we interviewed, a director general in the Department of Health and the Senior Responsible Owner (SRO) of a PSA, put the case succinctly:

“Targets which land on you from above do not work. We in government have to show more respect to people delivering service. We need to have much better communication between levels of government, develop common understandings and common ground, leading to common objectives and targets that flow from the objectives. Then there will be less of a problem about implementation” (interview)

There is also a danger that those at the frontline experience the new PSAs as just another target, inferring from the past how the future will be. Targets which do not reflect their experience at the community level may be resisted because they are not tailored enough to meet the contingencies of different situations. As the Health Development Manager at Coventry City council says:

“you cannot use a one-size fits all approach... targets have absolutely got to be locally driven” (Interview with Jean Arrowsmith)

The chief executive of Barking and Dagenahm Council (the former deputy chief executive of Lewisham Council) recently commented on the situational aspects of teenage pregnancy in the two boroughs with which he was most familiar.

“In Lewisham, you reduce teenage pregnancy by addressing the sexual behaviour of young black men. In Barking and Dagenham, you do so by addressing the low aspirations of young white women. Central government can set out the what and the why, but we at the local level need to decide on the how.” (Rob Whiteman, Chief Executive, Barking and Dagenham)

A key insight from interviews with local providers whose organisations have been successful at beginning to reduce health inequalities was that flexibility to meet local needs was crucial. In one of our case studies, the importance of local research was highlighted. The Hackney Reducing Infant Mortality Programme used two in depth local research studies as a basis for its efforts, *“having the right research is key to our success”* (interview with Jane Walker). Having detailed information on exactly who was missing out on health services provided a starting point for all the initiatives which followed. In combination with the research a wide ranging local consultation of all stake-holder groups was conducted in order not only to discover the problems with accessing maternity services in the area but to come up with solutions (which were based on providing services within the community). This meant that the initiatives to tackle the problem rather than being fed-down from above were designed by people on the front-line who really knew what the problem was. This helped to win the argument with some actors who were resistant to change. Walker, Co-ordinator of the project, says that even then:

“some people took convincing, PCTs can have difficulty seeing outside the acute setting”.

The importance of locally tailored solutions is reiterated by Jean Arrowsmith, Health Development Manager for Coventry City Council which recently won Beacon status for reducing health inequalities. Local authorities must:

“break the national target down into its elements, apply it nationally, then apply it to your local area, and then apply it to at risk-groups”.

Her health inequalities team has used many different schemes to reduce health inequalities, ranging from using a *Hollyoaks* actress to promote breast feeding to running men’s “health M.O.Ts”, to engaging with local religious groups (see **Error! Reference source not found.** Case Study 1). The point here is that even with one area there are different target groups.

“there is no use tackling ‘Coventry’ because the area is so diverse, you cannot use a one size fits all approach”.

Local flexibility not only produces a more accurate account of local needs, but also provides a legitimating narrative to persuade recalcitrant agencies to join in, and additionally it is clear from our interviews in these case studies that it conveys such a strong sense of local ownership that this further mobilises effort to achieve results.

7.6.3. Developing strategic leadership of the whole system

Despite the challenges discussed above there seems to be scope here for PSA targets to have a positive impact on health inequalities. It seems that provided a

change in the mode of operation of Whitehall, as promised in recent documents (Cabinet Office, 2008 and 2009) from vertical integration to adaptive mode can occur, real change can result (Sorajbi, 2008).

The role of the PSAs' Senior Responsible Owners (SROs) is critical. Project management methodology pins responsibility and accountability for achieving the PSA outcomes on these key individuals, usually the lead Director General on the subject. This focusing of personal responsibility on individual officials (below the level of permanent secretary, the accounting officer for the department) is counter-cultural and fraught with problems, but if the SRO quoted above is representative we may expect to see the role develop so that it is genuinely capable of leading a transformation in the integrative capacity of the system.

In the words of one writer on public service reform:

“accountability for delivery is increased, but the need to deliver directly is reduced. Reform will reward civil servants who deliver by devolving; it will reward effective strategies over ‘big government’ strategies; it will reward consistent progress over newsworthy initiatives” (Sorajbi, 2008).

Leadership is equally relevant across the rest of the system. Our interview with a Director of a (regional) Government Office revealed a clear sense that the answer to achievement of outcome targets lies with the key organisational leaders at regional, sub-regional and place level, rather than the real drive coming from Whitehall PSA targets.

“The jury is out on whether the system will really operate well. PSAs have not been in place for long. PSAs are a pretty mixed bag and you get a bunch of people in Whitehall pulled together who do not have much in common. But I am involved in 3 PSAs and I think we have a higher probability of achieving better outcomes with them than without them”

The interviewee saw the PSA targets as a statement of purpose, but these would only be achieved by the efforts of key leaders at sub-national level to bring together their efforts and work creatively and innovatively to achieve them in practice. She expressed a real personal commitment to achieving change in aspects of the health inequality agenda and saw herself as a key player in creating and implementing the integrated regional strategy which was recently called for in the Sub-National Review (DBERR and DCLG, 2008).

“I feel particularly that worklessness is a very important factor in this. We have 350,000 long term unemployed people in the region. They are detached from the workforce and often have mental health problems also. The poverty that goes with worklessness and the wider mental health problems have an impact on their families and their neighbourhoods. If we could make serious inroads into this worklessness we would also have a big impact on health inequalities (which are just a part of wider inequality). The public sector in this region accounts for half of the economy. There is no reason why we could not make big inroads into this problem.”

A Regional Director of Public Health told us:

“Targets are all very well, but you need to think about what model of change would bring about a transition to a genuinely outcomes-driven approach. We believe in this region that all the leaders will find the strength to do the difficult

things, particularly as we move towards much reduced public expenditure if they see themselves as one team. So we need to invest time together in developing the team and support each other as we go forward.”

Finally, the chief executive of a Strategic Health Authority was similarly focused on leadership, rather than the targets in PSAs themselves, as the key to success:

“PSAs provide a framework and it is better to have them than not, but the key drivers of improvement will be what we as the leaders and senior managers of the system decide to do.”

At the local level, leadership is equally critical. The local providers interviewed believed that PSAs did have a positive influence. However, our interviewee from the Hackney case study points out that:

“having sensible outcome targets does not tell you how you should go about achieving these.”

Our interviewee from Coventry Council says they are:

“genuinely helpful because they reflect what people need nationally”

but having the targets themselves in place does not effect their achievement.

“Innovative leadership is still needed to find creative solutions. PSAs will only serve to ‘focus attention on the problem’ if they are not followed in a ‘dogmatic fashion’ by ‘weak management’” (Interview with Jean Arrowsmith).

Leadership, rather than the PSA targets themselves, seems to emerge from the opinions of these senior stakeholders as the critical factor in achieving outcomes. There was a determination and commitment in how they expressed this which offers the promise of operating in complex adaptive mode, seeing the targets as pointers or expressions of the commitment of the key actors rather than the drive mechanism, with the work done to develop collaboration and mobilisation for common purpose the key intervention.

7.6.4. Measurement and evidence

Top-down vertically integrated targets generate a large amount of measurement and monitoring. The assumption is that such measures capture the essence of what is happening in policy delivery and are a good enough means of judging success and failure in achievement of policy objectives. This activity is resource heavy, both in the number of Whitehall posts which are devoted to it and in its impact on local service deliverers who have the duty to collect and report this information. It is instructive to see how local leaders who are achieving real success in achieving better health outcomes approach the task of measuring their own performance and evaluating their impact. They tend to see the national data as of less importance than the evidence they are able to collect locally.

The well-known problem of outcome measurement applies in health inequality as in other outcomes. It takes time to achieve change so how do you evaluate your performance in the meantime. One local interviewee said:

“you need sustainability for the projects to have an effect – you need to function for years before you can say whether it has had that outcome.”

Local organisations respond to this problem by using outputs as proxy measures for outcomes. The Hackney Reducing Infant Mortality Programme designed its own targets based on clinical evidence which suggested those targets would ultimately lead to a reduction in infant mortality. The danger is that using outputs as a proxy for outcomes results in a lot of monitoring activity which never actually gets used for anything.

“It seems that targets allow a lot of hard monitoring, and that is what they are about really, financially. But not a lot of qualitative feedback. We need a balance between statistics, number-crunching and something which gives you much more of a sense of what actually goes on.” (Interview with Jan Burkhardt).

Coventry uses a number of methods of assessment to evaluate their initiatives. For one of their schemes, they conducted a ‘health impact assessment’ which was both quantitative and qualitative and then it was assessed by an independent evaluator. They use needs based analyses prior to scheme development and health impact assessments after initiation to:

“measure target outcomes and the less tangible outcomes”.

“What you are measuring is not necessarily what the problem is. You need to have the knowledge base about your community in order to unpick it and work out what it means to you. If you just measure things in the way you expected, you’ll get what you expected – it won’t tell you anything. Counting how many buttons you’ve got will tell you you have got ten buttons but it won’t tell you what colour they are.”

Thus a variety of measures need to be used in order to capture the wide-ranging effects of schemes designed to tackle such a nebulous problem as health inequalities. The best achievers of better health outcomes do not rely on national data, but use local knowledge, local research and qualitative judgement in order to shape and guide their own performance. It begs questions about the value of some of the data collected at a national level where the wider qualitative judgments of those close to the ground are not available. There should be a greater recognition of the limited scope of nationally collected information on the means of achieving better health outcomes

7.7. Conclusions and recommendations

This case study takes a macro-level perspective on the place of targets as a planning mechanism in the system relevant to the social determinants of health. It is supported by evidence from government publications, interviews with key staff in central government, in the regions and with service delivery staff in local services. It draws on research conducted by others into the operation of targets in the public policy system, including the work of Doran and Exworthy, and the emergent research on how targets for outcomes might work.

The case study provides both historical background which explains the dynamic behind the creation of the targets regime, and also explores the emergent action being undertaken across the public policy and service system to ameliorate the negative impact of targets and develop a new formulation that facilitates the achievement of better outcomes.

We found in looking at the targets aspect of systems and mechanisms for the achievement of better health inequality outcomes that the system is poised at a point of transition between two modes of integration, with targets having been used over the last three decades as a means of creating vertical integration, so that priorities could be set at the top and then 'automatically' cascaded down the system. We argue – any many others with us – that this approach is not capable of dealing with the complexity of issues, multiple organisational jurisdictions and human behaviour involved in reducing health inequalities. But we do see the potential of an alternative mode of system integration which recognised that staff in the public policy system do not need to be driven unwillingly towards working for better health outcomes. Instead their energies and commitment needs to be mobilised to enable them to do so.

We have not been able to examine the role of targets without considering the context in which they are used, and our recommendations reflect the view that targets in a complex adaptive system are different animals from targets in a vertically integrated one. Our recommendations therefore are linked to desirable system change.

7.8. Key recommendations

Principles for action

- Central government, ministers and officials, should recognise that a new way of relating to the public policy system needs to be institutionalised. PSAs and LAAs should no longer be seen as new ways of operating, but become the only way of operating.
- Savings made on compliance monitoring should, at least in part, go into developing the capability necessary in a complex adaptive system. This would include ensuring that leadership development activities were consistent with this mode of integration.
- Government departments should model complex adaptive system behaviour in everything they do, and should carefully examine current actions to make sure that they are consistent with this mode. Permanent secretaries should give an annual commitment to the National Audit Office that they have not allowed the distortion of purposive activity in order to 'hit the target'
- The role of most policy officials should be re-framed so that they are genuinely engaged as partners with policy delivery organisations, as recommended in a recent report by the Sunningdale Institute (Adebowale, Omand and Starkey, 2009) Career development and training of policy officials should be changed to recognise this re-balancing of their role.
- As effective matrix working only occurs if there is a balance between the two axes of the matrix, further consideration should be given to innovation in governance for PSAs, to reflect on how the role of PSA SROs might be strengthened in leading the systemic achievement of policy outcomes such as

improved health inequalities. This might involve greater transparency around their personal accountability for delivery of the PSA, akin to being the accounting officer for this cross-cutting group of activities.

- Accountabilities for the key public services such as the NHS, police and education system should be examined to ensure that horizontal accountabilities at local, sub-regional and regional levels are as much a reality as the vertical accountability which has been established for some time. Greater transparency will be a step in the right direction.

What should be stopped

- Each department should examine how to reduce compliance requirements on local public service bodies, and the assumptions should be that systems extraneous to PSAs should be removed.
- Central government administrative resources should be re-configured to remove those posts predominantly involved in monitoring compliance with centrally set targets outside the PSA / LAA system.
- 'Tactical' tweaking of activities which leads to 'hitting the target but missing the point' should cease, despite the fact that missing the target may be reported as a failure by audit bodies or the media.

PART 8

The impact of England's health services on global health equity

Matthew Andrews and Don Matheson

The purpose of this briefing paper is to highlight issues relating to the possible impacts of any increases in health worker resourcing in England on health inequalities in other countries.

8.1. Background and issue

England has long been affected by the global shortage of health professionals, and traditionally relied on importing health professionals to meet the shortfall. The source countries have changed over time, from Australian dentists in the 50s (Davie, 2000) to nurses from the Subcontinent and the Caribbean the 60s and 70s (Martineau et al., 2004), and more recently doctors and nursing staff from sub-Saharan Africa and the Philippines (Martineau et al., 2004).

The other side of this flow has been that some lesser-developed countries that have lost health workers. For some countries this has produced a source of income and a way to upskill the health workers that eventually return. For other countries this has caused shortages of health workers and stretched health services – leading to increased health inequalities, both within the country and in comparison with developed countries such as England.

Concerns around this migration were initially raised at the Edinburgh Commonwealth Medical Conference in 1965. The World Health Organization undertook a study into the global flows of medical professionals in the late 1970s (Mejia, 1978). However, the issue did not gain much traction until more recently.

Recently the issue was highlighted by the impact of the NHS workforce expansion in the early part of this decade. *The NHS Plan: A plan for investment and reform* ("the *NHS Plan*"), released in July 2000 outlined plans to increase NHS staff by 7,500 consultants, 2,000 General Practitioners, 20,000 nurses and 6,500 therapists (Secretary of State for Health, 2000). The *NHS Plan* indicated that training would be increased to cover a large proportion of these positions. It also noted that, in the short term, international recruitment would be used to help fill these positions, although the NHS was committed against active recruitment from developing countries (Secretary of State for Health, 2000). Despite this, there appears to have been a rise in the number of health professionals trained outside of England working in the NHS after 2000 – with 8000 of the additional 16000 health professionals being trained outside of the UK (Eastwood et al., 2005). In the UK, the rate of overseas-trained doctors is over 6 times that of France and Germany (Eastwood et al., 2005). Furthermore the number of overseas-trained nurses working in the NHS increased significantly between the 1999/00 and the 2001/02 financial years. The number of nurses from two of the top four sources for overseas trained nurses, Australia and New Zealand, remained fairly constant, while numbers from the other two, South Africa and the Philippines, increased significantly. South African trained nurses doubled and Philippine trained nurses increased 7 fold during this time. There has been public comment and concern raised around this reliance on imported health professionals (Anonymous, 2005).

The 2007 report published by the Department of Health and authored by the UK's Chief Medical Advisor, Sir Liam Donaldson, on global health inequalities (Donaldson, 2007) also highlighted the need for the UK to be concerned about health inequalities globally. The report identified five particular reasons for global health inequalities to be of interest to the UK. These included: ensuring security in the UK and safeguarding investments in UK health and wellbeing; the centrality of reducing global health inequalities to the UK's sustainable development efforts in lesser developed countries; the importance of health industry exports to the UK economy; and that health is both a public good and a human right. This report reinforces the need to avoid efforts to increase healthcare provision by the NHS, that create health inequalities in lesser-developed countries and are not sustainable.

In light of these concerns, the UK Government has been involved in initiatives to address the issue of the depletion of health workforces in lesser-developed countries. It has taken steps to increase its local training capacity, and the Department of Health has developed a code of practice around international recruiting. This outlines that no recruitment of health workers should take place from less developed countries unless it has been agreed to between the Department of Health and the government of the source country (Martineau and Willets, 2004). Furthermore, in 2007 the Government announced its involvement in an International Health Partnership, which aims to improve the health services and capabilities of lesser-developed countries (Department for International Development, 2007). It has also made substantial investments in countries such as Malawi since 2004 enabling salary top-ups to key health professional groups which have enabled their retention in the country (Global Health Workforce Alliance Task Force on Scaling up Education and Training for Health Workers, 2008). More recently (September 2008) the UK government committed £450 to support health worker training in eight of the world's poorest countries (Global Health Workforce Alliance Task Force on Scaling up Education and Training for Health Workers, 2008).

8.2. Commentary

Although significant efforts have been made to address the issues of health worker migrations from less developed countries to England, health system fragility underpinned by an inadequate workforce remains a fundamental weakness for developing countries. Efforts to reduce health inequalities in England that demand that health workers deliver additional health services and programmes are likely to lead to increased demand for health workers from lesser-developed countries. There are clear implications of this in two particular areas. The first of these is the potential to export these health inequalities to countries less able to address them by importing health workers from these countries. The second relates to the sustainability of these efforts if they rely on the continued supply of health workers from less developed countries.

Additionally this may also impact on other Government policies, such as aid and development initiatives to improve health in the countries from which these health workers are being sourced. As such, the implications of any increase in resourcing for the health system need to be considered as part of any effort to address health inequalities in England. Ideally, these implications should be considered at the time of health policy development rather than relying on secondary measures once adverse migration flows have been established. The past decade has seen substantial NHS growth, with a worthy but late response to its impact on developing country health systems. A more proactive response would include national health systems as well as development programs, and also involve a wider range of actors that influence health worker migration.

The shortage of human resources is influenced by the global economy, incentives for migration, and global negotiation on services. Such influences go beyond the health sector and can only be modified through political action at the national, regional, and global level (Ministers of Foreign Affairs of Brazil France Indonesia Norway Senegal South Africa and Thailand, 2007).

8.2.1. Exporting health inequalities

The migration of health workers from lesser-developed countries to developed countries can have notable impacts on the countries they are leaving. Some positive impacts can occur – particularly in middle-income countries where some of the medical training is geared towards export of skilled migrants who continue to send remittances to their home country and generally return. The Philippines is an example of this where a number of those entering medical training, particularly those training in nursing, do so with the intention of working overseas, and the training institutions are intentionally training additional graduates for export. In these cases migration can provide foreign currency earnings and experienced health workers may return to their home country and contribute to practice and teaching in their field. However, economic benefits of remittances need to be balanced against the reality that there is limited evidence that health workers actually do return (Packer et al., 2008), and in the Philippines, despite training large numbers of health workers the country continues to experience increasing shortages of health personnel (Galvez-Tan, 2005).

For many countries, the migration of health workers results in significant shortages of workers in their health systems. This contributes to structural weaknesses in the delivery of health services to the population and in the research and training that helps to develop the health system. These migrations are also a drain on the finances of the governments that fund their training, losing both a valuable health worker and the benefit of their investment in their training.

In some of the poorest countries – particularly in sub-Saharan Africa – the loss of health workers is seriously affecting the viability of their public health systems, and costs their governments significant amounts in lost investment in training. The WHO notes that on average 25% of doctors and 5% of nurses trained in Africa are working in developed countries (World Health Organisation, 2009b). This includes 29% of Ghana's physicians and 34% of Zimbabwe's nurses (World Health Organisation, 2009b). One study notes particular instances where the migration of health workers has led to significant negative impacts on their countries' ability to deliver health services – between 1999 and 2001, 60% of registered nurses left one tertiary hospital in Malawi, and the recruitment the two anesthetists working at a spinal injury treatment facility in South Africa by a Canadian facility led to the temporary closure of the South African facility (Martineau et al., 2004). One recruitment drive for pharmacists in Zimbabwe by a UK recruitment firm led to the virtual collapse of the medical logistical system in the rural districts of Zimbabwe (Stamps, 2002).

This migration can also deplete the ability of these countries to continue health worker training and development as experienced teachers, specialists, academics and researchers leave for roles in developed countries. This not only compromises the ability of these countries to operate an effective health system, it also compromises the continuing supply of health workers to developed countries. The ability of many sub-Saharan countries to train health workers is already limited, 24 of the 47 countries in this region only have one medical training facility and 11 only

have a single medical training facility (Eastwood et al., 2005).

This increases health inequalities in these countries and affects the sustainability of health systems in both the source and destination countries. It is likely to impact on global health inequalities both between and within developing and developed countries. Wealthier segments of the population are more likely to buy health services outside of their public systems, whilst the poorer segments of the population are left to share in diminished health resources, thus exacerbating the existing health inequalities caused by poverty and social inequalities.

There has been notable discussion of this issue, and potential solutions have been put forward, including studies in medical journals (for example articles referenced in this paper that appeared in *Health Policy* and *the Lancet*), the WHO resolution WHA 57.19 (World Health Organisation, 2005), the Kampala Declaration in 2008 (World Health Organisation, 2008) and a number of international, health welfare and human rights non-governmental organizations. The solutions proposed for this, including the Commonwealth Code of Practice for the International Recruitment of Health Workers (World Health Organisation, 2008) and the development of the WHO Code of Practice (World Health Organisation, 2008), involve a complex range of measures undertaken by both countries involved in the exchange that recognize both the right of the health worker to seek better pay and conditions and the right of the population to access appropriate health care (World Health Organisation, 2008). However, as well as managing the conduct of the recruitment processes, this briefing argues any increased investment in health in the UK needs to be planned from the outset in a way that is globally sustainable as well as nationally and locally sustainable.

In addition, as Sir Liam Donaldson noted in the Health is Global report, strengthening health and reducing health inequalities in lesser developed countries strengthens their civil societies and guards against states 'failing', which in turn protects the security and wellbeing of developed countries like the UK (Donaldson, 2007). Exporting health inequalities can in turn have a direct impact on the health and wellbeing, and thus health equity, of the UK.

8.2.2. National and local sustainability of efforts to reduce health inequalities

The patterns of health worker migration from lesser-developed countries to work in the NHS have changed over time and are likely to continue changing. As a number of traditional supplier countries develop they are more likely to retain health workers who currently migrate, and countries with growing economies and growing demands for health care are likely to become competitors in attracting health workers to their systems.

Efforts to reduce health inequalities in England that are operated through the NHS (as opposed to broader efforts to reduce inequalities by improving the social determinants of health) will need to be sustainable in the long term to be effective. Reliance on migration to fill the gaps in the NHS workforce may allow health planners to avoid making the harder, more expensive decisions to set health worker training at appropriate levels, but has its costs.

Changing the social determinants of health to effect an improvement on health inequalities is likely to take time. For some actions, such as informing and encouraging healthy behaviours around nutrition, exercise and smoking, this is likely to be a slow and possibly generational change. A sustained effort will be needed to

reduce health inequalities, and this will be difficult to achieve if a supply of health workers cannot be secured.

8.2.3. Impact on other global policies

Domestic health policy is intricately linked with other government policies. In this paper, the impact on the health workforce in developing countries has been canvassed. However, such issues do not sit separately from issues such as trade and health (World Trade Organisation, 2001), intellectual property rights (World Health Organisation, 2004, World Health Organisation, 2009a), or the global impact of domestic responses to threats such as influenza (World Health Organisation, 2008). The global interface between health policies in England have a broad range and extend far beyond just the health workforce issues.

The UK's *Health is Global* argues its aim is 'to use health as an agent for good in foreign policy,' and 'to promote health equity within and between countries through our foreign and domestic policies' (Donaldson, 2007).

The impact of health worker migration from lesser-developed countries to England on the UK's commitment to the UN's Millennium Development Goals has been noted by a number of commentators. The UK Government is involved in a number of aid and development initiatives that are likely to be affected by any initiatives that draw health workers away from the countries that are the target of the aid and development initiatives.

It is important that any changes to NHS resourcing are considered in terms of how they might impact on the Government's foreign policy and development objectives.

8.4. Recommendations

8.4.1. Principles into Action

The English Health Sector has a global impact: Just as a social determinants approach is built on the premise that actions outside of the health sector strongly impact on health and health equity, it is also true that global health system equity is directly impacted by changes of significant actors within the global health system. In assessing the impact more broadly, we use the term health impact assessment, which is most effective if applied before a new policy is introduced. The same principle applies to the global health system. Global health impact assessment is required early in the policy process of significant English health system developments.

Health Sector Sustainability: England's Health Sector workforce development needs to be planned in a sustainable way such that when increased demand for health workers occurs, it is met without damaging its own, or developing countries' capacity to provide health care to their own populations.

PART 9

RECOMMENDATIONS: PRINCIPLES FOR ACTION AND WHAT SHOULD BE STOPPED

Maintaining the universal health care system and addressing inequalities in service delivery

Key recommendation 1: equity assessments

Equity assessments should be carried out on system changes (planned or implemented) to assess not only whether they are meeting their stated aims, but also whether they are having detrimental effects on the values and equity objectives of the wider system as a whole. There should be provision built into the system for taking action on the findings of these assessments.

Specific recommendations to improve equity aspects of QOF

- The ongoing reviews of both existing and potential new QOF indicators – conducted by the National Institute for Health and Clinical Excellence – should include a formal and comprehensive assessment of their impact on health care inequalities.
- Consideration should be given to including more primary preventive activities in the QOF, where these activities are appropriate for general practice and can be operationalised as QOF indicators. However, the QOF should not be viewed as the only vehicle for promoting primary prevention within general practice.
- The provision to ‘exception report’ patients should be retained. Exception reporting allows practitioners to exercise their clinical judgement and patients to opt out of care. It therefore ameliorates some of the perverse incentives of pay-for-performance schemes to coerce or to refuse care to patients.
- Maximum payment thresholds should be revised annually in light of patterns of achievement by practices. The effect of raising thresholds on levels of, and socio-economic gradients in, achievement and exception reporting should be closely monitored.
- Minimum payment thresholds, if raised, should be set at such a level that they continue to provide an incentive to practices with low baseline performance to improve.
- Indicators for which quality of care is generally high and variation in quality is low should be reviewed for possible ‘retirement’, but activity for these indicators should continue to be monitored.
- Activity data for non-QOF conditions should be routinely monitored.
- Data on quality of care should be monitored at the individual patient level, and linked to socioeconomic and demographic characteristics.

Sustaining a strong population health perspective

Key recommendation 2: ability of system to take population health perspective

The UK’s highly developed system for taking a population health perspective on assessing needs and delivering appropriate public preventive and health promotion services should be safeguarded and enhanced in planned system changes.

Principles for action:

- **Completing the jigsaw.** Strategies that rely just on local interventions will be insufficient to make a lasting and profound difference to the patterns of inequality across the country. Action at all levels of government and active engagement with civil society and the business sector is required over a sustained period of time (probably a decade or longer).
- **Recognise existing contributions.** Much of the NHS and other welfare services make a remarkable contribution to reducing (health) inequality and addressing SDH. Without them, the situation would be far worse. Specific areas of note here are primary health care, universal benefits, and open access (free at the point of delivery)
- **Resist regular re-organisation.** Health reform should take full account of the wider effects/impacts including the anticipated consequences (positive and negative) upon health equity and the social determinants of health. Formal re-organisation and 'natural evolution' of local organisational forms disrupt local partnership working and create planning blight over a period of 18-24 months.
- **Secure local accountability.** Accountability for action and inaction (to reduce health inequality and address SDH) should be more explicit and transparent at the local level, not just to national reporting mechanisms. Such accountability mechanisms would be enhanced by much closer working (and possibly, integration) between welfare agencies at the local level. Recent thinking on systems approaches point toward the benefits of this approach. One implication of local accountability will run the risk of greater inter-area/group variation even though intra-area/group equity will be enhanced. This trade-off should be made more explicit and justified.
- **Create a culture of equity.** Reducing health inequality and addressing the SDH should not be seen as additional activities or objectives but integral to the conduct of a well-functioning health system (in the widest sense of the term). It should become as much a part of the culture of an organisation as quality improvement, for example.
- **Equity starts at home.** The NHS and local government should take greater recognition of their potential to influence patterns of inequality locally through their decision-making (such as employment practices, procurement strategies and internal management of organisations). Inevitably, the extent of reliance of locally-inspired, developed and implemented policies will create the potential for wider variations between areas. This approach should be clearly justified as a response to local needs.

What does not work/areas for disinvestment

The evidence-based movement has placed significant emphasis on the transfer of evidence into practice. This has been captured under the rubric of "what counts is what works." This rubric fails on two counts in the field of health equity and social determinants of health:

First, the research evidence on what does not work has become more unequivocal, including:

- Top-down implementation on its own
- Strategies that rely solely on behaviour change
- Strategies that ignore the role of context as a mediating factor

Second, the emphasis on counting is double-edged. ‘Counting’ refers to a largely quantitative measure. Targets based on measurable aspects have their place and should not be ignored. However, there is scope for greater qualitative input, reflecting the degree to which local context shapes and is shaped by interventions. ‘Counting’ also refers to the degree to which the issue matters. In this case, health equity, the potential number of stakeholders involved is significant. Local voices are invariably lost in determining ‘what counts.’ Stronger efforts should be made in this regard, a point which is supported by a greater emphasis on local accountability.

Championing local multi-sectoral work on social determinants

Key recommendation 3: Local leadership on facilitating joint working

Local mechanisms need to be initiated to make multi-sectoral work on social determinants of health both easier and more effective, through the principles for action set out below.

Key recommendation 4: National and local synergy

Government departments need to support rather than undermine local joint working on the social determinants of health and inequalities. This includes demonstrating that this kind of work is valued nationally through the targets and performance management mechanisms that are put in place; through the setting of adequate timeframes for setting up the joint work and evaluating impact.

Key recommendation 5: Workforce development on determinants of health

Government departments and regional workforce development agencies need to expand capability to understand and act on the social determinants of health in the non-specialist, as well as the specialist, workforce. This requires both reaching out to include practitioners in sectors other than health, as well as expanding capacity in educational establishments to carry out this development work.

Principles for action on working with other sectors on social determinants

- Local mechanisms need to be initiated to make multi-sectoral work on social determinants of health both easier and more effective. These include:
 - agreement on common goals and targets between agencies focused on addressing inequalities in health and wellbeing;
 - the setting up of joint appointments and joint operational units;
 - the increasing use of joint funding mechanisms which are sustainable (moving away from reliance on short-term project funding); and
 - the provision of long-term timescales for the processes of setting up and maintaining partnerships.
- Health and local authority leaders need to demonstrate the legitimacy and priority given to this kind of work by committing their organisations to the above action.
- Government departments need to support rather than undermine local joint working on the social determinants of health and inequalities. This includes:

- demonstrating that this kind of work is valued nationally through the targets and performance management mechanisms that are put in place; and
 - the setting of adequate timeframes for initiating such work and assessing impact.
- Workforce development should include development of understanding of social determinants of health among a wide range of practitioners and the promotion of inequalities sensitive practice.

Having a direct influence on wider social determinants of health

Key recommendation 6:

Local public agencies should be proactive in assessing how they can confront poverty, unemployment and disadvantage in their communities more directly. This includes using opportunities in health care settings to help patients get the social welfare benefits they are entitled to; contributing to rehabilitation of people with longterm sickness to help them get fit for work; and using their organisation's employment and purchasing power for the benefit of the local communities that they serve.

Co-ordinating efforts across the whole of government: targets as a planning mechanism

Key recommendations

Key recommendation 7: Developing common view

Policy makers, professionals and service managers across the system need to escape from the blame culture which has emerged during the operation of previous target regimes. They need to harness the considerable scope for developing common ground, and particularly the scope for developing a common view about the key priorities and how they should be tackled. The new generation of Public Service Agreements (PSA) and the creation of the Local Area Agreement (LAA) system provide promising vehicles for developing the desired common ground on values and outcomes.

Key recommendation 8: shared targets on shared objectives

Targets which are based on shared objectives, and driven through relationships based on mutual respect and appreciation of the logics which drive different players, stand every chance of helping to influence the social determinants of health inequalities.

Principles for action

- Central government, ministers and officials, should recognise that a new way of relating to the public policy system needs to be institutionalised. PSAs and LAAs should no longer be seen as new ways of operating, but become the only way of operating.
- Savings made on compliance monitoring should, at least in part, go into developing the capability necessary in a complex adaptive system. This would include ensuring that leadership development activities were consistent with this mode of integration.

- Government departments should model complex adaptive system behaviour in everything they do, and should carefully examine current actions to make sure that they are consistent with this mode. Permanent secretaries should give an annual commitment to the National Audit Office that they have not allowed the distortion of purposive activity in order to ‘hit the target’
- The role of most policy officials should be re-framed so that they are genuinely engaged as partners with policy delivery organisations, as recommended in a recent report by the Sunningdale Institute (Adebowale, Omand and Starkey, 2009) Career development and training of policy officials should be changed to recognise this re-balancing of their role.
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- Accountabilities for the key public services such as the NHS, police and education system should be examined to ensure that horizontal accountabilities at local, sub-regional and regional levels are as much a reality as the vertical accountability which has been established for some time. Greater transparency will be a step in the right direction.

What should be stopped

- Each department should examine how to reduce compliance requirements on local public service bodies, and the assumptions should be that systems extraneous to PSAs should be removed.
- Central government administrative resources should be re-configured to remove those posts predominantly involved in monitoring compliance with centrally set targets outside the PSA / LAA system.
- ‘Tactical’ tweaking of activities which leads to ‘hitting the target but missing the point’ should cease, despite the fact that missing the target may be reported as a failure by audit bodies or the media.

Considering the global equity impacts of UK initiatives

Key recommendation 9: assessment of global impact

Policies which lead to increased health resourcing in England need to be assessed in terms of their impact on health and health equity in other countries.

Key recommendation 10: sustainable workforce development

Expansion of the England’s Health work force needs to be planned in a sustainable way so that it does not exacerbate the health workforce deficiencies in developing countries.

Principles into Action

The English Health Sector has a global impact. Just as a social determinants approach is built on the premise that actions outside of the health sector strongly impact on health and health equity, it is also true that global health system equity is directly impacted by changes of significant actors within the global health system. In assessing the impact more broadly, we use the term health impact assessment, which is most effective if applied before a new policy is introduced. The same principle applies to the global health system. Global health impact assessment is required early in the policy process of significant English health system developments.

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