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Aims of the report

The aims of this report are threefold:

- update on the ten *London Health Strategy* high-level indicators
- 'looking back' from the perspective of the *Health in London* report; including to:
 - review trends in the current set of high-level indicators of determinants of health and health outcomes in London
 - look back over the earlier reports' key findings and implications for action on determinants of health and health inequalities identified in *Health in London* reports 2002–2005
 - review actions taken by London Health Commission (LHC) partner organisations in relation to the 'implications for action'
- 'looking forward' to the future opportunities and needs for action on determinants of health and health inequalities in London.

Focus of the report

The focus of this report, 2006/07, is on a review of progress, both in relation to progress against our *Health in London* high-level indicators and in relation to progress on the 'implications for action' that have emerged as recommendations from previous reports. The latter focuses mainly on regional-level work that supports local action, and does not capture the full extent of work that has been progressed and is ongoing at local level.

This review is timely in relation to new powers of the Mayor and other significant opportunities for London in relation to improving the wider, social determinants of health and reducing health inequalities. This report therefore also includes:

- reflections and personal perspectives of Professor Sue Atkinson who, up to August 2006, was the Regional Director of Public Health for London, and Health Adviser to the Mayor and Greater London Authority (GLA), and has been instrumental in developments in London tackling health inequalities (Section 2)
- a summary of findings and implications for action identified in previous *Health in London* reports 2002–2005 (Section 3)
- information on developing trends in relation to our high-level *Health in London* indicators, as well as the 2006/07 update on the indicators (Section 4)
- findings from a 'looking back' exercise that we commissioned from the University of East London (UEL) on progress related to the 'implications for action identified' in previous *Health in London* reports (Section 5)
- a review of future opportunities for action to improve health and reduce health inequalities in London (Section 6)
- conclusions and 'implications for action' arising from this year's report (Section 7).

Background to the Health in London reports

The LHC has published a *Health in London* report annually since 2002. All four publications reported on progress against ten high-level indicators of health in London identified in the London Health Strategy as a basis for tracking trends in London.

The report series allows comparisons over time, giving some indication of trends in London, and provides further information on the high-level indicators, in particular highlighting inequalities between different places and different groups in London, and between London and elsewhere. In addition, each of the previous three reports has also focused on the health of one of the London Health Commission's priority groups, i.e. disabled Londoners (2003), black and minority ethnic communities (2004), and children and young people (2005).

The reports have been designed to be useful to a wide range of stakeholders, including individuals, organisations, agencies and partnerships at local, regional and national level. Each has highlighted 'implications for action' which have emerged as recommendations from the findings of the reports.

The need for the *Health in London* report was identified in the London Health Strategy 2000, which was developed by a partnership of regional and local agencies and aimed to improve the health of Londoners and reduce health inequalities across the capital. The strategy focused on making a difference to the wider, social determinants of health, i.e. the factors that help people stay healthy such as housing, education and transport, rather than the services that help people when they are ill. Initial priorities for action on

health inequalities were regeneration, transport, community development and the health of black and minority ethnic communities in London. For a fuller discussion of health inequalities and the wider determinants of health see *Health in London* report 2002 (LHC website, www.londonhealth.gov.uk/hinl.htm)

The development of the London Health Strategy coincided with major legislative and structural changes in regional government for London. These included the Greater London Authority (GLA) Act (1999), establishment of the GLA and the election of a new Mayor of London. The London Health Strategy was developed by a multi-sectoral partnership – The Coalition for Health – which subsequently formed the basis for the independent London Health Commission (LHC), established by the new Mayor of London in 2000.

The LHC took responsibility for production and publication of the annual *Health in London* report, working with the GLA and the London Health Observatory (LHO). The Mayor is committed to regularly tracking and reporting on health issues in London, and as a key part of delivering this commitment, the *Health in London* report series is funded by the GLA.

Role and origin of the high-level indicators

Part of the process of developing the London Health Strategy was identifying a set of high-level indicators that would be used to measure changes in determinants of health and in health outcomes over time, and to monitor progress towards reducing health inequalities. These indicators are shown below.

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London Health Strategy: high-level indicators

- 1** Life expectancy at birth
- 2** Infant mortality rate
- 3** Self-assessed health: proportion of people with self-assessed good health
- 4** Unemployment rate
- 5** Unemployment rate among black and minority ethnic people
- 6** Educational attainment: percentage of pupils achieving 5 GCSE grades A*–C
- 7** Proportion of homes judged unfit to live in
- 8** Domestic burglary rate per 1000 resident population
- 9** Air-quality indicators – NO₂ and PM₁₀
- 10** Road traffic casualty rate per 1000 resident population

The first three indicators – life expectancy at birth, infant mortality rate, and the proportion of people with self-assessed good health – offer a means of judging health outcomes themselves, i.e. the results for individuals and communities of the interplay of different determinants of

health. The other seven indicators relate to some of the key factors affecting health.

These indicators were selected from those in use in 2000, and covered a range of factors known to impact on health, as well as providing some measure of health outcomes. They were largely derived from the government's sustainable development strategy, *A Better Quality of Life* (Department of the Environment, Transport and the Regions (DETR), 1999). They were amended and added to on the basis of consultation and further research, and were described in the statistical supplement to the *London Health Strategy* (Dawson and Hamm, 2000).

The indicators are, by definition, limited and selective. The set of indicators was designed to provide a 'snapshot' of health in London, to provide information on, and to monitor, trends in key determinants of health – and in particular, trends in inequalities in health and in the determinants of health. This was intended to enable trends to be measured over time, to enable comparisons to be made between different places within and outside London and between different groups in the population, and to help to identify areas for action to improve health and reduce health inequalities.

These indicators were considered to be the best available at the time, but it was acknowledged that some of the indicators were less than ideal for the purpose, and their limitations were recognised in the *London Health Strategy*, which also emphasised that they need to be developed and combined with other data. It was also recognised in the London Health Strategy that progress was being made in local, regional and national initiatives to develop better approaches to

measuring health inequalities and quality of life, and that, over time, some improved measures would be developed.

The LHC will be undertaking a review of the *Health in London* high-level indicators during 2007/08, in relation to the future development of the *Health in London* report and in the context of developments in health inequalities policy and strategy locally, regionally, nationally and internationally.

Legislative and policy landscape

In common with many other areas of organised society, public policy and legislation provide the context within which public health and associated societal change (i.e. the reduction in health inequalities) must be delivered. Policy and legislation can be both an aid and an obstacle to public health practitioners. However, an increasing awareness of the importance and relevance of public health across the policy spectrum over the last five to ten years has seen policies and legislation developed that contribute towards the reduction of health inequalities.

Legislative landscape

The legislative context within which current public health and health inequalities policies have been created has primarily been shaped by the UK Human Rights Act (1998) and various equality acts. However, this landscape has changed significantly in the last few years with the passing of the Disability Discrimination Act (2005) and the Equality Act (2006).

The Disability Discrimination Act (2005) made substantial amendments to the Disability Discrimination Act (1995), including general and specific duties for the public sector. Therefore, as of

December 2006, public authorities have a general duty to promote disability equality and have due regard to eliminate unlawful discrimination, and most public sector organisations have disability equality schemes.

The Equality Act (2006) has three main functions: to create a single equality commission (the Commission for Equality and Human Rights (CEHR)); to make discrimination on the grounds of religion, belief or sexual orientation unlawful in the provision of goods, facilities and services, the disposal and management of premises, education, and the exercise of public functions; and to create a duty on public authorities to promote equality between men and women, and prohibit sex discrimination in the exercise of public functions.

Global and European policy

Publication in 2003 by the World Health Organization (WHO) of a revised version of its seminal 1998 text *Social Determinants of Health: the solid facts* (Wilkinson and Marmot, 1998 and 2003) reaffirmed the importance of the social determinants of health and the role public policy can play in shaping a social environment conducive to better health. This was followed in 2005 by a re-invigoration of the WHO's Health for All framework, which presents national policy makers with a values-driven architecture for health policy that employs a broad vision of health and is delivered through national health systems that reflect ethical choices. The WHO's Healthy Cities initiative has redefined 'healthy city' status as the existence of a process striving for health improvement rather than the current health status, and is in its fourth phase. Phase IV (2003–2008) has three main and one complementary theme: healthy ageing; healthy urban planning;

health impact assessments; and physical activity and active living, respectively. On a European level, the European Commission adopted a public health programme in 2002 that focuses on health information, the determinants of health and threats to health. A €324.15 million second programme has been entered (2007–2013), encompassing three main objectives: improving citizen's health security; promoting health; and generation and dissemination of health information and knowledge.

National policy

A year before the London Health Strategy, Sir Donald Acheson published his *Independent Inquiry into Inequalities in Health* (1998). Acheson highlighted the essential contribution of all government policy to reduce health inequalities, and publication a few months later of 'the first comprehensive government plan' to improve health and reduce inequalities, *Saving Lives: our healthier nation* (Department of Health, 1999a) established a new cross-government template for public health.

The establishment of public service agreement (PSA) targets in 2000 provided the economic environment required to support this new collaborative approach, through a funding model in which national and regional government are obliged to contribute to the reduction of health inequalities. Targets include health indicators such as childhood mortality, cancer and smoking, and contribute to a central, bold commitment to 'By 2010 increase life expectancy at birth in England to 78.6 years for men and to 82.5 years for women' nationally.

Tackling Health inequalities: a programme for action (Department of Health, 2003)

and *Tackling Health Inequalities: what works?* (Department of Health, 2005a) respectively have delivered a framework and set of best practice interventions to help realise these 2010 targets. Furthermore following Sir Derek Wanless' 2004 report *Securing Good Health for the Whole Population* that reinforced the economic need to focus on the most marginalised and excluded groups and areas, the public health white paper *Choosing Health: making healthy choices easier* (Department of Health, 2004) provided a vision of how to move towards the 'fully engaged' model that is required.

Regional policy

In 1999 the Greater London Authority Act re-established arrangements for regional government in London, following an extended period without Londonwide government. The GLA was established in 2000, and the GLA Act identifies its principal purpose as promoting economic development and wealth creation, promoting social development, and promoting the improvement of the environment in Greater London.

The Act specifies that, in carrying out its regional role, the GLA must consider potential impacts on health and 'exercise its powers in the way which it considers best calculated to promote improvements in the health of persons in Greater London'. In addition, the GLA is required to have regard to the principle that there should be equality of opportunity for all people, and to the achievement of sustainable development in the UK.

As required by the GLA Act, the Mayor has developed Londonwide strategies for transport, economic development, spatial development, culture, and a range of environmental issues, all of which have

significant health implications. In addition, he has produced strategies and developed programmes in a range of areas beyond those that the Act required, including children and young people, older people, alcohol and drugs, and domestic violence, to name a few. The Mayor also established a small GLA health team to support and influence regional and relevant national policy development, as well as supporting partnership action on key health issues for London, including mental health and sexual health, and working with the LHC and others to support effective local implementation of health-related policy.

Local policy

The need to effectively target areas of deprivation underpins the National Strategy on Neighbourhood Renewal, which was launched in 2001 and reviewed in 2005 with the publication of *Making it Happen in Deprived Neighbourhoods* (Department of Communities and Local Government (DCLG) 2001, 2005). This strategy focuses on five determinants of wellbeing (i.e. health, education, housing, crime and unemployment) and represents a major shift away from shoring up poor public services in a few areas towards ensuring high-quality public services in all neighbourhoods.

PSA targets agreed in the 2004 Government Spending Review gave an increased profile to tackling health inequalities by including specific targets to address geographical inequalities in life expectancy, cancer, heart disease, stroke and related diseases. These targets aim to see faster progress in the 'fifth of areas in the worst health and deprivation indicators' compared with the average. Designated the 'Spearhead Group' of areas, this includes 70 local authorities and 88 primary care trusts (PCTs) nationally,

with 11 London boroughs within the group. Achievement of relevant PSA targets will be assessed on the outcomes in 2010 for this Spearhead Group.

In addition, a range of policies has also been created to target specific key determinants of health, and require or facilitate action at local level. For example, there are policies and initiatives with significant health implications in the following areas:

- **Housing** – including *Sustainable Communities: homes for all* (ODPMa, 2005), Housing Health and Safety Rating System (ODPMb, 2005), and the UK Fuel Poverty Strategy (DTi, 2001). Introduction of the Housing Health and Safety Rating system through 2006 marks a shift from policy focused on the notion of 'unfit' housing, to a focus on relating how the condition of the building is likely to affect the most vulnerable occupant. It includes licensing of houses in multiple occupation and improving energy efficiency, and strategically supports the role of the private sector, particularly the rented sector, as a major housing provider.
- **Transport** – for example *A New Deal for Transport, Tomorrow's Roads – Safer for Everyone* (Whitty et al., 2000) and *Making the Connections – Transport and Social Exclusion* (Social Exclusion Unit, 2003) and the Dealing with Disadvantage programme.
- **Poverty** – such as *Tackling Child Poverty: giving every child the best possible start in life* (HM Treasury, 2001), *Opportunity for All, Tackling Poverty and Extending Opportunity* (HM Treasury, 1999), the national minimum wage and pension credit.
- **Employment** – for example, the New Deal Programme, Pathways to Work

(DWP, 2003), Working Neighbourhoods pilots (2004), *Revitalising Health and Safety* (DFT, 2000), *Securing Health Together* (HSE, 2000) and Healthy Workplace Initiative and NHS Plus programmes.

- **Education** – a range of policies and programmes which includes Sure Start, Sure Start Plus (2001), Excellence in Cities programme, Extended Schools, National Healthy Schools Standard, Food in Schools programme, *14–19 Education and Skills* (DFES, 2005), Connexions, Aim Higher programme, Skilled for Health pilots, Front-line Workers programme and *Skills Strategy: 21st century skills realising our potential* (DFES, 2003).
- **Crime** – including Crime and Disorder Partnerships and Crime Strategies, Drug Action Teams, *Reducing Crime – Changing Lives, the Government’s Plans for Transforming the Management Of Offenders* (Home Office, 2004), Reducing Re-Offending Action Plan (2004), Anti-Social Behaviour Act and Action Plan (2003), *Alcohol Reduction Strategy for England* (Cabinet Office, 2004), Domestic Violence Strategy and Bill (2004) and the introduction of ‘neighbourhood wardens’.

There is a huge variety of local programmes and policies in each of these areas, with a potential to benefit health and achieve other local targets at the same time. For example, local initiatives on green transport are contributing to cross-cutting themes of sustainable land use and improving air quality, as well as increasing physical activity. Most make use of public consultation processes to assess local needs and plan for residential areas and business and employment areas to be in close proximity to each other where

possible, with easy walking distances from homes to essential services such as shops, doctors, schools, post offices and other leisure and social facilities. Such initiatives reduce the need to travel, particularly by car, and green transport plans also seek to find acceptable alternatives such as accessible community and public transport services, made financially viable through increased usage, provision of suitable and safe cycling routes, introducing speed reduction measures, making areas more pedestrian – friendly, supporting bus priority, use of controlled parking zones, and raising awareness through initiatives like ‘walk to school’ schemes and car-sharing clubs.

Another area in which local policy decisions are making a big difference is smoking and health, in this case ahead of national legislation and supported by the regional Big Smoke Debate and related work led by the LHC and SmokeFree London to enable Londoners to speak out on the issues of smoking in workplaces and public places. The NHS in London, encouraged by a joint communiqué from the LHC and the NHS Confederation, set an excellent example of local action on smoking in workplaces by going smoke – free in 2006.

London has continued to lead the way in pressing for smoke-free workplace legislation since 2003, and is now preparing for the Smokefree England legislation on 1 July 2007. This is providing a major opportunity to tackle health inequality at local level, by involving a wide range of local businesses, schools and common parts of residential buildings. Local councils have the opportunity to take a strong lead, drawing partners together across the local strategic partnerships and building on partnerships with PCTs, linking

to stop-smoking services. Local action is being supported by additional funding for local authorities, regional training and support, national guidance and regional support.

Across these and a range of other policy areas, the ongoing rollout of local area agreements (LAAs) is providing opportunities to develop locally tailored approaches to address health inequalities. Recognising specific local needs, LAAs set out short- and medium-term priorities for an area, and provide a local framework to deliver a more strategic vision of existing local community strategy through joint priorities shared by partners.

LAAs also form a central plank of the local government white paper, *Strong and Prosperous Communities*, 2006a), which heralds a reconfiguration of the relationship between and responsibilities of central and local government. Further details on the range of local policies and opportunities for action are provided in *Creating Healthier Communities: a resource pack for local partnerships* (DCLG, 2006b).

