



Health Inequalities Action Framework

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Background

Reducing health inequalities requires action on the social determinants of health and will not be achieved by focusing only on improving the health of individuals (Beeston et al, 2013). Actions or programmes to improve health across the whole population can risk increasing inequalities (Lorenc et al 2012). Consequently, health and social inequalities must be considered in the planning stages of services and programmes in order to maximise their potential for contributing to reducing health inequalities. The Health Inequalities Action Framework offers a scheme for assessing plans against theoretical concepts that explain the link between social factors and inequalities in health outcomes, and encourages consideration of the range of actions that might be taken.

The framework was originally developed by Glasgow Centre for Population Health in conjunction with Community Health Partnerships (CHPs) in NHS Greater Glasgow & Clyde as they developed their early plans for addressing health inequalities (Craig, 2010). The framework was subsequently applied by a number of structures, such as: CHPs for developing inequalities strategies, including for a whole CHP (Dundee); children's services (East Glasgow); community mental health services (South East Glasgow: Ross and Craig, 2011); for training and education with practitioners and master's degree students; and four multi-agency partnership *Equally Well* test site groups (Craig 2010).

The framework aimed to establish a generic approach for partnerships to address health inequalities, which used a common theory base and indicators of progress, but could be adapted to the diversity of need in different neighbourhoods and to different planning levels from local practice to national policy.

The main principle behind the framework is that reducing health inequalities requires action on the social determinants of health, and draws from the same theory base as used for the WHO *Levelling Up* reports (Whitehead and Dahlgren, 2006), for the Scottish Government's *Equally Well* strategy (Macintyre, 2007) and for the Marmot Review (Marmot, 2010). A more recent addition to the original framework is a scheme for setting out three levels of interventions as:

- mitigating the impact of inequality on health
- preventing inequality
- undoing inequality (Geronimus, 2000).

These three levels of action are also reflected in a report following up the Marmot review, *Working for Health Equity* (UCL, 2013), which explores the roles of health professionals in acting on the social determinants of health.

The theory base described above makes clear that the NHS alone cannot reduce health inequalities. However, compelling arguments have been made for actions and advocacy by the NHS (Marmot, 2010) and the wider public sector (Christie, 2011)

that can contribute to the prevention and reduction of the widening health inequalities. The Health Inequalities Action Framework aims to support organisations and partnerships to identify and agree the dimensions of action they can take to contribute to reducing the impact of social inequalities on health. This paper provides a brief overview of the concepts underlying the framework and its application to implementation of NHS Health Scotland's strategy for 2012–2017: *A Fairer Healthier Scotland* (NHS Health Scotland, 2012).

Framework summary

The framework should be taken into consideration at an early stage in the planning process, before devising logic models or results chains for outcomes and activity, and the specifics of establishing the planned activity should flow from application of the framework. An impact assessment should be carried out at a later stage in the planning process to identify and mitigate differential impact of the planned service or programme on different population groups. Ideally, the impact assessment should cover social determinants of health, human rights and protected equality characteristics, in order to uncover all groups potentially at risk from material or social disadvantage and discrimination.

As described above, the framework is based on key messages from the theory base and these can be summarised as follows:

- the fundamental cause of health inequalities is the unequal distribution of income, power and resources resulting in patterns of material and social disadvantage that are linked to differences in health outcomes (Whitehead and Dahlgren, 2006)
- action should be aimed specifically at addressing determinants of health inequalities rather than at determinants of health (Graham and Kelly, 2004)
- include lived experience, in particular the voice of the voiceless, to understand the impact of social determinants on health and in designing a response (Whitehead and Dahlgren, 2006)
- distinguish between targeting vulnerable groups and reducing inequalities across the whole population (Graham and Kelly, 2004; Marmot, 2010)
- collaborate across the public sector and vertically through communities to policy, including ensuring participation of communities and individuals in decision making (Christie Commission, 2011)
- actions on fiscal policy, legislation and cultural change are likely to be most powerful in reducing the impact of social inequality on health, but actions that improve equity of access to services and facilities, and that focus on improving health in the most vulnerable groups, can make important contributions to preventing further increases in health inequalities (Macintyre 2007; UCL, 2013)
- measuring progress will depend on setting clear objectives and realistic outcomes at the outset, and indicators should be specific to reducing health inequalities rather than population health improvement (Graham and Kelly, 2004; Marmot, 2010).

The Health Inequalities Action Framework takes the planner through a process of considering these principles in relation to their own topic, strategy or work programme using a series of questions. A summary of the framework is given on pages 4–6 and also provided as a diagram on page 10.

1. Why is action being taken? (Identification of need and knowing the population)

The first step is to really understand the problem. We need to know the demographic make-up of the population we are interested in, for example, age ranges, ethnicity and deprivation indices, and the population or groups most at risk of poorer health. For example, if we were developing a programme on alcohol we might want to know: who is most at risk of problematic use or most at risk of harm; different patterns of risk and impact on health outcomes, including differential impact on groups across the population; and use of services (for example, men and women show different patterns and impact of excessive alcohol use). We would also want to know about individual and social factors associated with increased risk, including the views of populations at highest risk (for example, on service use, prevention, behaviours, impact, carers and experience of alcohol).

This requires a combination of 'hard' and 'soft' data including data: from routine demographics, service use and epidemiology; social data such as levels of deprivation, housing, environment, employment available; and research data which might include direct engagement with target groups, self-reported health and wellbeing surveys, academic social research, third sector service provision and advocacy organisations, health and social service use. The Scottish Public Health Observatory (ScotPHO) website provides analyses of routine and neighbourhood health and social data including topic-based reports specifically for service planning. Lived experience and local surveys are often collected and reported by locally based public and third sector organisations.

2. What is the aim of your action?

Reducing health and social inequalities will require different actions than improving health across a whole population. For example, actions might aim to improve health in a targeted group faster than a comparator group (reducing the gap), or it might aim to reduce inequalities for any disadvantaged group or individual by strengthening equitable provision of universal opportunities or interventions in proportion to need (reducing the gradient).

For example, targeted actions might include an increase in the minimum wage, a service for homeless people, or free swimming for children from low-income households. The targeted actions would clearly benefit those on least income, or in most need, but they could not claim to reduce the gap without action or at least robust comparison at the other end of the scale.

Provision of universal interventions in proportion to need requires understanding of need, including barriers to access to the intervention. For example, NHS services are often assumed to be universal but factors such as disadvantage, ethnicity and disability have been associated with poorer access (EHRC, 2010; SHRC, 2013) and poorer patient experience (Scottish Government, 2011), and additional efforts are required to ensure equality of access to services for those furthest from service provision (Marmot, 2010).

3. How can we act to contribute to reducing health inequalities?

As mentioned above, interventions can be considered through three levels of mitigating, preventing and undoing inequalities (Geronimus, 2000).

Mitigation is where action is taken to reduce the impact of social inequalities on individuals' health and social outcomes. This is where most health and social care services will act as their core work is to improve outcomes for individuals through 'downstream' action on problems. Action at individual level is unlikely to reduce population health inequalities, but can contribute to mitigation if services are sensitive to the impact of the social context around a set of symptoms including the barriers that some people might encounter on accessing services. For example, treatment for a mental health problem stimulated or exacerbated by domestic abuse will be more effective if the abuse is dealt with, or instructions for treatment might not be followed if the service provider is unaware that the patient cannot read well or is not fully conversant with the English language. Services' contributions to reducing inequalities come through ensuring that social factors are addressed, and that equal access to services is available to all regardless of circumstances or ability to articulate or understand health issues. The focus is on improving health of individuals, but in a way that recognises the barriers to health related to social circumstances and takes action on them where possible.

Preventing health inequalities means, essentially, that we are working towards preventing social inequalities having an impact on health and social outcomes. Those most at risk of poor health resulting from social circumstances are those who have least access to health-enhancing living and working conditions, such as high quality housing, affordable healthy food, safe environments and good working conditions. 'Upstream' action is required to ensure that facilities and services are accessible and health-enhancing, for example, by NHS staff advocating for health to be considered in strategies for housing, local environment, transport, education. The focus here is on advocating for change in the structures that provide services and facilities to do more to prevent negative health impact. Community Planning Partnerships, where the NHS contributes to local planning, provide

opportunities for the NHS to influence action to prevent social inequalities impacting on health.

Undoing health inequalities requires a reversal in the policies and social processes that are resulting in increasing social inequality and, consequently, health inequality. For example, economic policies that lead to increasing the wealth gap between rich and poor also result in an increase in the health gap between rich and poor. Reversing health inequalities, therefore, requires action for fiscal, cultural and legislative change, including legislation to prevent discrimination or to establish progressive tax systems (Whitehead and Dahlgren, 2006).

4. Measuring progress: how do we know we're making a difference?

Indicators for measuring progress will depend on the aim and nature of the action. Health inequalities has been described as a 'wicked issue' which means that there is likely to be a variety of actions required, each with a different indicator for measuring progress. For a targeted action, indicators will need to be identified for the targeted group and for a comparator group. The comparator group might be identified as a similar group in a different neighbourhood or the average for a whole population. If a comparator group is not identified at the outset, no judgement can be made of whether a reduction or increase in inequalities has been achieved over time.

Outcomes as a result of proportionate universal provision are more complex to measure as comparisons have to be made across the whole population in order to assess impact on the gradient rather than measuring gaps between named groups. But, where service or structure change is planned, process measures might be used to assess whether services are meeting need more equitably across population groups, that is, achieving greater equality of service access. For example, results of patient experience surveys, uptake of inequality, equality and human rights training or demonstration of changes in strategy or practice as a result of implementation of findings from health inequalities impact assessment.

Conclusion

Reducing health inequalities is a complex ambition and requires different actions taken at all levels. Applying current inequalities theory systematically to planning can help to break down the required actions to the level of tasks that can be planned, implemented and reviewed in order to strengthen our contribution to reducing health inequalities in Scotland.

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Framework to review action on health and social inequalities



