

In sickness and in health

How the NHS can help tackle health inequalities



What is the NHS Confederation?

The NHS Confederation is the independent membership body for the full range of organisations that make up the modern NHS.

We help our members improve health and patient care, by:

- influencing policy, implementation and the public debate
- supporting leaders through networking, sharing information and learning
- promoting excellence in employment.

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Introduction

The NHS Confederation is to begin a major programme of work looking at health inequalities and the role of the NHS. There are many examples of innovative projects and programmes across the country where trusts and their partners are successfully targeting disadvantaged groups. The service is less good at reaching out to people not accessing services and at spreading best practice. We need

to design the right health policies and levers at a national level to tackle inequalities.

This report summarises the current problem and suggests some possible solutions. It sets the context for the major work on health inequalities the NHS Confederation will be undertaking over the coming year.

Summary

Two facts are clear on health inequalities. First, despite substantial investment, key measures are still widening. Second, the causes are complex and stubbornly hard to shift: employment, education, housing, poverty and background all play a part.

Health inequality exists in many different forms. Different regions of the country have different health outcomes. Children born in lower socio-economic backgrounds are more likely to die at birth, suffer more illness throughout their life and die younger. Ethnicity plays a major role with a higher prevalence of disease among different racial groups. Health inequality is found by gender, disability, sexual orientation and lifestyle.

The health service alone cannot tackle the problem. Housing, local authorities, employment agencies, the police and employers all have a major role to play. And such a complex problem has no simple national solution. Each local area will have within it many different kinds of inequalities with different underlying causes.

However, there are specific aspects of health and healthcare that either exacerbate inequalities or could be better used to narrow the inequality gap. This report focuses on three ways the health service can help tackle the problem.

1. Find the missing people

It is estimated that there are millions of people who are not accessing the services they need. Finding them must be the first step in tackling inequality in access. This requires significant investment nationally and locally in sophisticated data and disease mapping to enable a better understanding of who and where the missing people are.

2. Improve access to health services

It is in the early stages of disease, where cure or condition management is possible, that those from poorer economic backgrounds are failing to access services. Improving access is a crucial part of tackling inequality.

There are many different tools within the health service that can be used to encourage a more targeted approach towards tackling health inequalities. Two simple examples of where the Government should change the incentives are:

- GP practices are given around £600 million a year according to their historic levels of funding rather than the real needs of patients. Known as the minimum practice income guarantee (MPIG), this payment prevents equitable distribution of resources and should be abolished.
- The new method of rewarding performance – the Quality and Outcomes Framework (QOF) – pays practices with high disease levels at a lower rate per patient than practices with low disease prevalence. This means that the existing payment system has disadvantaged certain

practices, particularly those in deprived areas. This part of the formula therefore needs to be changed.

3. Use the NHS as a corporate citizen

1.3 million people work for the NHS. The service employs more people than any other organisation in the country. The power that this brings as a local employer could be used more effectively to tackle inequalities. The NHS must ensure it offers equal opportunities in employment.

As part of the local community, the NHS has a considerable role to play working with other agencies to find broader solutions to health inequalities. Harnessing collective power, services must work together locally to put health inequalities at the heart of local priorities. Tackling the root causes of health inequality: employment, poverty, housing etc, is only possible when all organisations work together.

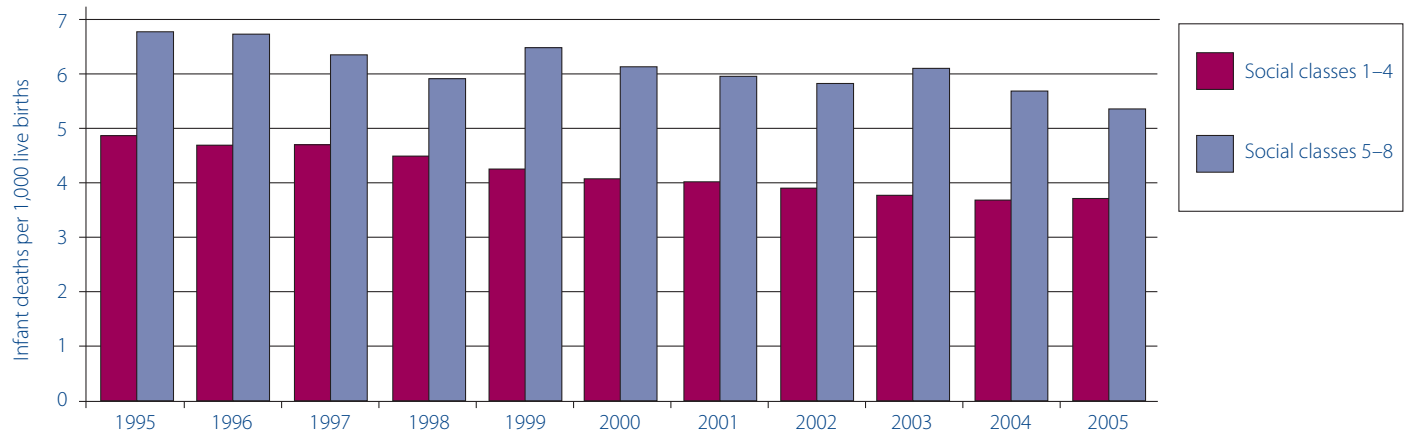
The challenge

Inequality in health is one of the starkest challenges facing Britain today – and some claim the hardest inequality to reverse. Although we are a richer society, with more jobs

and more investment in public services, we are also creating an increasing divide between the health outcomes of the poorest and the richest.

Infant mortality¹

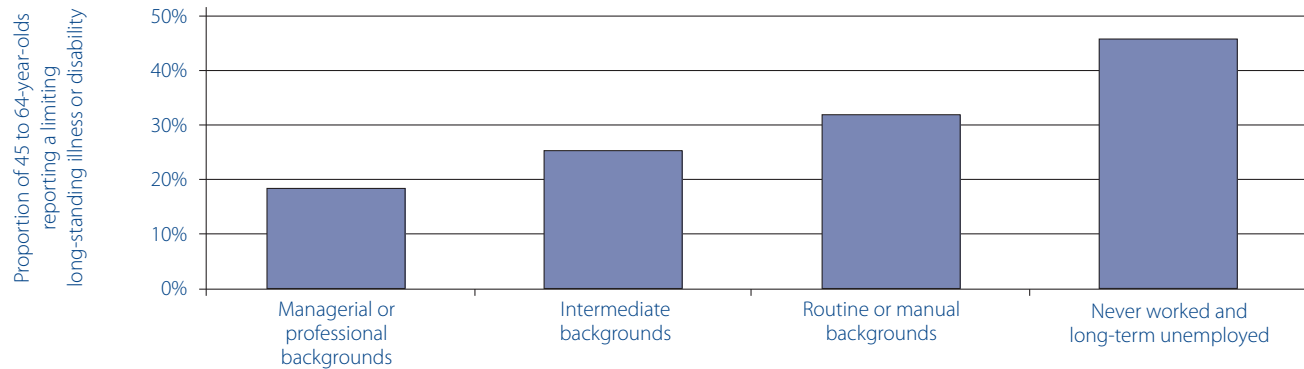
Although falling, infant deaths are 50 per cent more common among those from manual backgrounds than among those from non-manual backgrounds



Source: Childhood, infant and perinatal mortality statistics, DH3, ONS; England and Wales; updated April 2007

Chances of illness and disability²

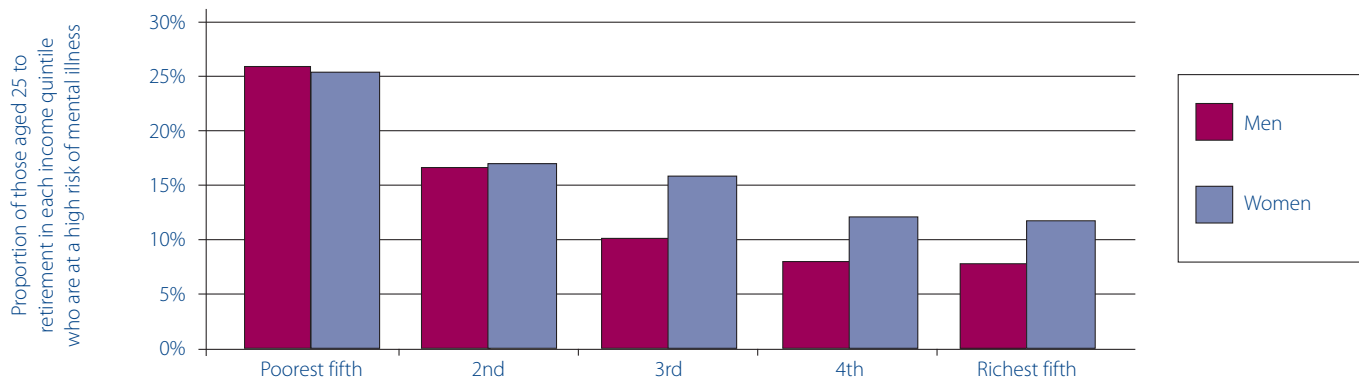
Adults aged 45–64 in routine and manual occupational groups are much more likely to have a limiting long-standing illness or disability than those from non-manual groups



Source: General Household Survey, ONS; the data is the average for the three years to 2005: Great Britain; updated March 2007

Mental health³

Adults in the poorest fifth are around twice as likely to be at risk of developing a mental illness as those on average incomes



Source: Health Survey for England, DH; the data is the average for 2003 to 2005; England; updated July 2007

Geographical inequalities⁴

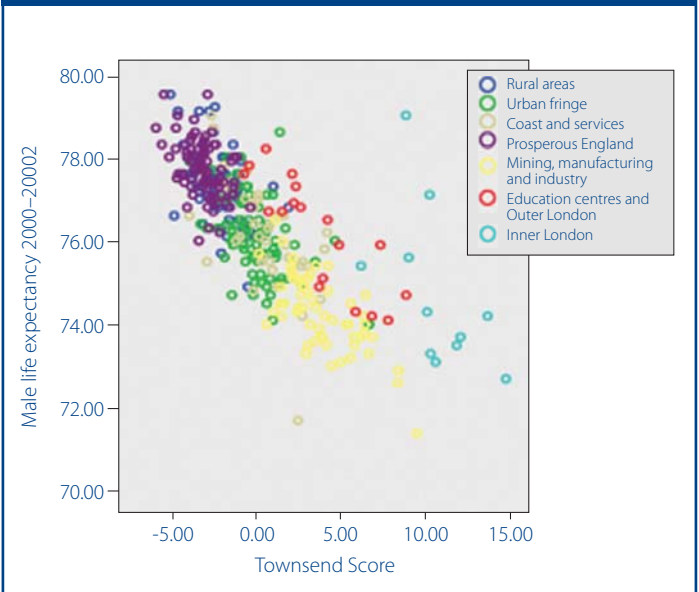
Years of ill health and disability by SHA region (all people)



Life expectancy

There is a direct correlation between life expectancy and deprivation. In many areas the gap is stark. For example, in London there are eight stops on the Jubilee Line from Westminster to Canning Town. Travelling east, each stop marks nearly a year of shortened life span.⁵

Correlation between deprivation and life expectancy for English local authorities by ONS Family, males 2000–2002⁶



Health inequalities – the numbers

- Children from manual social backgrounds are 1.5 times as likely to die during infancy as those from non-manual social backgrounds.⁷
- The rate of infant deaths is 70 per cent higher in the West Midlands than in the South East.⁸
- UK infant mortality rates are higher than in France, Spain, Germany and Italy.⁹
- Manchester men have the lowest life expectancy in England, at just 72.5 years. Men in Kensington and Chelsea can expect to live until they are 82.2 years old. The national average is 76.5 years.¹⁰
- In the North East of England the prevalence of diabetes is 45 per cent higher for women and 28 per cent higher for men compared to the national average.¹¹
- People with schizophrenia are 90 per cent more likely to develop bowel cancer and women with the condition are 42 per cent more likely to develop breast cancer.¹²
- Health inequalities widen during retirement, with people from working-class backgrounds experiencing a much shorter disability-free lifespan.¹³
- African Caribbean people are three to five times more likely to be diagnosed and admitted to hospital for schizophrenia than any other group.¹⁴
- People from black and minority ethnic (BME) groups are up to six times more likely to develop diabetes.¹⁵
- People in lower socio-economic groups are 50 per cent more likely to smoke.¹⁶
- Obesity levels are nearly 50 per cent higher among women from lower socio-economic groups.¹⁷

The Government's approach to tackling health inequalities

The Government commissioned an independent inquiry into health inequalities, led by Sir Donald Acheson. The report was published in 1998¹⁸ and made 40 recommendations on a wide range of areas including poverty, income and ethnicity. The report contributed to the health strategy, *Saving lives: our healthier nation*,¹⁹ which was published in July 1999 together with *Reducing health inequalities: an action report*.²⁰

The NHS Plan was published in July 2000, committing the Government to setting national health inequality targets.

The 2004 Wanless Review included recommendations for radical changes in primary care, investments in workforce and a much more rigorous approach to tackling public health.

Tackling health inequalities is one of the Department of Health's top six priorities for the NHS.

Public Service Agreement targets

The Department of Health's health inequalities Public Service Agreement target is that by 2010 health inequalities will be reduced by 10 per cent, as measured by infant mortality and life expectancy.

Tackling the most deprived areas

The objective for life expectancy is focused on narrowing the gap between the average for England and the areas with the worst health and deprivation levels. The latter are known as the 'Spearhead Group', and are made up of 70 local authority districts defined as those in the bottom fifth of districts nationally for three or more of the following five indicators:

- male life expectancy at birth
- female life expectancy at birth

- cancer mortality rate in under-75s
- cardiovascular disease mortality rate in under-75s
- index of multiple deprivation 2004 average score.

Initiatives to tackle inequalities

There are a number of Government initiatives to tackle inequalities, including:

- the national minimum wage
- Working Families Tax Credit
- Child Tax Credits
- Minimum Income Guarantee for pensioners
- winter fuel payments
- the New Deal
- Sure Start
- increased investment in health services.

The impact on existing inequalities

To date, the impact of initiatives targeting health inequalities has been minimal.

There has been a slight reduction in the gap for male life expectancy. However, there has been a slight increase in the gap for female life expectancy for 2002–04 compared to 2001–03.

Between 2001–03 and 2002–04 there was no change in the inequalities levels on infant mortality.

There were signs of a widening of inequalities in smoking in pregnancy between the routine and manual group and all mothers between 2000 and 2005.

Sir Derek Wanless, in his 2007 review of NHS funding and performance for the King's Fund, expressed regret that his recommendations on public health have not been implemented.

Public opinion on inequalities

While the public view the NHS as incredibly important, what they believe about health inequality is less clear. They are sympathetic about the income gap between rich and poor.²¹

Government should redistribute income from the better off to the less well off

Agree	42%	
Neither agree nor disagree	24%	
Disagree	32%	
Base		3,621

Ordinary working people do not get their fair share of the nation's wealth

Agree	61%	
Neither agree nor disagree	23%	
Disagree	13%	
Base		3,621

In a recent analysis of survey evidence the Joseph Rowntree Foundation has highlighted that:

- over the last 20 years a large and enduring majority of people have considered the income gap to be too large. In 2004, 73 per cent of people thought the gap between those with high and low incomes was too large
- clear majorities in all groups think that the gap between those on high and low incomes is too great, but some groups – principally those on higher incomes – are significantly less likely than others to believe this.²²

Steps towards a solution

The reasons for health inequalities are complex and multi-faceted. Long-term solutions for preventing illness in the first place will only be found when poverty, education, housing and employment are tackled and the specific causes associated with ethnicity,

gender, sexual orientation and lifestyle are better understood.

However, this report focuses on some specific aspects of health and healthcare that either exacerbate inequalities or could be better used to narrow the inequality gap.

Step 1: Find the missing people

It is estimated that there are millions of people who are not accessing the services they need at the time they need them. Finding the missing people must be the first step.

Evidence on the levels of disease we would expect to find – nationally, regionally and locally – is in most cases inadequate. Investment in research and proper disease mapping is therefore crucial.

We can only estimate the number of people with diseases who are not accessing services.

- The British Lung Foundation estimates that two million people in the UK with lung disease – chronic obstructive pulmonary disease (COPD) – have not been diagnosed. COPD kills around 30,000 people a year in the UK, but it is preventable and treatable. Early diagnosis and treatment can slow the illness down.²³
- Diabetes UK estimates that nearly three million people in the UK have diabetes but 750,000 are undiagnosed. Diabetes is a long-term condition and early diagnoses and good management of the disease make a major difference

to quality and length of life. By 2010 it is estimated that more than 5 per cent of the UK's population will have diabetes.²⁴

- The British Heart Foundation has suggested around 2.6 million people in the UK have coronary heart disease (CHD).²⁵ However, only 2,253,867 people were listed as having CHD and registered with a GP surgery in 2006.²⁶

This suggests that approximately 350,000 people with CHD are either not accessing a GP or not diagnosed or recorded as suffering from CHD.

Many local primary care trusts (PCTs) are beginning to use sophisticated social marketing techniques to find the people who are not accessing services.

Case study: Finding people with diabetes in Slough

Berkshire East PCT is using a technique called Health Needs Mapping (HNM) to design services for the traditionally hard-to-reach South Asian population which is at a high risk of type two diabetes. HNM links socio-economic and lifestyle data from multiple sources with data on the incidence of illness, including hospital episodes statistics and local data sources such as disease registries and GP practice information. It is possible to break down communities into postcode units – clusters containing on average 14 households.

The first three months of the Slough project saw a 164 per cent increase in early detection of diabetes. The work has enabled the PCT to better target services for the South Asian community, delivering better health for the whole community.

“We’ve been able to calculate where the highest concentration of undiagnosed sufferers are, and implement a local marketing campaign to target these groups. We believe that around 7 per cent of the local population has diabetes, and half don’t know until they need help for a related medical condition. We want to find them early.”

Grace Vanterpool, diabetes clinical lead

Step 2: Improve access to health services

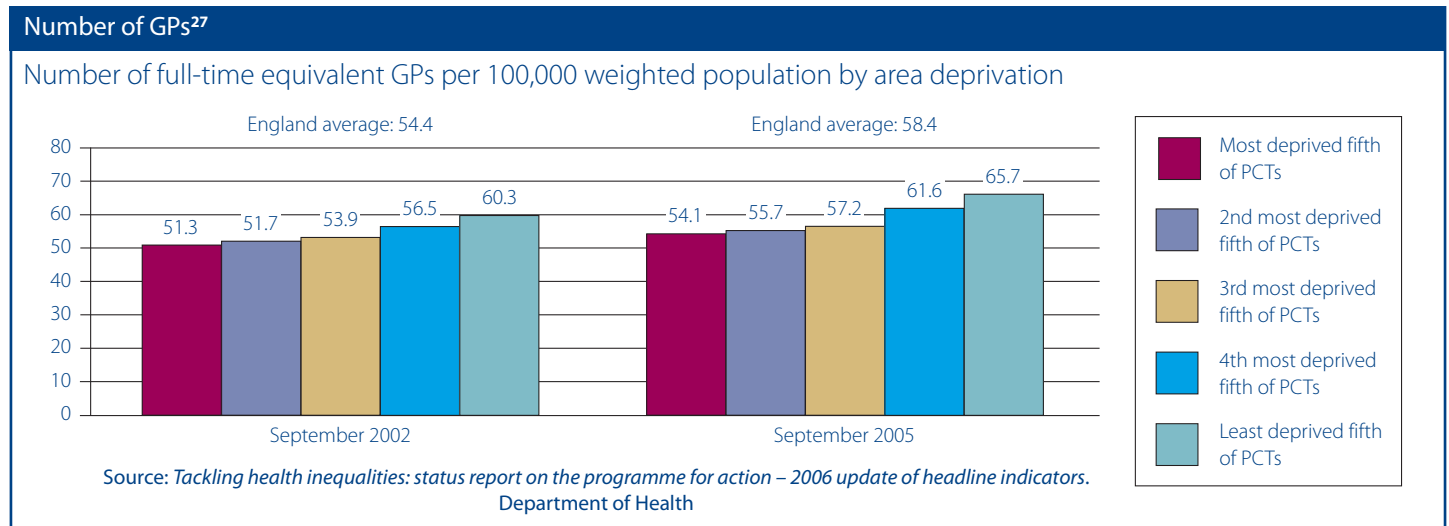
“The availability of good medical care tends to vary inversely with the need for the population served.”

Julian Tudor Hart: ‘The inverse care law.’ *The Lancet*, 1971

To tackle health inequalities, the missing people need to be identified. Services must then be designed to

ensure that the people who most need them are able to access them.

It is in the early stages of disease, where cure or condition management is possible, that those from poorer economic backgrounds are failing to access services.



Case study: Accessing GP surgeries in Tower Hamlets

In Tower Hamlets, research had shown that there were problems with inappropriate hospital visits – people attending A&E when they should have been accessing a GP.

A special software programme, by Experian's Mosaic Origins, which sifts people into 200 'origin types' by their name or by religion, language or geography, found that while many ethnic groups were misusing A&E, the largest group was Bangladeshis aged between 20 to 30.

They found that 30 per cent of those attending A&E had visited the hospital three or more times that year. So they decided to target this section of the community to try and find out why and to tackle the root causes and misconceptions.

There were particular cultural issues underlying the problem. For instance, some patients wrongly believed

they would get better treatment at the hospital – believing that the hospital doctors' uniform implied they were more professional.

Dr Joe Hall fronted-up the campaign, designed by Dr Foster (an independent health information company), appearing on the posters explaining why the family doctor is best for non-emergencies. These posters were then displayed in community centres and mosques and patients were leafleted.

Language had been a big problem because people could not understand where to go and when. Other patients were frustrated at how difficult they found it to get appointments with their GPs.

The campaign has resulted in a 6 per cent cut in A&E admissions at the nearby Royal London, matched by a corresponding rise in GP visits. As A&E services could cost between £55 to £100 a visit, this has saved money that can be spent improving GP accessibility.

Creating the right incentives

There are many different tools within the health service that can be used to incentivise the right behaviours and encourage a more targeted approach towards improving access. Some examples are detailed below.

There are three immediate ways of improving general access to primary care in deprived areas that many PCTs are already using:

- use the power of contracts already available, to drive improvements in performance in access
- publicise quality performance measures locally so the public can compare practices
- commission one or two GP practices to extend opening hours where dissatisfaction with opening times is high. Choice and competition can motivate other practices to extend their opening times.

Tower Hamlets, which has a particular challenge with patient access and a very diverse community, has

commissioned extended hours from 30 of its 36 practices. However, this is a costly approach and only offers value for money in areas with significant problems such as the 70 spearhead areas with the highest levels of inequality.

Payments for primary care services

When the new GP contract was set up in 2003, general practices were concerned they would receive less funds than they had in the past. The minimum practice income guarantee (MPIG) was established, which guaranteed that practices would at the very least be paid what they were under the old contract. MPIG applies to part of the payment GPs receive called the 'global component', which is just over 50 per cent of total investment in general practice and pays for essential services for patients.

Ninety five per cent of practices get some form of MPIG protection, which costs around £600 million a year nationally. This means practices are being paid according to MPIG rather than according to the real needs of patients. Practices in deprived areas are often smaller, with poorer facilities and buildings and therefore their historic levels of

funding are lower and they lose out under MPIG compared to distribution of resources based on need.

The joint BMA and NHS Employers review of the GMS formula in 2007 said that the historic constitution of MPIG prevents equitable distribution of resources. MPIG should therefore be abolished.

The Quality and Outcomes Framework

The Quality and Outcomes Framework (QOF) was introduced as part of the new General Medical Services Contract in 2003. The aim of the QOF was to reward general practices for providing a high quality of care to patients. Practices get points for 146 'quality indicators' and each point earns them money.

Encouragingly, overall performance has improved in primary care since the introduction of the new contract. However, research into the impact of the QOF in its first two years shows that practices with multiply deprived populations tend to have lower rates of achievement. However, it is not known whether the poorer performance

of practices in deprived areas is principally attributable to the characteristics of the population or to the quality of the practices themselves and the GPs working in them.

A further concern is that the QOF formula currently remunerates practices with high disease prevalence at a lower rate than practices with low disease prevalence. This means that the existing payment system has disadvantaged certain practices, particularly those in materially deprived areas.

Compared with practices in more affluent areas, practices in deprived areas tend to have fewer patients overall but a higher incidence of diseases such as diabetes, coronary heart disease and mental health problems. Due to the formula currently used to calculate payments, although practices with more patients with a particular condition receive more money overall, the greater the prevalence of a disease the less money the practice receives per patient.

As an example of the difference in rewards for achieving all the points available for coronary heart disease, a very small practice with very high prevalence (which would

normally be associated with more disadvantaged areas) could receive as little as £13 per patient. A very large practice with very low prevalence (associated with more affluent areas) could receive as much as £27,600 per patient.²⁸ These figures are at the extreme ends of the spectrum and unlikely to be replicated widely, but they highlight the inequality in the way QOF payment formula distributes the rewards. This formula therefore needs to be changed.

Designing the right services

Extending open hours in the evenings and at weekends is of course important. But improving access to traditional services may not be the most effective way to tackle

health inequalities in some excluded groups. For example, where high levels of child mortality may be due to complications caused by inter-family relationships, access to a GP may make no difference. Getting behind the reasons for inequality requires a much more sophisticated approach.

Many PCTs are using new ways of reaching out to local communities. For example, in Tower Hamlets there were plenty of dentists, but people weren't using them. The introduction of a mobile screening service to travel round the local community, proved to be the solution – 30 per cent of those attending had never been to a dentist before. And more than half went to a high street dentist within a month of visiting the mobile service.

Case study: Tackling smoking in pregnancy and breast feeding rates in Stoke-on-Trent

Maternal smoking during pregnancy has a significantly adverse effect on foetal growth and the outcome of pregnancy. However, in Stoke-on-Trent, people were not using the smoking cessation services on offer. The PCT decided to use social marketing to understand why, and improve access.

The PCT sought advice from the National Social Marketing Centre and worked with the Directorate of Health Promotion on social marketing research to understand what influences pregnant smokers in Stoke-on-Trent, and why the current services were not being used.

Following the results from focus groups, analysis of information, the employment of healthcare support

workers and staff training, there has been a significant improvement in smoking cessation rates of women using the services. The next stage of their social marketing intervention is due to begin in the autumn.

Breast feeding rates in Stoke-on-Trent are lower than the national average. The PCT has prioritised improving breast-feeding rates to help reduce infant mortality and reduce levels of obesity.

Through the employment of breast-feeding facilitators and parent practitioner workers, the levels of breast feeding at six weeks have significantly improved. The PCT is now taking the work further with the Department of Health social marketing unit to understand what actions and services could better improve breast-feeding rates.

Case-study: Joint working in Blackpool

Men in Blackpool have the second-worst life expectancy for men in England and Wales. The PCT and the council appointed a joint director of public health and analysed the reasons for such early deaths. They found alcohol-related disease, injuries and poisoning, heart disease, chest conditions and cancer were the biggest killers.

A set of negotiated agreements were made between the council, the police and the PCT, with extra investment and a cooperative approach.

Alcohol treatment and relapse prevention services were reshaped so residents could get to them within a

maximum of two weeks of asking for help. A major multi-agency training programme on brief interventions took place, focused on alcohol, drugs, diet and exercise.

A range of falls prevention and road safety activities for older people reduced the number of people admitted to hospital.

Nutrition and physical activity teams were expanded.

Support schemes for the employment of vulnerable young people by the council, PCT and police were agreed.

A raft of outcomes are being measured, from ambulance call-outs for falls, road traffic accidents, completion of alcohol treatment to the smoking quit rate.

Step 3: Use the NHS as a corporate citizen

1.3 million people work for the NHS. The service employs more people than any other organisation in the country. Using the power this brings to make change happen locally is crucial to tackling inequalities.

South West London and St. George's Mental Health NHS Trust has set up a User Employment Programme to assist staff with mental health problems and also to encourage previous service users to apply for posts within the organisation. This is a recognition that it would be a waste of valuable resources (skills, training and manpower) and of

the valuable positive insight that people with mental health problems can bring to patient care.

A joined-up approach

Services are already working together locally through local strategic partnerships, where the local authority and other local organisations, businesses and agencies come together to agree the local priorities for an area. Local areas must prioritise inequalities in order to tackle such a multi-faceted problem.

Case study: Tackling life expectancy in Walsall

Walsall is confronted with a range of inequalities – the most stark being the ten-year gap in life expectancy between the East and West of the borough.

The Walsall Strategic Borough Partnership invested in an extensive piece of action research on health status and service provision ward by ward. The subsequent health action plan is ward-focused and targeted at the areas that would impact most on life expectancy and child mortality.

Walsall Teaching PCT strongly believes that the only way to tackle health inequalities is to target investment, supported by active social marketing, particularly in

communities with greater needs, with precisely designed public health interventions.

An example of one of their interventions is the development of health trainers – locally employed people providing ‘advice from next door, not from above’. Running now for nine months, the results are already showing in local communities. The trainers offer advice, counsel and, because they come from their own local community, they are trusted and listened to.

Key to their approach has been the development of practice-based commissioning groups, led by local clinicians, who have responsibility for commissioning local services to improve health.

Case study: Tackling mental health stigma in Oxleas and South Essex

Only 24 per cent of adults with long-term mental health problems are in work – the lowest employment rate for any of the main groups of disabled people. Employment is a key driver in tackling inequalities.

The governors at Oxleas and South Essex Mental Health Foundation Trust wanted the trust to focus on helping users and patients find work, and removing the stigma attached to mental health. The new trust went to

organisations like Job Centre Plus, the local police and the chamber of commerce, because of the help they could offer in terms of jobs, housing and community involvement.

“What is interesting is to see users and carers sitting down with the business community and educating them about mental health. We have always been a Cinderella service, but with the help of involved governors we are making a real difference.”

*Dr Patrick Geoghegan, Chief Executive,
South Essex Partnership NHS Foundation Trust*

Case study: A pan-London approach to tackling inequality

People with mental health problems become ill and die younger than others. Capital Volunteering is a pan-London programme which aims to tackle issues of mental health and social inclusion through volunteering. The lead partners are CSV and the London Development Centre, and the programme is funded by the Treasury through its Invest to Save Budget (ISB). Other key partners include a wide range of local voluntary and community organisations, employers, local authorities and NHS trusts.

Projects are located across London and cover a wide range of interests and activities. These include BME projects, mentoring and befriending, self-help and social groups and supported volunteering.

As part of Capital Volunteering, the Institute of Psychiatry is evaluating the effects that participating in Capital Volunteering is having on the quality of service users' lives. Capital Volunteering also supports a pan-London learning network made up of people from over 200 organisations across London. There are opportunities to share approaches and tools, and to reflect on experiences of developing similar projects.

Each borough has its own steering group, comprising mental health service users and key mental health, voluntary, statutory, local authority and employer organisations. The steering groups oversee the development and implementation of the project in their boroughs and in turn report to their local mental health partnership board and the Capital Volunteering Partnership Board.

Conclusions

The NHS Confederation is beginning a major programme of work to investigate health inequalities further. This report is designed as a starting point for that work.

Tackling health inequalities will be hard and will require a joint approach across all agencies, both nationally and locally. Tackling poverty, poor housing, education and

employment are all crucial. However, this report has shown that there are things the NHS can do to help tackle the problem, if the right incentives and processes are in place.

“We shouldn’t just sit back and wait for someone else to do something.”

Dr Sam Ramaiah, Director of Public Health at Walsall PCT

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This publication is designed to raise the debate around health inequalities and the role of the NHS. The NHS Confederation is to begin a major programme of work on three key aspects of inequality:

- **Missing people** – who are the people we are not treating and who are their carers?
- **Access** – why don't all people access services and what can be done through social marketing and primary care to encourage this?
- **Life chances** – how in the long term can we improve the life chances of people in lower socio-economic groups?

If you are interested in getting involved or require more information about this report, please contact Sarah Jones, Head of Public Affairs, on 020 7074 3303 or email sarah.jones@nhsconfed.org

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