Glasgow Centre for Population Health

BRIEFING PAPER 30 FINDINGS SERIES

Focus on inequalities: a framework for action

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INTRODUCTION

The persistence of health inequalities has been described as a 'wicked issue', posing a complex set of problems, with multiple causes and no clear solutions[1] . Health Policy in Scotland since the publication of Towards a Healthier Scotland in 1997[2] has prioritised health inequalities as an overarching theme across government and delivery organisations. However, despite best efforts, there is evidence that health inequalities across the Scottish population are increasing[3]. Equally Well[4], the 2008 report of the Ministerial Task Force on Health Inequalities in Scotland, set out strategic recommendations for public sector service structures for addressing health inequalities and set up eight Test Sites to develop new ways in which services can be re-designed to respond to the complexity of health inequalities. When Equally Well was published, Glasgow Centre for Population Health (GCPH) was in the process of developing a framework to support Community Health (and Care) Partnerships (CH/CPs)[a] to plan, monitor and evaluate action on health inequalities, based on principles developed by Whitehead and Dahlgren[5] for country-level policy. The framework has since been further developed and applied to a variety of settings, programmes and topics, including three of the Equally Well Test Sites, supporting service providers to define their approaches to health inequalities and identify objectives and indicators to enable measurement of progress. This briefing paper describes the application of the framework in order to stimulate further development of action to address health inequalities in Scotland. The approach continues to be developed, and recommendations are made for strengthening planning and practice to reduce health inequalities.

BACKGROUND

Overview of health inequalities research, theory and policy

One step to take in attempting to break down the complexity surrounding health inequalities is to clarify the assumptions made behind the terminology used. The phrase 'health inequalities', and related terms, can be interpreted in different ways. For example, the terms 'health inequality' and 'health inequity' are often used interchangeably although the former more accurately refers to observed measurement, while the latter suggests an element of unfairness with factors in play that are potentially amenable to change[5]. Differences within the population are to be expected, but it is when these differences are as a result of an unequal distribution of resources or when the differences prevent an individual reaching their potential that they are unfair. The term 'health inequalities' is more commonly used in UK literature and policies but the usual interpretation involves more than observable, measured variation. For example, Equally Well seeks indicators for measurement of progress in reducing the health gap but at the same time clearly emphasises the links between health inequalities and social justice.

[a] Greater Glasgow and Clyde NHS Board set up Community Health Partnerships and Community Health and Care Partnerships, hence the abbreviation, CH/CPs. National policy documents and most other NHS Boards use only the title of Community Health Partnerships (CHPs). Both are referred to in this document depending on the structures under discussion.

Recent Scottish evidence demonstrates that inequalities in mortality are increasing between social classes and between more and less deprived areas, partly due to increases in diseases relating to alcohol and drug use in deprived areas and, at the same time, reductions in ischemic heart disease in affluent areas[6]. Narrowing the health gap is now recognised as one of the major policy challenges for Scotland. Graham and Kelly[7] argued that the causes of poor population health are different from the causes of health inequalities and that different strategies are required to reduce health inequalities from those to improve health more generally. They noted that the causes of poor health such as poor diet, poor educational attainment and unsafe environments were unevenly distributed across the population, with risk of poor health decreasing as social class ascended. Lower social positions arising from, for example, low income, gender assumptions, belonging to a minority social group or combinations of these factors, reduce opportunities for access to resources for health such as good quality commodities (for example, housing and food), social mobility, or attending the best schools. Therefore, strategies to improve health require improvements in, for example, housing, food, and environments; and strategies to tackle health inequalities require not only these health improvement approaches but also action on the causal factors for social inequalities: discrimination and lack of access to resources.

Government-funded reviews of health inequalities in the UK, from the Black Report in 1982[8] to the recent Marmot Review[9] in England, have recommended concerted action by public sector services to improve living standards, focus on early years, and to work together to prevent social inequalities arising as well as to deal with the consequences. However, there is a well documented dearth of specific interventions that will unequivocally reduce health inequalities[10]. For example, one study found that only 0.4% of published public health research could provide recommendations about interventions that might reduce health inequalities. The lack of effectiveness evidence for reducing inequalities is said to be in part due to the lack of robust evaluation studies measuring specific outcomes relating to health inequalities[10,11] but the complex nature of the multiple causes and impacts of inequalities in health does not lend itself to effectiveness studies of discrete health interventions.

The lack of published research for public health interventions should not translate into a lack of action as there is a wealth of less formalised research and practice to draw on from a variety of disciplines. Academics studying health inequalities have proposed recommendations for planning policy interventions to address health inequalities. For example, Whitehead and Dahlgren drew on almost 40 years of inequalities research to create a list of ten principles for policy action on social inequalities in health[5]. Macintyre also drew on much of the same research as well as results of intervention research studies from a variety of disciplines to inform the Scottish Government's Equally Well strategy[4] and identified that in recent years, more evidence is beginning to emerge in the UK and Scotland for actions that can potentially reduce inequalities in health[11] . In particular, Macintyre identified some characteristics of policies that might result in reduced inequalities including structural and legislative changes, support for increasing income to counter poverty, and prioritising certain groups such as young people and people living in deprivation.

The Equally Well strategy currently provides the main policy context for cross-sector action on reducing health inequalities in Scotland together with Achieving our Potential and The Early Years Framework, and aims to use and contribute to the emerging evidence base. Equally Well focuses on the potential for the public sector to reduce inequalities through service redesign within existing budgets, and leads the public sector in tackling the underlying causes of poor health and health inequalities including poverty, environmental

factors and climate change. The strategy sets out the principles underpinning these recommendations, helping to clarify the rationale for actions. These can be summarised under the headings of Causes of Health Inequalities, and Public Sector Responses, as follows:

Causes of health inequalities
An individual's health is shaped by their physical and social environment starting from the very early years. Early intervention is crucial in terms of the individual's age and timing of the input, in order to offset problems before they become entrenched. Individuals, families and communities who are at greatest risk of poor outcomes must also be enabled to contribute to decision-making in order to reach relevant solutions and build capacity for self determination and wellbeing.

Public sector responses
Public services should work on providing routes out of poverty and other difficult social circumstances for individuals, act to prevent societal barriers to wellbeing, and deal with the consequences of problems. The focus for the public sector is to change service delivery by shifting resources towards improving life circumstances and environments, developing mainstream responses rather than projects, prioritising those most at risk within universal provision, and responding better to people with complex problems. Services should use evidence and evaluation to inform and drive action, seeking short and long term impact. They should also develop shared outcomes across partner agencies, supported by performance management, public reporting, alignment of resources and a workforce able to work effectively together across organisational boundaries.

A Scottish Government study of Community Health Partnerships (CHPs) published in 2010 identified that CHPs were aware that improvements in health had been achieved in Scotland in recent years but that the gap between affluent and deprived areas continued to widen[12]. The study found that some CHPs worked closely with Community Planning Partnerships, or were involved in Equally Well or Keep Well initiatives. Even though they could describe examples of good practice in addressing inequalities, most CHPs believed that addressing health inequalities was one of the hardest of their responsibilities to tackle and that further work was required to strengthen their roles. The study suggested consideration of CHPs' roles in exerting influence across Community Planning Partnerships to tackle health inequalities. The role of the CHP services themselves in addressing inequalities was not discussed in the report.

The framework described in this paper provides a mechanism for translating the research and policy principles for health inequalities into practice. It provides illustrations of applications by Scottish partnerships and programmes in order to support further development of practice to address health inequalities in Scotland.

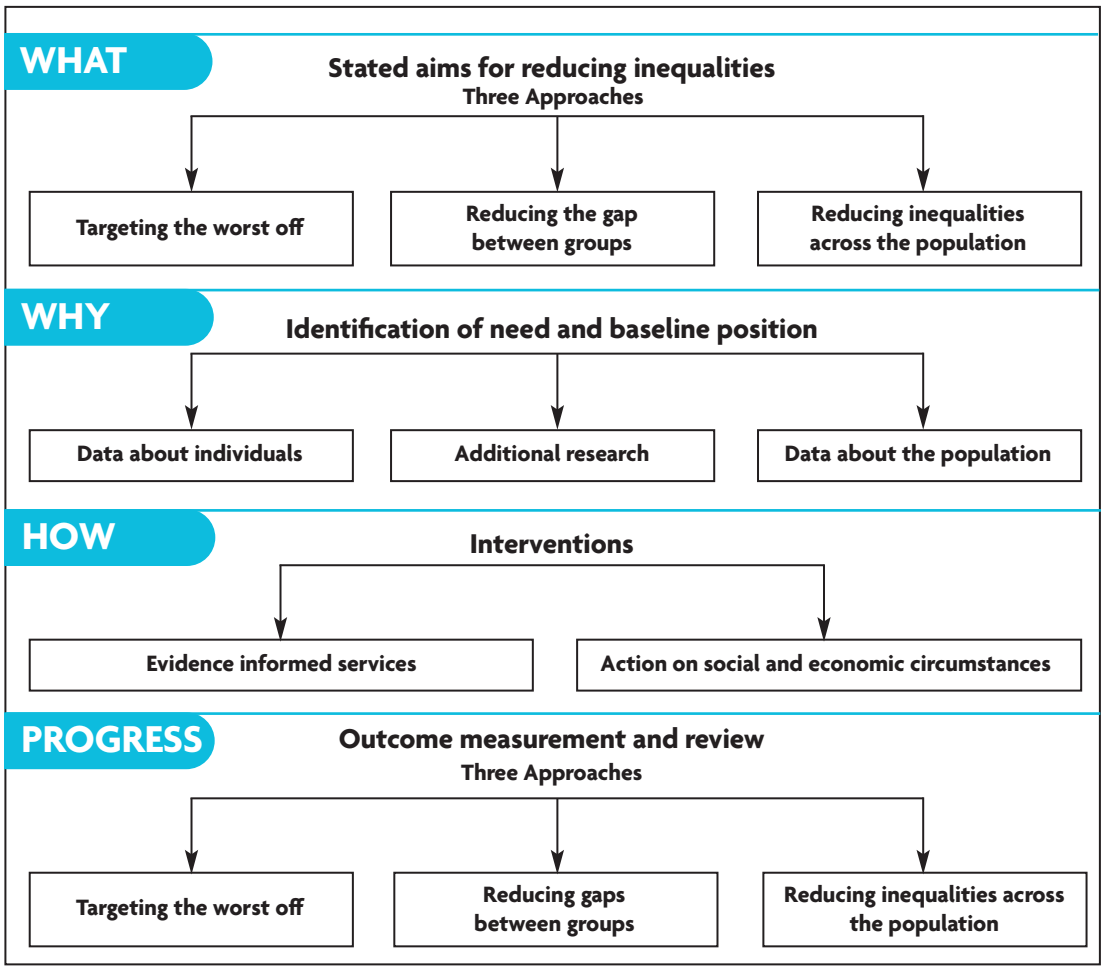
Development of the GCPH inequalities framework

The Glasgow Centre for Population Health (GCPH) was established in 2004 to generate insights and evidence and provide leadership for action to improve health and tackle inequality. GCPH works across the boundaries of research, policy, implementation and community life to develop a better understanding of health in Glasgow, evaluate the health impacts of local strategies and explore new ways of enhancing population health. The GCPH programme for Health-Related Services and Inequalities aimed to bring together research, policy and practice for addressing health inequalities relevant to health-related services and in its first few years, the programme focused on Community Health (and Care) Partnerships (CH/CPs) and their developing roles in addressing health inequalities.

In 2006, the Directors for NHS Greater Glasgow and Clyde CH/CPs asked GCPH to evaluate their progress on addressing health inequalities. They were new organisations and their service plans were not yet finalised at that time, which provided an opportunity to create baseline profiles, described in another GCPH paper[13]. Action research projects were undertaken by GCPH staff and others in order to better understand the processes and actions developing within CH/CP service structures that might impact on health inequalities. Whitehead and Dahlgren's ten principles for policy action[5] were used to assess the CH/CP plans in order to help clarify health inequalities[14,15] objectives. Initially, the intention was to propose indicators relevant to CH/CPs for monitoring their progress on reducing health inequalities. However, a great deal of variability in the type and intensity of actions across and within the CH/CPs came to light during the action research projects, which meant that general indicators would be too broad to capture the impact of specific actions at CH/CP level. Consequently, a generic framework was agreed for the CH/CPs to use to articulate the inequalities dimensions of their specific programmes and services so that they could then identify objectives and indicators relevant to their own programmes for monitoring and evaluating progress.

The generic framework has since been applied to a range of programmes, topics and partnership structures across Scotland and has been used to support planning, practice development and evaluation processes. It is coherent with the Equally Well principles summarised above, and provides a practical tool for implementing Equally Well and other policy recommendations for addressing health inequalities. A summary diagram of the framework is given below. A full description of its elements with examples follows.

Figure 1 GCPH Inequalities Framework



APPLYING THE FRAMEWORK

As shown in Figure 1 above, the framework sets out the elements of action into 'what, why, how and measuring progress'. 'What' requires a statement of the aim together with clarifying the approach that the programme or service might take and 'why' asks for a full description of the evidence and baseline position for the action proposed. 'How' proposes two types of intervention to address causes as well as health consequences of inequalities, and 'measuring progress' identifies different methods of monitoring and evaluation depending on the approaches taken. The distinct elements of the inequalities framework are discussed below with examples.

Stating the aim

Whitehead and Dahlgren[5], Graham and Kelly[7] and Macintyre[11] all emphasised the need to clarify whether a strategy aimed to improve population health or to reduce health inequalities. Due to the likelihood of the better off gaining more from most types of universal social and public health programmes these two goals might conflict. For example, more overall health gain might be achieved with a population-wide programme but if the programme was information-based or required proactive uptake, it would be more likely to appeal to those with more resources and education, thereby benefiting the better off and increasing inequalities as a result. However, if the main aim of a programme was to address health inequalities, it might start from a different premise, that is, that the highest risk group's needs should be taken into account first. The aim to reduce health inequalities should be stated at the outset of programme planning, as a programme addressing health inequalities is likely to require a different mindset and possibly a different set of skills than a programme aiming to improve overall population health.

The consequences of stating different aims for a population programme and a programme to address inequalities was illustrated in the East Lothian Equally Well Test Site (Table 1). The Test Site participants set themselves ten objectives, one of which was to *increase the number of children with no obvious caries experience in P1*. Working through the inequalities framework encouraged them to develop a specific aim for the inequalities dimension of this objective, which was agreed as to *reduce inequalities in caries experience between targeted communities and East Lothian as a whole*. For the first aim, programmes would normally begin by thinking about the interventions that might be adopted and who might deliver them. However, for the inequalities aim, the first issue for the Test Site was how to engage the targeted communities, as past experience led them to believe that some families would not usually come forward readily to participate in a preventative programme. This example suggests that the different aims might require different lead agencies and different starting points for project development.

Table 1. Stating the Aim

Aim for improving health	Increase the number of children with no obvious caries experience in P1
Aim for reducing health inequalities	Reduce inequalities in caries experience between targeted communities and East Lothian as a whole

Three approaches

Graham proposed that there are three approaches to addressing health inequalities, each requiring a different set of aims, questions, actions and measurement tools[16]. The three approaches are: targeting the worst off, narrowing the gap between defined groups and reducing the population gradient. These approaches should be described separately but in practice they need to work together if inequalities are to be reduced. The first approach targets interventions at a named group and aims to achieve improved outcomes for that group only. The second 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 narrowed, measured and monitored over time. The third approach, reducing the population gradient, is described by Graham as requiring a combination of the first two approaches. However, exploration of this approach with CHPs and other teams in the project required further explanation as their actions on the gradient were less developed than the policies at the heart of Graham's analysis. Clearly, identifying a group with a comparator for targeting and closing the gap is more straightforward for service planners than identifying and describing groups at all points in a spectrum. Instead, the project proposed that service structures might adopt an approach to reducing the health gradient by aiming to change the ways in which they routinely respond to different needs of different population groups so that barriers to improving health might be removed. One application of this approach could be enabling equality of access and outcomes from services, such as that described in NHS Greater Glasgow and Clyde as inequalities-sensitive practice[17]. This aims to ensure that services tackle discrimination, unequal access to high quality services and facilities, and the poorer service outcomes known to be associated with legally protected characteristics including ethnicity, gender and age or lower social status.

The three approaches, although distinct, are interlinked. Graham's argument is that each approach can represent the goal for specific policies, with targeting and closing the gap contributing to reducing the gradient and each adding a further layer to policy impact. However, policies targeting geographical areas with or without consideration of comparator areas have not always demonstrated reductions in mortality levels with the gap in health experienced by rich and poor continuing to widen rather than close, and the health gradient from poor to rich remaining in place[6]. There are few policies that encompass all three approaches and for CHPs in the development project as well as for most of the teams, actions that might be argued to be contributing to reducing the gradient through inequalities-sensitive practice were not explicitly connected with actions to target the worst off or to close the gap. If Graham's argument that the three approaches are complementary is correct, a team or strategy might have more impact on health inequalities if it planned for all three approaches together.

Depending on the topic or programme, a team might act as a system in itself or in conjunction with others as part of a wider system, such as a Community Health or Planning Partnership, Health Board, or Scottish Government strategy. All three approaches taken together within a system's goal to reduce inequalities would enable partnerships and teams to identify specific actions within the scope of their work programme and to identify actions that would need to be taken elsewhere. For example, some teams or services might work most effectively to reduce discrimination and enable equality of access to their mainstream services while others might be in a better position to target some activity towards particular communities. However, to achieve success in reducing health inequalities they might have to plan for both to happen together with additional actions in partnership with others, for example, with financial decision makers, if resource re-allocation was required to close the gap.

A crucial point is that plans should clarify the respective roles of different parts of the system in taking action forward where different administrative levels might take different approaches to the same issue, and measurement of progress and outcomes might take place within different time scales. For example, a specific service covering a universally deprived area might only be able to target that area and therefore measurement of outcomes would identify the impact of the service in that area. However, decisions about resource allocation in order to reduce the gap between that area and others might be taken at a different structural level, such as a Community Health Partnership, Council or Health Board but the impact of these decisions, being further removed from practice, might take longer to assess. The impact of an inequalities sensitive service might take longer again to assess at a population level although the impact of service provision for individuals could be measured at least in part through monitoring service use. The development and application of the framework suggested that by adopting all three approaches, services can contribute to tackling the spectrum of causes of poor health and health inequalities as well as the consequences.

Examples of the three approaches are shown below from the Fife Equally Well Test Site:

Table 2. Examples of the three approaches from Fife Equally Well Test Site

Targeting the worst off	Templehall estate itself? Or the 15 datazones that include Templehall? (Although the whole CHP could be described as deprived). Target population of the test site is under 16s.
Reducing the gap between groups	Gap between Kirkaldy & Levenmouth and Fife. Need to have a re-allocation of resources towards Templehall. Recognise poverty and attract resources for improving the environment eg use of buildings for meetings etc.
Reducing inequalities across the population	Aim for strategic change across Fife based on learning from the pilot.

As shown in Table 2, the Fife Equally Well Test Site aimed to work in a deprived geographical area within the CHP. However, in the early discussions, the actual target group for the interventions had not been agreed, and therefore indicators to measure progress had not been developed. Possible target groups were discussed as being the main housing estate in the area which was affected by many social problems, or a wider area which overall had a similar level of deprivation to the housing estate, or the whole CHP, which was the most deprived CHP within the Fife Health Board area. Alternatively, as the Test Site aimed to focus on young people affected by alcohol, the target population for the interventions could be young people under the age of 16 in the area.

In relation to closing the gap, different models of working or resource allocation would have to be deployed in favour of the targeted group in order to reduce the gap between the targeted group and other areas or groups. This could be done in different ways: for example, by favouring the area for activities that could bring in resources such as better use of existing facilities, or making the case for mainstream services to refocus resources in relation to environmental improvements.

The Fife group's thoughts on reducing inequalities across the population were to work on the mainstream service structures to build on the learning from the Test Site.

Below is another example of the three approaches, this time as applied to the development of an Equity Action Plan in Dundee CHP. The framework was used by staff in the CHP to agree a shared understanding of inequalities to underpin development of their Equity Action Plan. Their thoughts on the three approaches are summarised in Table 3 below:

Table 3. Examples of the three approaches from Dundee CHP

Targeting the worst off	Mainstream redesign should target SIMD-defined deprived geographical areas and population groups including homeless, BME, Keep Well. Also through patient need, eg intensive follow up for people not attending services. Community development to build resilience.
Reducing the gap between groups	Measuring wellbeing between 15% most deprived and 15% most affluent. However, would need better social capital indicators to capture the impact of community development.
Reducing inequalities across the population	Inequalities sensitive practice. Understanding better why people do not use services: issue of hard to reach services (move away from concept of hard to reach people). Do we know enough about engagement, who, how? Learn from partners and last ten years of action on inequalities.

Most of the teams applying the framework used the approaches in a similar way to the Dundee team, although there were differences in the population groups they wanted to target. For some teams the framework required them to agree a specific target group as most had not specified the target groups in a way that would enable them to measure outcomes, nor had they considered the comparator groups for measuring changes in the inequalities gap. Discussion of the specific role of services in reducing the gradient was generally regarded as more complex and required a focus on delivering changes in services rather than short term outcomes for particular population groups.

Needs assessment and baseline data

With an aim to reduce inequalities, an understanding of the extent to which inequalities exist within the population of interest is required as is a baseline from which to measure progress over time. Some of the information required will be the same as for a population-wide programme but there is an additional need to understand the contexts and causes of inequalities, and the outcomes for different population groups or geographical areas.

The GCPH health inequalities framework uses three headings for the information that is needed in order to understand inequalities in the population and their impact on health. First, there are data about individuals – such as age, sex, ethnicity, life expectancy and morbidity – that are available from routine databases (although data on ethnicity are not always complete)[18] . Second, data are needed about social and wider circumstances, including levels of deprivation (usually using the Scottish Index of Multiple Deprivation), housing, environment, education, and health service availability and use. These are important for understanding the contexts for individual outcomes and can be obtained from community or population profiles[19,20]. Third, as Whitehead and Dahlgren[5] stress, the complexity of combinations of social factors and the interactions between individuals and their environment needs to be understood in order to effectively address inequalities in health. Therefore, data alone will not provide the full picture of the impact of inequalities in health or provide the means for addressing it. Academic research, surveys, local research and additional knowledge from community perspectives are crucial for understanding this complexity and in illuminating the lived experience of inequalities, such as the impact of belonging to a black or minority ethnic group or gender roles on health, how poverty affects families, or communities' perspectives on local services.

For example, STEPS, a Primary Care Mental Health Team in Glasgow, used the framework to explore their role in addressing inequalities in mental health. They identified the following information as being important in helping them understand better the inequalities in mental health in their population and what they might do about it.

Table 4. Needs Assessment and Baseline Data

Data about individuals	STEPS collects gender, age, ethnicity. Anti-depressant prescribing. Do not actually know local need for preventative Mental Health services.
Data about the population	SIMD, CHCP profile, knowledge of regeneration areas.
Additional research	Service uptake eg are we targeting effectively? Does the stress control service take into account inequalities issues such as literacy levels or relevance to men? How do we know what the need is, or why people default appointments? How do we collect community views? What can we learn from use of Callback (which has a greater proportion of use from the most deprived areas)?

The missing information for the STEPS team raised the issue of capacity for collecting and analysing data. This gap was also noted by others, including Torry Medical Practice in Aberdeen. Most teams lacked members with the remit, time or skills base to carry out research or needs assessments relating to inequalities in their populations, or in some instances to engage directly with their communities. Teams that were focused on service delivery at practice level, such as STEPS and Torry Medical Practice, had insufficient working relationships with public health or health improvement structures to enable them to draw on skills for population research and needs assessment.

Interventions

Whitehead and Dahlgren[5] suggested that social inequalities that are linked to poor individual outcomes should be addressed alongside the needs of individuals. Therefore, a programme or service to address health inequalities requires interventions at an individual level that are inequalities sensitive, together with action on the causal factors. These types of actions have also been described as upstream and downstream actions, using Irving Zola's much-cited river analogy of medical care, with downstream referring to meeting the immediate need (pulling a drowning man out of the water) and upstream are the longer term actions that might be taken to act on the structural factors at the root of the problem (preventing him falling in to the stream in the first place)[21].

With regard to individual-level interventions to address inequalities, inequalities sensitive practice would mean that service providers would be aware of the social circumstances that might impact on the health of the patient or client and would take them into account in diagnosis and treatment. For example, difficulties in accessing services or getting the best outcomes from services might arise as a result of language barriers, literacy levels, discomfort due to experience of discrimination, lack of childcare or the cost of travelling to the appointment. The patient or client might also be living in difficult circumstances that are directly or indirectly related to the consultation. The service provider might, if appropriate, explore any additional action that could be taken to address the causes alongside dealing with the problems that are the basis of the consultation. Exploration of causal factors might then result in referrals on to other agencies if further help is required outwith the scope of the individual consultation. For example, a service provider might be in a position to create or strengthen pathways between their services and community based social support or financial inclusion services.

Action to contribute directly to reducing the impact of adverse social circumstances on health is unlikely to come within the day to day functions of frontline staff. However, opportunities for joint working or advocacy to act on the causal factors might present through membership of local partnerships. This type of influence might involve a strategic team member or manager rather than the staff member providing direct services, but requires engagement and integration with staff working at different levels within a service or organisational structure. For example, the GP practice in Torry identified that they might strengthen their links with the local community planning partnerships through their CHP public health structures and the STEPS team identified a senior manager within the CHCP with whom they would liaise regarding strategic approaches to inequalities.

Examples of the two types of interventions, individual and societal, can be illustrated by the potential application of the framework to an antenatal services strategy, as follows:

Table 5. Possible interventions for an antenatal inequalities strategy

Evidence informed services for individuals	Action on social and economic circumstances
How antenatal services for individual women address inequalities: • Are they inequalities sensitive? • Are different models of practice used for different population groups (eg teens, persistent defaulters, deprived areas)? • Is provision made for women with particular needs or can they be referred on?	How antenatal services deal with circumstances threatening health and wellbeing of mother and child such as violence, substance use, mental health problems, poverty, discrimination etc. This might include data collection, research, advocacy for tackling these through other service delivery and planning structures, or specialist staff within antenatal services.

Measuring progress

Policy interventions should include strategies for monitoring changes to inequalities, particularly as research has demonstrated that population programmes requiring buy-in can increase inequalities[5].

Different measures are required for each of the three approaches identified earlier, as each approach sets out to achieve a different outcome. With a targeted approach, the focus is on the targeted group or area alone, and on whether improvements can be measured for that group. For example, the Dundee CHP team identified a number of population groups that might be prioritised in their Equity Action Plan, such as homeless people, a black or minority ethnic community, or a geographical area defined as deprived though the SIMD. Depending on the intervention, they would define a set of indicators that they would then measure over time for that named group. If they were going on to address an inequalities gap, they would use the same indicators within their targeted group and compare with another group. The example given for Dundee CHP was that they would compare the outcomes for people living in the 15% most deprived areas within the CHP boundary with outcomes for people living in the 15% least deprived areas. For the third approach, with an aim to reduce the gradient, they might measure the extent to which their services achieved inequalities sensitivity perhaps by identifying the level of service use or engagement across the population, or the uptake of staff training on inequalities issues.

The Govanhill Equally Well Test Site worked to define specific indicators for each of their approaches, as follows:

Table 6. Measuring change in inequalities in Govanhill Equally Well Test Site

Targeting the worst off	One targeted intervention was to focus on a small area of privately-rented housing with particular difficulties. However, the area was too small to isolate for measurement of change. Instead, the impact of a Hub development was measured through observation and qualitative feedback from services involved to identify how the intervention could deal with the housing–related difficulties.
Reducing gaps between groups	Comparison between outcome indicators for Govanhill and for West Pollokshields – the local community action group suggested the comparator area as it has a similar population size and services are managed within the same CHCP structure, but more affluent. From December 2010, a baseline for future follow-up was agreed with the Health Board to include indicators relating to mortality, early years, and alcohol- and drug-related hospital admissions.
Reducing inequalities across the population	A number of surveys had been carried out in the area and there was a possibility of repeating local health and wellbeing and housing conditions surveys to assess population change.

In general, all teams tended to rely on routine data and geographical comparisons which covered larger areas than the areas they were targeting for action. This meant that routine data were unable to provide demographic information such as ethnicity in the population or specific service need data for their targeted areas. Consequently, there were difficulties in identifying methods for measuring progress in a way that would enable clear comparisons between groups or attribution of outcomes to the teams' actions. Identifying specific objectives and indicators for measuring progress on inequalities was time consuming and complex, but, as mentioned above, most teams lacked input from data analysts.

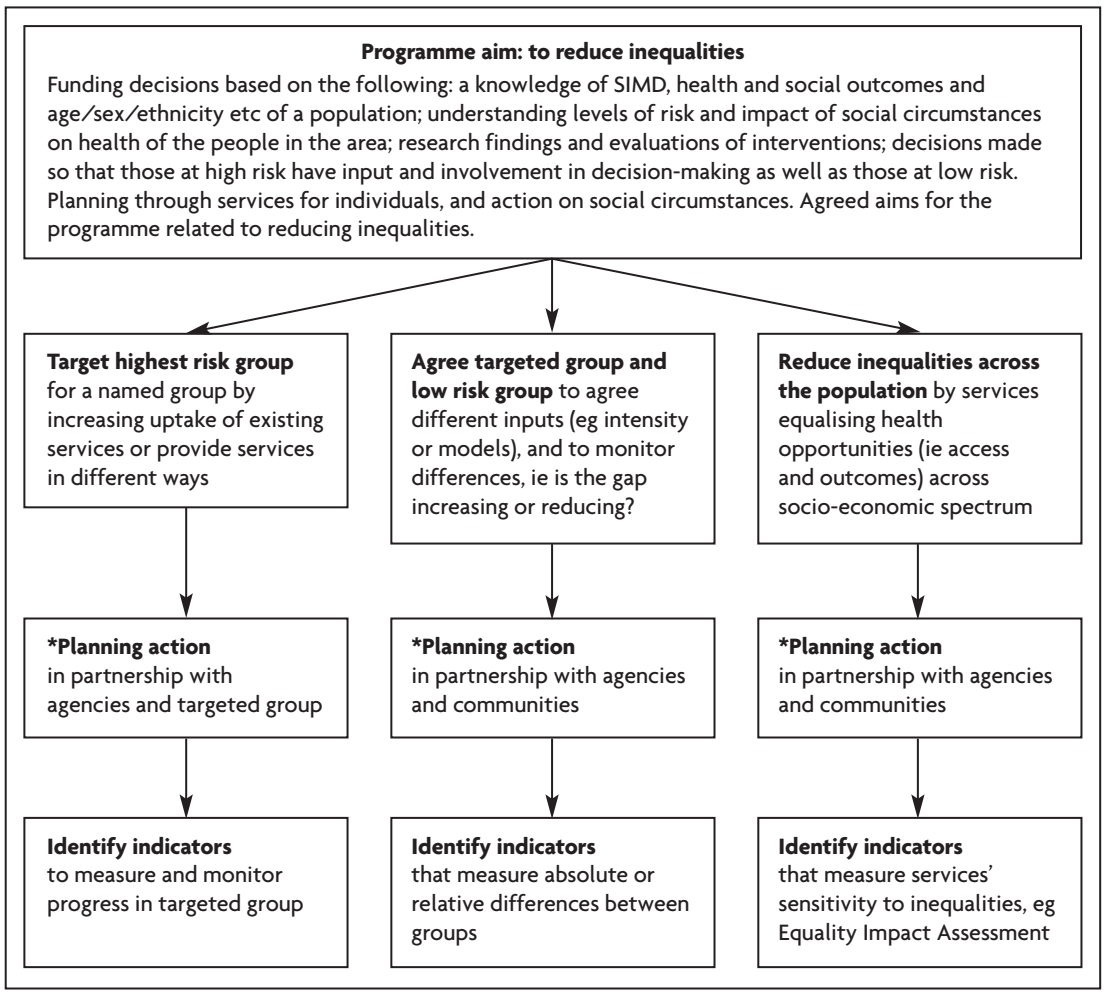
DISCUSSION

Application of the framework to a variety of settings illustrated the ways in which service teams and multi-agency partnerships might articulate their aims and plans for addressing health inequalities. In particular it highlighted issues for consideration when identifying indicators for measuring progress.

As part of the work carried out with the three Equally Well Test Sites, the GCPH team proposed that outcome-based planning such as results chain methodology (or other logic modelling processes) could be used to plan projects and actions. We proposed that this methodology should be applied after agreeing the inequalities dimensions of a project or programme in order to strengthen planning for actions to address health inequalities as well as to identify indicators to measure progress. Some of the Test Site teams had already embarked on planning their programmes before considering the inequalities framework but the discussions highlighted clear differences between proposed actions aiming to reduce health inequalities and those aiming to improve population health. It follows therefore that early identification of the inequalities dimensions of a programme or topic would be important in order to strengthen the likelihood that outcomes relating to inequalities are achieved.

The scheme illustrated in Figure 3 demonstrates the point in application of the inequalities framework where outcomes-focused planning tools might fit with the planning process.

Figure 3. Schematic planning process using the GCPH framework



* Outcomes-focused planning process might use logic modelling or results chain methodology to identify inputs, involvement, actions, outcomes and timescales[22].

The opportunity to apply and explore the use of the framework in a variety of settings led to the identification of four common themes linking the very different structures and settings seeking to develop action to address inequalities.

First, the framework filled a theory-practice gap for the teams involved. It helped to foster an understanding of inequalities in all their complexity and to relate this to practice through pinning down the what, why, how and areas for development in addressing inequalities within their specific areas. Second, it linked equality issues with action on inequalities. These are often regarded as two separate objectives within service structures, with different policy streams and consequently different staff groups engaged in acting on them. The framework places discrimination and barriers to access to services among the causes of health inequalities, and this offered a structure for planning for equality in service provision and action on health inequalities as part of the same process. The third common theme was that by articulating the inequalities dimensions of a programme at the start of a planning process, specific outcomes, approaches, interventions and indicators for measuring progress on inequalities could be identified and carried through as a priority within any programme or service.

The final theme was preparedness of teams to confidently aim to reduce inequalities. The inequalities framework and some of the research was new to many of the teams that used it, and feedback indicated that teams which were keen to strengthen their impact on health inequalities generally found the framework to be a useful tool for planning action to address inequalities. However, health inequalities remained a 'wicked issue' for the teams and most believed that they still lacked capacity for reducing the health gaps in their areas. Experience of applying the framework suggested that to achieve a reduction in health inequalities, teams need capacity (or access to support) for the following processes:

- community engagement
- agency engagement
- planning
- inequalities research
- data analysis and interpretation
- evaluation
- service redesign, and
- change management.

While the framework helped teams identify the actions that needed to be developed to address health inequalities, most were dependent on capacity beyond the teams themselves to put these actions fully into operation.

CONCLUSION AND RECOMMENDATIONS

In summary, the response to application of the inequalities framework suggested that service planners and practitioners were often already engaged in activity that aspired to reduce health inequalities. However, action tended to be planned and measured in a way that did not always reflect the complexity of health and social inequality and, crucially, did not tap into the full potential for tackling inequalities of service delivery structures and planning partnerships. The concepts that stimulated the greatest degree of creative discussion were those that highlighted the difference between actions required to reduce

inequalities and those required to improve population health, and also that different approaches could be taken by different parts of the system. The potential for stronger partnerships in planning actions to reduce health inequalities was underlined by discussion of the concept that services to improve individuals' health might contribute to addressing wider social determinants if both were consciously planned together. Such discussions within some of the teams highlighted that they might need to cross practical and ideological boundaries between service delivery structures and the service planners and public health specialists.

The findings from this project offer an opportunity to build on the Equally Well recommendations in order to further develop current approaches to reducing health inequalities in Scotland. For example, Equally Well included recommendations that proposed targeting interventions towards vulnerable groups such as people with learning disabilities or prisoners. Application of the framework identified that service planners and delivery structures generally did not fully articulate the boundaries of the population group they intended to target or identify the sources of data they would access to measure the impact of interventions on the inequalities experienced by the targeted group. The framework highlighted that objectives for tackling inequalities between a named group and others, or for improving outcomes for a targeted group, should be agreed in the early stage of programme development in order to provide the baseline for reviewing and measuring progress as the intervention is delivered. The framework might also support the Equally Well recommendations on developing processes to tackle inequalities, for example in providing a shape for teams to agree common values, knowledge and skills for developing practice that can take into account and address inequalities, and for helping to identify and articulate indicators for measuring progress on absolute and relative health inequalities. Finally, the framework illustrated that equality impact assessment and, potentially, integrated impact assessment (Equally Well Recommendation 77) could be developed further to better connect equality and diversity actions with those aiming to reduce health inequalities as well as to provide the basis for planning different ways of tackling inequalities based on a sound knowledge of a population or community.

There are three recommendations proposed for teams and services engaged in planning action to address health inequalities which aim to strengthen and develop current practice. Acting on the recommendations would enable public sector organisations within Scotland to meet policy expectations relating to the causes and impact of inequalities on health and to clearly demonstrate progress.

The recommendations for planning and practice are as follows:

1. All dimensions of social inequalities and population diversity are taken into account when planning action to address health inequalities.
2. The setting of clear objectives and outcomes, and aims for evaluation and monitoring for health inequalities are built into programme planning from the start in addition to planning evaluation and monitoring of population health improvement.
3. When planning programmes and actions to address inequalities, teams should consider all the skills and resources they will need at the outset and build the necessary relationships with partners from the start.

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