Glasgow Centre for Population Health

BRIEFING PAPER 23 FINDINGS SERIES

The development of a framework for monitoring and reviewing health and social inequalities

January 2010

KEY FINDINGS

A framework for Community Health (and Care) Partnerships was developed to review their actions on addressing health inequalities, based on Whitehead and Dahlgren's *10 Principles for Policy Action on Social Determinants of Health*[1] together with the findings from an analysis of CH(C)Ps' development and service plans.

The analysis proposed that CH(C)P plans for reducing inequalities could be strengthened by the following:

- Using equity principles as the basis for planning;
- Including statements of their aims and objectives for reducing inequalities;
- Clarifying the different approaches they might take;
- Carrying out further analyses of routine data such as linking geography to gender and ethnicity;
- Using new and existing research evidence to gain a better understanding of inequalities in their populations;
- Linking actions more clearly to knowledge about the population together with research evidence for inequalities theory and practice;
- Using appropriate measuring tools for monitoring and reviewing progress on addressing inequalities.

Learning points during the process of developing the framework contributed to the further development of CH(C)Ps' strategies and actions to address inequalities. The final framework has been applied in a variety of settings in order to support development of strategy and action for addressing inequalities and to identify indicators for evaluation and monitoring.

[1] Whitehead, M & Dalgren, G. (2006) *Levelling up (part1): A discussion paper on concepts and principles for tackling social inequalities in health,* WHO Europe

BACKGROUND

In 2006, the Directors of the Community Health and Care Partnerships and Community Health Partnerships (CH(C)Ps) of NHS Greater Glasgow and Clyde (NHSGGC) requested that the Glasgow Centre for Population Health (GCPH) take on the task of evaluating their actions on health inequalities. An Evaluation Project Board was formed to oversee the work and to bring the inequalities evaluation together with another two evaluation processes ongoing at that time which were exploring progress on health and social care integration, and developing a joint performance management system for the integrated CHCPs. The Steering Group comprised representatives from GCPH, NHSGGC, Glasgow City Council (GCC) Social Work Department, CH(C)Ps and Organisational Development, and was chaired by a CHCP Director. At the start of the project the CH(C)Ps were in the process of finalising their re-organisation from Local Health Care Cooperatives (LHCCs) and were in the early stages of establishing their development plans. This timing provided an opportunity to create baseline profiles of the CH(C)P areas from which to draw indicators of progress in the future.

The policy and research drivers in 2006 for CH(C)Ps, to address health and social inequalities, were unclear in relation to the roles they might play and the interventions they might develop despite the fact that many Scottish and UK policies had included the aspiration of cross-sectoral actions to address health inequalities. The Scottish Executive Community Health Partnership Statutory Guidance required CH(C)Ps to address inequalities, but the only advice offered as to how they should do that was that they were expected to:

> *"identify and address the specific needs of the full range of community [groups] such as low income groups, homeless people, asylum seekers, minority ethnic groups and travellers, people with HIV/AIDS or children with complex health needs, and work in partnership to address their needs"*[2]

Recommendations from research were equally vague. One study found that only 0.4% of published public health research could provide recommendations about interventions that might reduce health inequalities, due to a lack of research studies that included an inequalities perspective[3]. The absence of clear guidance for CH(C)Ps from policy and research for addressing inequalities meant that they had little support for, or obligation to, develop strategies to address inequalities. In the absence of clear aims, objectives and interventions for CH(C)P actions to address health and social inequalities, a traditional evaluation study could not be undertaken. Instead, the project required to first explore fully the policy, research and practice potential for CH(C)P actions to address inequalities before going on to identify indicators for monitoring and reviewing progress.

[2] Scottish Executive (2005) *Community Health Partnership Statutory Guidance,* Scottish Executive, Edinburgh, p18

[3] Kelly, M.P., Speller, V. & Meyrick, J. (2004) *Getting evidence into practice in public health*, Health Development Agency, London

AIMS AND PURPOSE

The purpose of the overall project was to develop a local monitoring framework for reviewing CH(C)Ps' progress on action to address health and social inequalities, taking into account knowledge of the local populations, legislation, national and local objectives and strategies, available research evidence, and national and local routinely collected data.

The aim for Phase 1 was:

To explore and define an inequalities-sensitive planning process for NHSGGC CH(C)Ps that incorporates a population perspective.

Objectives for Phase 1:

1. Identify the definitions and actions for addressing health and social inequalities described in CH(C)P development plans.

2. Explore the implications of planning for health and social inequalities within CH(C)P development plans and three specific service plans.

3. Produce a model service plan in conjunction with NHSGGC and participating CH(C)Ps that demonstrates the ways in which action on health and social inequalities might be incorporated.

4. Ensure relevance to NHSGGC CH(C)Ps by providing stakeholders with regular feedback and opportunities to contribute.

The aim for Phase 2 was:

To create a framework for identifying indicators for CH(C)Ps to monitor and review progress on actions to address inequalities.

APPROACH AND METHODS

The project adopted an action research approach[4] to guide the exploration, in order to create a process of mutual learning as the CH(C)Ps established their objectives for addressing inequalities. The balance between action and research for this project was weighted more towards exploratory research in the first instance with action building on feedback to key CH(C)P stakeholders at a later stage.

An analysis of the CH(C)Ps' initial development plans for 2006-2007 was carried out to inform the project's aims and objectives. Further clarification of strategies and actions taken by CH(C)Ps for health and social inequalities for the Phase 1 exploration was sought by analysing the second round of development plans (for 2007-2010), and three CH(C)P service structures: for children's services, learning disability services and for health improvement. Phase 1 also included the development of new community profiles providing health, social and environmental information for the NHSGGC CH(C)P boundaries[5].

The policy, strategy and research contexts for the analysis included national drivers from the 2005 Scottish Executive CHP Guidance and local expectations from the NHSGGC Priorities and Planning Guidance. The Glasgow City Council (GCC) social work objectives were also included for the Glasgow CHCPs. The analysis was carried out by comparing the inequalities actions from the development plans against a set of 10 principles for action on social inequalities in health produced by Margaret Whitehead and Goran Dahlgren for WHO Europe in 2006[6]. Whitehead and Dahlgren assimilated a large body of policy research on social inequalities in health to produce the principles which were intended to inform country level policies. However, their application to CH(C)P level planning was as a relevant foundation for discussion of the CH(C)P actual and potential roles in addressing health and social inequalities.

Findings from the CH(C)P development plan analysis were fed back to, and comments invited from, key stakeholders in a variety of ways throughout the process. The regular interactions with stakeholder groups resulted in findings contributing to and stimulating new actions throughout the project.

The full analysis included all but one of the development plans from the 10 NHSGGC CH(C)Ps (the 10th CHP had been set up too late to have produced its plan at the time of the analysis), and plans for children's services in East Glasgow CHCP, learning disability services in East Renfrewshire CHCP and health improvement in South East Glasgow CHCP. Data were collected through document analysis of written plans, with additional data for service plans collected from locally available papers and minutes, and interviews and focus groups with key informants. The full report of the analysis is available from GCPH[7] and is summarised in the following section.

[4] Hart, E. & Bond, M. (1995) *Action Research for Health and Social Care: a guide to practice*, Open University Press, Buckingham

[5] GCPH Briefing Paper, Findings Series number 14, *Community Health Profiles of Greater Glasgow and Clyde*, Glasgow Centre for Population Health – http://www.gcph.co.uk/component/option,com_docman/task,cat_view/gid,18/Itemid,71/

[6] Whitehead, M & Dalgren, G. (2006) Levelling up (part1): A discussion paper on concepts and principles for tackling social inequalities in health, WHO Europe

[7] Craig, P. (2009) Framework for monitoring and reviewing health and social inequalities, 'Report from Phase 1: exploration of CH(C)P plans for addressing health inequalities, Glasgow Centre for Population Health

PHASE 1

Summary of findings from inequalities analysis of CH(C)P plans

The exploration and analysis of the development and service plans provided insight into the CH(C)P planning processes and the potential for further development of strategy and practice for addressing inequalities. The main findings are summarised here under the headings of: *Objectives for reducing inequalities; Action plans; Practice; and Indicators*.

Objectives for reducing inequalities
Only four of the plans included some aspect of inequality in their stated aims. Aspirational statements for reducing inequalities rather than operational objectives were included in most, and equity principles were not evident in planning processes. Instead, they appeared to be estranged from the development plans and embedded in separate equality and diversity plans.

None of the plans appeared to use research evidence as the basis for addressing inequalities. For example, Whitehead and Dahlgren's principles call for a clear distinction between actions that aim to promote health across populations and those that aim to reduce inequalities. CH(C)P plans tended to conflate the two despite a well-established body of research evidence that demonstrates that careful consideration of population approaches needs to be taken if they are aiming to reduce inequalities. For example, CH(C)P population-wide approaches often required individuals to opt in, such as including a requirement to take up appointments or attend group sessions. These types of actions have been shown to benefit those that are willing and able to take them up but there is strong research evidence that individuals with the poorest health or greatest disadvantage are least likely to take part[8]. Consequently, the CH(C)Ps' population approaches might contribute to increasing rather than reducing health inequalities. Another example, where a large body of research was missed by the CH(C)Ps, was in their choice of 'targeting' as their stated approach to addressing inequalities, with little discussion about how local information or wider research informed their decision making processes. In the absence of complex analysis of population demographics together with full consideration of implications for a proposed intervention, there could be the potential for certain groups or individuals who were already vulnerable to be further disadvantaged by redistribution of resources away from them to target another priority group.

The Whitehead and Dahlgren principles also included Graham's analysis[9] that distinguishes a targeting approach to reducing health inequalities from two other approaches – namely 'narrowing the gap' between defined groups and 'reducing the population gradient'. The three approaches should be described separately in order to agree research questions, policy implications and measurement but in practice they need to work together if inequalities are to be reduced. To clarify the three approaches: the first one targets an intervention at a named group and would aim to achieve improved outcomes for that group only. The second

[8] Gwatkin, D. (2003) How well do health programmes reach the poor? The Lancet, 361 (9357), pp 540-541

[9] Graham, H. (2004) Tackling inequalities in health in England: remedy health disadvantages, narrowing health gaps or reducing health gradients?, *Journal of Social Policy*, 33 (1), pp115-131

approach, of reducing the gap, requires a comparator group to be named in addition to the targeted group so that a difference, or a gap, between them can be achieved, measured and monitored over time. The third approach, of reducing the population gradient potentially requires a different method as it would be impossible to name and to measure differences between all the different population groups throughout the social spectrum. Instead, services adopt the third approach by aiming to change the ways in which they respond to different needs of different population groups. This approach to health service provision has been described as inequalities-sensitive practice[10]. Services can develop inequalities sensitive practice by ensuring that they tackle the discrimination, lack of opportunity and poorer service outcomes associated with lower social status thereby addressing causes as well as the results of poor health.

While each of the three approaches stands alone as a method of addressing health inequalities, they are interlinked. For example, reducing the gap cannot be done without targeting an intervention at population groups with poorest health, and inequalities-sensitive practice is required within all interventions to ensure that everyone in the population has their needs understood and met. None of the CH(C)P plans included this type of analysis and instead, the majority appeared to assume that targeting alone would reduce inequalities without establishing clear objectives or measurements of progress. While Equality Strategies were in development at the time of the study, they were in their early stages and were regarded as additional to core planning processes.

Action plans for inequalities

Most plans included data that suggested a link between social factors and poor health outcomes but plans for action were generally not explicit about the implications of this link for CH(C)P services. For example, one plan mentioned different patterns of alcohol-related illness in men and women but service plans for alcohol problems did not include mention of gender. Some plans stated aspirations to address inequalities but linked these aspirations to targeted health behaviour change or through working with Community Planning Partnerships without specifying what that work would entail. Specific actions, leadership or accountability for reducing inequalities were rarely given for named staff groups or individuals.

Practice for reducing inequalities

Some examples of CH(C)P practice for action on health inequalities that embodied the Whitehead and Dahlgren principles included Health Impact Assessments, which some CH(C)Ps had either already carried out or intended to carry out. Health Impact Assessment was proposed by Whitehead and Dahlgren as a useful method to ensure that vulnerable population groups will not be further disadvantaged by new policies and strategies. Another example of practice, in accordance with the principles, was where CH(C)Ps had put in place processes to gather the views of particularly vulnerable groups in order to inform planning and delivery of services. However, these practices were not universal or part of mainstream services and in some cases depended on additional resources being sought to carry them out.

[10] Developed by NHSGGC as 10 Goals for Inequalities Sensitive Practice, website: http://www.equalitiesinhealth.org/current_activities_10goals.html [Accessed Jan 09]

Indicators

Most of the development plans described links between ill-health and the health and social inequalities in their areas and used geographical differences to rank themselves against other areas. However, all of the plans used different indicators to describe their inequalities *and* used different geographical levels, including: comparisons between one or more SIMD datazones; or comparisons between their CH(C)P and a variety of geographical levels including other CH(C)Ps, Glasgow City, NHSGGC, Scotland, UK, and one compared their CHCP with Europe. Whitehead and Dahlgren's principles proposed that analyses of gender and ethnicity and their interaction with geography were important in gaining better understanding of the extent of social inequality and its impact on health. With very few exceptions, the CH(C)Ps did not include mention of the impact of gender and ethnicity on health inequalities although a small number of plans recognised the complexity of the interaction of different factors and the impact of this on health.

Conclusions and recommendations from Phase 1

Examples of practice drawn from the CH(C)Ps' plans met or partially met some of the principles set out by Whitehead and Dahlgren. While targeting the worst off was the basis of most of the proposed actions, there was aspiration in some of the plans that service improvement for the most vulnerable members of the population would work towards more equitable service provision and closing of the health inequalities gap. Whitehead and Dahlgren suggest that targeting the most vulnerable groups is likely to be a good place to start in taking action on inequalities, and the CH(C)Ps' plans suggest that further development could build on work already taking place.

The exploration highlighted actions for policy, strategy and practice which could potentially be strengthened and further developed in order to enable CH(C)Ps to work more closely to the principles for action proposed by Whitehead and Dahlgren. Based on the results of the application of Whitehead and Dahlgren's principles to CH(C)P plans, the following recommendations were made (Table 1).

Table 1

Recommendation	Responsibility
1. Equity principles should be explicitly used as the basis for planning inequalities strategies and accountability in order to **clarify CH(C)Ps' aims, objectives and roles** in reducing health and social inequalities.	Scottish Government, NHSGGC, GCC, CH(C)Ps
2. CH(C)P corporate management teams and practitioners should explain the **approaches** they aim to take to address inequalities in order to strengthen the effectiveness of their actions and clarify the basis for measuring progress. Consideration should be given to the capacity for actions within different parts of the system.	NHSGGC, GCC, CH(C)Ps
3. Routine data should be broken down where possible in order to advance understanding of the **demographic profiles and potential health and social needs** of local populations. For example, breakdowns for gender, age and ethnicity, and combinations of factors should be explored, such as geography with gender and ethnicity, or linking health outcomes with social circumstances.	CH(C)Ps, GCPH, NHSGGC, GCC and ISD[11]
4. New and existing **research evidence** should be used (or commissioned) to better understand the impact of inequalities on health and wellbeing of local populations. This should include consideration of the less 'measurable' impacts of discrimination and gender roles on health, and knowledge, gleaned from engagement with local populations - for example through the Public Partnership Forums.	GCPH, NHSGGC, GCC, CH(C)Ps
5. Proposed **actions** to address inequalities should build on the stated aims and approaches, information, research and practice in order to maximise their effectiveness and relevance to the local population. Actions should include meeting individual needs and addressing the social inequalities that can lead to health inequalities.	CH(C)Ps, NHSGGC, GCC and GCPH
6. Appropriate **measurement tools** for each of the three approaches should be used to review and monitor progress on addressing inequalities taking into consideration national targets, performance management and local actions.	CH(C)Ps, GCPH, NHSGGC and GCC

[11] Information Statistics Division Scotland – part of NHS National Services Scotland

PHASE 2

Establishing an inequalities framework

Phase 2 aimed to create a framework for identifying indicators for CH(C)Ps to monitor and review progress on actions to address inequalities. The exploration and analysis of CH(C)Ps' plans using Whitehead and Dahlgren's principles identified that more detail on CH(C)Ps' intentions would be required before specific indicators could be agreed. In addition, during the exploratory phase, a new national context for addressing inequalities arose through publication of *Equally Well*[12] together with new aims to incorporate inequalities dimensions to NHS performance management targets (HEAT targets) and to Local Authority and Community Planning progress measures for meeting agreed local and national outcomes (Single Outcome Agreements). The search for indicators was therefore influenced by a number of factors:

- existing data from the GCPH Community Profiles;
- policy and strategy, in particular, *Equally Well*, HEAT targets, the NHSGGC Priority and Planning Guidance and the Single Outcome Agreements;
- evidence about relevance to NHSGGC CH(C)Ps from the Phase 1 exploration described above;
- evidence and theory from inequalities research, particularly the work of Whitehead and Dahlgren[13] and Graham and Kelly[14];
- additional expert opinion from CH(C)P, NHSGGC and GCC representatives through a consultation event and additional meetings with the Evaluation Project Board, CH(C)P Heads of Planning and other NHS senior managers.

A mixed approach was adopted, similar to that described by Parkinson[15], taking into account data, policy, research evidence, theory and experts' perspectives. Expert opinion from stakeholders confirmed that meaningful indicators for monitoring and reviewing progress could not be agreed without first clarifying priorities, actions, roles and responsibilities. Consequently a generic framework was proposed that would support the CH(C)Ps in specifying the scope of their actions on inequalities for any priority or programme in order to provide the background for identifying relevant indicators for reviewing progress.

The framework is illustrated as Figure 1. Each of the boxes in the framework is underpinned by the research-informed principles described by Whitehead and Dahlgren and set out in a way that links the principles with the objectives and work programmes of CH(C)Ps as defined by the Phase 1 findings. The boxes are sorted into sections labelled *What, Why, How* and *Progress* but the sections are not intended to be hierarchical or depicted as a step-wise process: in contrast, use of the framework could potentially begin with any of the What, Why or How sections and the Progress section could be discussed alongside the What section. However, the aim of addressing inequalities within the topic, programme or intervention should be agreed at the outset.

[12] Equally Well: Report of the Ministerial Task Force on Health Inequalities – http://www.scotland.gov.uk/Publications/2008/06/25104032/0

[13] Whitehead, M & Dalgren, G. (2006) Levelling up (part1): *A discussion paper on concepts and principles for tackling social inequalities in health*, WHO Europe

[14] Graham, H and Kelly, M.P. (2004). *Health Inequalities: concepts, frameworks and policy*. Health Development Agency/ NIHCE, London

[15] Parkinson, J. (2007) Establishing a core set of national, sustainable mental health indicators for adults in Scotland: Rationale paper. Health Scotland, http://www.healthscotland.com/documents/2160.aspx

Figure 1: Framework for reviewing action on inequalities

What

1. Stated aims for reducing inequalities

2. Three approaches

- *2.1 Targeting the worst off*
  Focus initiatives to most deprived areas or named groups
- *2.2 Reducing the gap between groups*
  Different interventions or resource allocation between groups
- *2.3 Reducing inequalities across the population*
  Wider cultural change
  Inequalities sensitive services

Why

3. Identification of need and baseline position

- *3.1 Data about individuals*
  Routine data e.g. gender, age, ethnicity (where available) etc
- *3.2 Data about the population*
  Prevalence, risk factors, social circumstances, geographical differences
- *3.3 Additional research*
  Service uptake, local demographic changes, equity impact assessment, impact of social inequalities on topic, public perspectives

How

4. Interventions

- *4.1 Evidence informed services for individuals*
  Clarify how service interventions for individuals and groups focus on inequalities e.g. by targeting, resource re-allocation, workforce development, reflective practice, patient/public involvement, employers policies etc
- *4.2 Action on social and economic circumstances*
  Poverty (e.g. nutrition, benefits, employment etc), discrimination and isolation, social and family support, access to and equal outcomes from services, transport, environment, cultural and leisure opportunities, local partnerships

Progress

5. Outcome measurement and review
Three approaches

- *5.1 Targeting the worst off*
  Absolute improvements seen in targeted group
- *5.2 Reducing gaps between groups*
  Relative or absolute differences reduced between the different groups identified
- *5.3 Reducing inequalities across the population*
  Reduction of the gradient across the population.
  Shorter term process measures relevant to services might include resource re-allocations, workforce inequalities competences etc

The framework assumes political commitment to reducing health inequalities and that actions to do this will include aiming to improve health for individuals as well as to tackle the social dimensions of inequalities that lead to health inequalities. Sections 1 and 2 in the diagram highlight the importance of clarifying that a particular programme or action is developed in a way that aims to address inequalities and that the approaches taken are clearly articulated. As discussed in the findings section for Phase 1, the three approaches to addressing health inequalities require a different set of aims, questions, actions and measurement tools but they are closely linked. For example, targeting alone (Box 2.1) is unlikely to reduce inequalities although it would form a crucial arm of a wider, whole-system health inequalities strategy that included resource allocation in favour of a targeted group and inequalities sensitive practice that addressed the causes of poor health as well as the results. Reducing the gap (Box 2.2) might include the actions taken within a targeted approach with the addition of re-allocation of resources or different interventions being applied to a comparator group. As discussed previously, inequalities sensitive practice (Box 2.3) should underpin all actions to address health inequalities but should be measured separately to identify progress in service provision and, in the longer term, changes in the health gradient across the whole population. Consideration of the different approaches taken within a programme or intervention can help to identify the respective roles of different parts of an organisation or partnership in taking strategic action to address inequalities. For example, responsibility for decisions about resource allocation, development of the workforce for addressing inequalities and for delivering a targeted intervention are likely to lie within different parts of the system.

Section 3 in the diagram identifies the factors involved in assessing need and creating a baseline for measurement of progress. Whitehead and Dahlgren emphasise the need to take into account the complexity of inequalities to enable full understanding and to develop effective action. Routine data on individuals and populations including demographics, health outcomes, morbidity and social circumstances can paint some of the picture about social determinants of health, but often, additional research will be required to provide local context and enhance understanding of the complexity. For example, social factors linked to poorer health (such as poverty, gender and ethnicity) should be considered in combination and together with geographical measurements in order to gain a better understanding of the differences in the health and wellbeing of the population. Additional research would be required to fully understand the impact of these factors on health outcomes.

For interventions (Section 4), social inequalities that are linked to poor health outcomes should be addressed alongside the needs of individuals. In the CH(C)P context, some health and social service providers might regard action on social inequalities to be outwith their scope; in that case, thought should be given to where that service as a whole might interact with other services or structures that are taking such action. Section 5 links measurement with the approaches identified for the programme or intervention. Measurement of progress and outcomes for each approach will require different methods and could take place within different time scales. A targeted approach would only measure change in the targeted group; reducing the gap would measure inequalities between the targeted group and another, named group; and a reduction in the gradient would be measured by longer term population change or process measures relating to the actions taken by the organisation.

CONCLUSION

Analysis of the CH(C)Ps' development and service plans identified that further development was required for action to address inequalities to meet the research-based principles. Since the analysis was carried out, the Scottish Government has published Equally Well and this has provided the policy context for further work to strengthen CH(C)Ps' roles in addressing inequalities. During the process of developing and finalising the framework, it demonstrated its utility across a range of settings for facilitating discussion on the complexity of addressing health inequalities. In doing so it has helped teams to specify what they can realistically set out to achieve in addressing health inequalities, agree collectively where they should focus their efforts, and define the basis for evaluation strategies. The main strength of the framework identified to date lies within its ability to pinpoint the inequalities-related dimensions for health and social programmes or interventions. However, further work needs to be carried out by the teams to plan fully the implementation from setting objectives through to measuring progress.

At the time of writing, work is underway to explore integration with NHS Greater Glasgow and Clyde's planning processes, apply the framework to a variety of practice and strategy developments and pilot its application with Equally Well test sites for identifying generalisable indicators for measuring progress on health inequalities across Scotland. Links between the framework and planning tools such as logic modelling are also being explored. The results of these applications will be reported in future GCPH publications.

CONTACTS

Dr Pauline Craig

Glasgow Centre for Population Health

1st Floor, House 6

94 Elmbank Street

Glasgow G2 4DL

Tel: 0141 287 6263

Fax: 0141 287 6955

Email: Pauline.Craig@drs.glasgow.gov.uk

Web: www.gcph.co.uk