The health of people in England has improved over the past ten years. Life expectancy has increased, infant mortality has fallen. Government targets to cut premature death from heart disease and stroke by 2010 have already been met. But if the big picture is positive, stark problems remain. Inequalities in the health of people from certain areas and social backgrounds has stubbornly resisted improvement, and has even increased in some cases.

A potent measure is the gap between the worst areas and the England average. This is captured in the difference between the England average and performance in the spearhead local strategic partnerships (LSPs), the one-fifth of areas with the worst rates of deprivation and early death. On that measure, the gap in death rates for both men and women rose between 1998 and 2007 – from 16.1 per cent to 18.6 per cent and from 13.9 to 15.2 per cent respectively. For infant mortality, the gap had begun to narrow and had been on course to meet the government’s target - a 10 per cent reduction by 2010 from a 1998 starting line. But the latest figures show no improvement on the three-year average from 2005 to 2007 (Ref. 1).
Complex problems such as teenage pregnancy have proved challenging, despite some progress. New problems have emerged, for example obesity, though the rate of growth of obesity in children may now be slackening. Problems with alcohol have grown. If today’s trends continue, NHS hospitals in England will admit 1 million patients with alcohol-related conditions in 2011 (Ref. 2).

There has been no shortage of government policy on these issues. *Giving Children a Healthy Start* (Ref. 1), the Audit Commission's recent report, identified 27 new national policies aimed at improving the health of children since 1997 – about one every six months. And there has been national action, including, for example, the ban on smoking in public places. But local authorities and primary care trusts (PCTs), working in combination, have been seen as the main agents. They have been the focus for policy and action as well as the recipients of significant extra money.

**Local performance**

Local bodies have good evidence about what works in improving health. The National Institute for Health and Clinical Excellence has issued 22 pieces of guidance on public health matters, ranging from school-based interventions on alcohol to promoting physical activity in the workplace, with 34 more on the way (Ref. 3).

A wealth of data measures health outcomes, such as life expectancy, infant mortality, alcohol-related hospital admissions and teenage pregnancy. There are 18 indicators alone for the health of the under-fives for each local area, which will be published alongside the Commission's recent study (Ref. 1). The data is not perfect. For example, where outcomes are expressed as a rate per thousand, the information may depend on the accuracy of population estimates. And there is always room for sharper measures and better data quality. But what we have is a good enough guide to the problems that areas face and the progress they are making.

Of course, health varies according to the wealth and other characteristics of communities. Not surprisingly, progress in tackling problems also varies. Yet differences can be striking and beyond what might reasonably be expected.

Take teenage pregnancy: there was a modest decrease of 13 per cent in the rate of teenage conceptions over the ten years from 1998 (Figure 1). The government’s Public Service Agreement (PSA) target was a 50 per cent reduction by 2010.
The difference between the spearhead LSPs and the average for England increased slightly over the period and most areas saw some improvement. But deprived areas recorded both large increases in teenage pregnancy and notable falls, which may show that local strategies can work.

No LSP hit the government’s target for a 50 per cent cut; Bracknell Forest comes closest with one of 45 per cent. Some LSPs have gone in completely the opposite direction. Halton has had an increase of 11 per cent but next door, and not so different, Warrington managed a cut of 33 per cent. Manchester saw an increase of 14 per cent but its neighbour Oldham saw a reduction of 38 per cent. Many LSPs chose teenage pregnancy as a priority but hardly any are on course to meet their target. Teenage conceptions are highest in the London Boroughs of Lambeth, Lewisham, Southwark and Greenwich, and in Manchester, Hull and Doncaster. Recent notable increases in the rate took place in Torbay and the London Boroughs of Bromley and Bexley (Figure 2).
On a more positive note, the mortality rate for women of all ages is forecast to be 455.5 per 100,000 this year, easily beating the PSA target of 466 per 100,000 by 2010. The 1998 rate was 589.5, falling to 488.7 in 2007. All LSPs saw a reduction in death rates for women over the same period, but again, performance is variable. While the mortality rate fell by over 40 per cent in Kensington and Chelsea between 1998 and 2007, it barely budged in Hartlepool (Figure 3).
The picture is repeated for each indicator; performance varies significantly. An LSP that performs well on some issues may not do so in others, even if the spearhead LSPs face the most difficult challenges and tend to make slower progress.

The Oneplace website (Ref. 4) lays out the progress that areas have made on their priorities, as well as performance across the board. Assessments are compiled jointly by the Audit Commission, Ofsted, the Care Quality Commission and HM Inspectorates of constabulary, probation and prisons. Oneplace is based on answers to critical questions about the performance of the local statutory bodies and the prospects of services improving. It assesses strengths and weaknesses, identifying notable practice as well as highlighting where local statutory partners could do better.

* Spearhead local strategic partnerships

Health and health inequalities were major issues for many in setting priorities in their local area agreement (LAA). Four of the top ten priorities chosen by local areas related to health and wellbeing. (Table 1).

<table>
<thead>
<tr>
<th>LAA priorities and the number of areas selecting them in rank order</th>
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<tbody>
<tr>
<td>16 to 18 year olds who are not in education, employment or training</td>
</tr>
<tr>
<td>Under-18 conception rate</td>
</tr>
<tr>
<td>Net additional homes provided</td>
</tr>
<tr>
<td>Number of affordable homes delivered (gross)</td>
</tr>
<tr>
<td>Obesity among primary school age children in Year 6</td>
</tr>
<tr>
<td>Per capita reduction in CO₂ emissions in the local authority area</td>
</tr>
<tr>
<td>Serious acquisitive crime rate</td>
</tr>
<tr>
<td>Proportion of population aged 19 to 64 for males and 19 to 59 for females qualified to at least level 2 or higher</td>
</tr>
<tr>
<td>Stopped smoking</td>
</tr>
<tr>
<td>All-age, all-cause mortality rate</td>
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Source: Improvement and Development Agency/Communities and Local Government

But they were also one of the issues that local partners found most taxing. Twenty-one areas had red flags related to progress in tackling health issues. These flags mark where the inspectorates had significant concerns and where action was needed by the local statutory bodies. There were few green flags to denote exceptional performance or innovation from which others can learn, but they do show that local strategies can be successful, even on difficult issues.

The LSP in Hackney received a green flag for its work in reducing infant mortality (Ref. 4). It saw deaths of children under one year fall from a rate of 8.1 per 1,000 live births in 2001-03 to 5.4 in 2005-07, just above the England rate of 4.9. Hackney has an ethnically diverse population. Almost 90 per cent live in an area classified as being in the top five most deprived areas in England.

The national overview of Oneplace assessments (Ref. 5) linked success with leadership, good information that enables money and activity to be targeted effectively, strong partnership working, and engagement with local communities that draws on and enhances their capacity. But it also showed that proven ways of tackling problems were not consistently adopted and few areas were successfully addressing the causes of inequalities. There was also little evidence of successful measures to cut alcohol abuse.
Spending

NHS spending rose from £40 billion in 1999/00 to around £98 billion in 2009/10. But it is hard to know how much has been spent on tackling the causes of ill-health and on reducing health inequalities, or what the impact has been.

PCTs are required to address public health problems and health inequalities as routine business. Their general allocation reflects differences in health. PCTs in deprived areas, which therefore have poorer health outcomes, have had more money to spend per head than those in wealthier ones.

The formula for allocating money to PCTs now explicitly includes a health inequalities element that targets funds at the places with the worst health outcomes. We estimate that some £21 billion has been allocated in 2009/10 according to this aspect of the formula. But the new formula has not resulted in any further systematic shift of resources to deprived areas.

Figure 4: Comparison of PCT target allocations in 2009/10 before and after formula changes

Source: Department of Health allocations exposition book, Table 17 (changes to 2009/10 opening targets); world class commissioning data packs 2008 (for deprivation data).
Even so, in 2010/11, PCTs in spearhead areas will have considerably more to spend than the England average. For example, in 2010/11, the seven most deprived PCTs – Heart of Birmingham, Liverpool, Tower Hamlets, City and Hackney, Manchester, Knowsley and Newham – will typically receive £2,050 per head, about £400 more than the England average. The total additional money available to these seven will amount to some £900 million.

Some of the money given to local authorities also has a health component. For example, our joint report in 2006 with the National Audit Office and the Healthcare Commission, *Tackling Child Obesity: First Steps* (Ref. 6), noted that between 2005 and 2008, £939 million would be spent on healthy school meals and school sports programmes, with the aim of making children fitter and healthier. Similarly our recent report, *Giving Children a Healthy Start*, identified that between 1998/99 and 2010/11 £7.2 billion would be spent on Sure Start programmes to promote the physical, social and intellectual development of children under five (Ref. 1).

However, it is not clear what has been spent on tackling the causes of ill-health and on reducing health inequalities. The Department of Health does not collect such information. In its recent evidence to the House of Commons Health Select Committee (Ref. 7) the Department referred to recently published work by Health England (Ref. 8). Health England estimated that £3.7 billion was spent on prevention and public health in 2006/07, excluding spending on pharmaceuticals such as lipid lowering drugs. This is about 4 per cent of total health spending.

Some of the extra money that has been directed to deprived areas has found its way into funding higher hospital costs. There is some evidence that trusts in deprived areas have higher reference costs than those in less deprived areas. Previous Audit Commission analysis has shown that the higher costs of hospitals in deprived areas are not the result of treating sicker people (Ref. 9). The reference costs already adjust for this. The explanation may lie in the fact that there has simply been more money available in deprived areas. We estimate the difference in costs between trusts in areas of high deprivation and those in areas of lower deprivation to be some £2.4 billion (Figure 5).
This may be an argument for ring-fencing funds, particularly as there have been strong complaints that funds intended for public health were diverted elsewhere when resources were tight. Ring-fencing could also help in judging the impact of spend. But it would also constrain local flexibility – a significant disadvantage.

However, it would be hard to know how much to ring-fence. One possibility would be to make a central judgement. The upper limit would seem to be the £21 billion associated with health inequalities in the funding formula, although the overwhelming majority of this money would be needed for health service provision and ring-fencing would be meaningless. Another possibility would be to start from what PCTs, and perhaps local authorities, currently spend on a defined list of services or tasks. This would require comprehensive data collection that carries its own risks of local bodies deciding what to include in any return.
The amounts involved might also turn out to be relatively small. Health England’s report and the implied 4 per cent spend might be a guide. But, of the £3.7 billion, centrally set contracts accounted for £1.5 billion in the form of dental check-ups and sight tests (£1.15 billion) and payments to GPs under the Quality and Outcomes Framework (£450 million). Centrally determined immunisation and screening programmes cost a further £513 million. Central bodies such as the Health Protection Agency and NHS Blood and Transplant accounted for £325 million. This leaves some £1.4 billion, roughly £10 million per PCT. But of that about half was devoted to maternity services and family planning, services that it would seem inappropriate for local authorities to fund if the ring-fenced money was to be given to them. In fact, very little of the £3.7 billion was spent on direct public health interventions where there could be local flexibility. The largest sums were £159 million spent on the school health service and £172 million spent on lifestyle issues and smoking cessation services.

The latest programme budget information does not help much either. Most of the £1.8 billion spent on Healthy Individuals in 2008/09 is described as ‘other’. It includes screening and immunisation.

Even where there has been ring-fencing, it is not clear whether the impact of the money has been significant. Local authorities were given a small (£27.5 million in 2007/08) annual ring-fenced grant to address teenage pregnancy between 2002 and 2007. But the most significant change in the rate of teenage pregnancies occurred before the introduction of the grant (Figure 6).
Over the last nine years, local areas received similar amounts of Department of Children, Schools and Families ring-fenced funding to implement their teenage pregnancy strategies but have achieved very different levels of success in reducing their rates. There seems to be little relationship between the amount spent and the change in the rate of conceptions (Figure 7). The ring-fencing has now ended.
Conclusions

Some key points emerge from this analysis.

There has been much policy and accompanying guidance – but probably too much and from too many different sources for people in the field to keep up with. PCTs and local authorities have also faced conflicting demands from central government as our research for Giving Children a Healthy Start (Ref. 1) found. A more consistent and lasting set of policy statements would aid implementation on the ground.

Local communities and their health needs vary. Local statutory bodies are attuned to this, as, again, our research for Giving Children a Healthy Start (Ref. 1) found. But the impact of their actions has been highly variable. Strong partnerships with well-developed performance arrangements, as described in Working Better Together? (Ref. 10), are essential. One agency working alone cannot tackle problems of smoking, poor diet, physical inactivity, excessive alcohol consumption and child health.
The Oneplace website lays out publicly the performance of local statutory agencies, putting the raw data into context, increasing both transparency and accountability for public bodies on the outcomes they achieve for their communities. It also provides case studies for learning and pointers for improvement. Spurring on mediocre performance through greater transparency is as important as identifying and helping those at the bottom and sharing the good practice of those at the top.

The amount associated with health inequalities in allocations has been considerable – £21 billion in health budgets alone in 2009/10. But the amount that has actually been spent on tackling the causes of ill-health and narrowing health inequalities is unclear. It is hard to see an obvious link between spending and improvement, or get any clear view of value for money. Progress in reducing inequalities, and in some aspects of health such as that of very young children, has however been disappointing, even if general progress on, for example, life expectancy and other broad measures has been very positive.

Without such a link, it is hard to argue that higher spending – even if it were an option – would itself result in significant gains. Ring-fencing funds for public health would protect them. But it is not clear what would be ring-fenced or whether doing so would help lead to improvement. The amounts involved might also be relatively small.

With or without ring-fencing, there needs to be more ruthless targeting of money and services and close attention to outcomes. This requires much clearer sight of what is being spent and much sharper evaluation of its impact. Much of this must be done locally. It is why the Commission's recent report, Giving Children a Healthy Start (Ref. 1) included a sample analysis of local spending aimed at improving the health of children that other local areas can follow. We are looking to extend that analysis to spending at ward level and also to provide indicators of the health of young children.

More generally, the recently published Marmot review, Fair Society, Healthy Lives, argues that health inequalities will remain until we tackle the inequalities in society (Ref. 11). It argues that the government should focus on reducing differentials in the wider determinants that create societal inequalities such as income distribution, employment, education and poor environments and that doing so will also create economic benefits. It also emphasises investing in care and education for very young children since the seeds of future health inequalities are planted at an early age.
References


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