CLES BULLETIN

CLES Bulletin is a topical summary of an issue which has recently emerged. Its aim is to provide a pithy précis of the issue, thus creating a quick and easy to read document which directs to more detailed material, if required.

CLES Bulletin No. 41
Health Inequalities and Lifestyle Health Choices

CLES Centre for Local Economic Strategies

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Introduction

Time and time again, statistics show the same pattern of health inequalities across England in both spatial and socio-economic terms. Inevitably, these two factors coincide, with the most deprived wards in the UK aligning with the poorest health. The north-south divide in health is particularly pronounced, with the North West and North East continually scoring poorly in health indicators (see table 1) and highly in levels of deprivation[1]. Factors of particular concern include cardiovascular disease and cancer rates.

Table 1 – National Statistics Health Indicators

Indicator	Manchester	Brighton
Male Life Expectancy*	71.8	75.1
Heart Disease Diagnosis† (Males 16-59)	1,204	370
General Health: Not Good‡	12.5	9.0

* At birth, 2001 – 2003

† Number of Hospital Episodes, April 2002 – March 2003

‡ Percentage of resident population, as defined by National Statistics, April 2001

Central Government have recognised that health and health inequalities are a major concern centrally, regionally and locally. These concerns have shaped a number of government policies, programmes, outcomes and targets. The development of the Spearhead Group of Primary Care Trusts (PCTs) and local authorities, and dedicated Public Service Agreement (PSA) targets outlined in the 2004 spending review highlight this commitment. A further significant development in recent years has been the *Choosing Health: Making Healthy Choices Easier* White Paper published in 2004. This CLES bulletin seeks to investigate these policies in greater detail and to look at some of the more local interventions being developed across England to tackle health inequalities. In particular the bulletin seeks to:

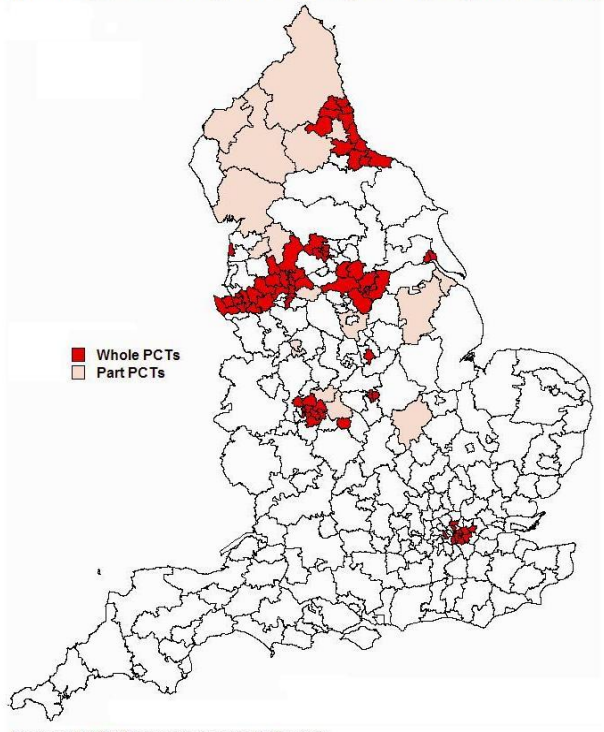
- investigate health inequalities across the country;
- outline the main health issues that are prevalent today;
- look at some of the policy interventions that the Government has introduced to tackle health inequalities;
- summarise a number of successful local case studies.

Inequalities of Health in the UK

The *Spearhead Group* is made up of 70 LAs and 88 PCTs (see Fig.1), based upon the LA areas that are in the bottom fifth nationally for 3 or more of the following 5 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 (LA Summary), average score.

Figure 1 - Spearhead Group areas - Primary Care Trusts (whole and part)



Sources: ONS (Life expectancy, mortality data)
ODPM (Index of Multiple Deprivation)
Taken from http://www.dh.gov.uk/assetRoot/04/09/54/13/04095413.pdf

[1] For more information on the Index of Multiple Deprivation (2004) see the Department for Communities and Local Government: http://www.dclg.gov.uk/index.asp?id=1128440.

The Spearhead Group is attempting to *"address geographical inequalities in life expectancy, cancer, heart disease, stroke and related diseases"* by speeding up the progress of the fifth most deprived wards in comparison to the national average. Manchester, home to a substantial proportion of these most deprived wards, has a significantly higher combined incidence of hospital episodes for cancer, heart disease and stroke related illnesses, than say Brighton, home to none of the fifth most deprived wards. Despite being less than twice as large in population terms, Manchester displays more than three times the number of these hospital episodes, 3312, compared to Brighton's 1000 (between April 2002 and March 2003)[2]. Manchester's mortality rates for all cancers and for Coronary Heart Disease (CHD) between 2002 and 2004 are also disturbingly far above the average for all of England. For all cancers Manchester comes in at 167 compared to England's average of 121.6 and for CHD, Manchester is at 160 compared to England's 96.7[3].

Tackling health inequalities as highlighted above forms a key part of Department of Health's PSA. For example, objective 1 of the PSA is to improve the health of the population and by 2010 have increased life expectancy to 78.6 for males and 82.5 for females. As part of this objective, the PSA identifies that the DoH must "*Reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth"* [4].

Lifestyle Choices

A significant contributor to the geographical inequalities identified above is the lifestyle choices that individuals and groups of people make. The Choosing Health White Paper found that with *"widening health inequalities, a sharp rise in obesity, a slowing in the decline of smoking rates, growing problems with alcohol, teenage pregnancy and sexually transmitted diseases, old ways of thinking about and responding to public health problems were, increasingly being shown to be inadequate"*. Keen to avoid the idea that health policy was dictated down to the public from Whitehall, they conducted extensive consultations with the public and identified three 'core principles' to underpin the whole of their future strategy. These were:

1) Informed Choice,
2) Personalisation,
3) Working Together.

It was in this first core principle that the public outlined their desire to be free to make their own decisions on choices that impact on their health, but at the same time it was agreed that balancing the rights and responsibilities in ways that protect health was necessary. The public were also keen to extend a 'special responsibility' for children, since they are too young to make informed decisions on health.

The final two core principles highlighted how each case was different and as a result needed support that was *"tailored to the realities of individual lives"*, but that individuals alone cannot make progress on healthier choices without the effective partnership working of local government, the NHS, business, the voluntary and community sector (VCS), the media, faith organisations, advertisers and many others, in line with core Government and regeneration principles around local delivery, partnership working and addressing the needs of the most socially excluded.

The *"extensive and unprecedented consultation"*[5] that went into the production of the DoH white paper, established that the public were keen to be left to decide for themselves on what choices to make with regard to 'lifestyle health issues' such as whether to smoke or not, how much alcohol to drink, what measures to take against Sexually Transmitted Infections (STIs), whether to exercise or not and what food to eat. However, the Government and a number of voluntary groups believe that the costs and increasing health implications of these lifestyle

[2] Taken from National Statistics Neighbourhood profiles at; http://neighbourhood.statistics.gov.uk/dissemination/.
[3] Taken from the Manchester City Council website at http://www.manchester.gov.uk/health/jhu/intelligence/city.htm.
[4] For a detailed list of DoH PSA targets for 2005-2008 see HM Treasury at: http://www.hm-treasury.gov.uk./media/4B9/FE/sr04_psa_ch3.pdf.
[5] DoH (2006) *Choosing Health: Making healthy choices easier*. Department of Health, London.

issues need addressing. Lifestyle health incorporates diseases and illness relating to a number of factors but primarily it is associated with excessive drinking, smoking, eating; a lack of exercise; and general sexual health.

Smoking Facts

- Smoking is the most prevalent among 20-34 year olds and those in routine or manual households.
- Smoking peaked in the 1960s but fell dramatically in the 1970s. Decline slowed during the 1980s and levelled off from 1992.
- In 2004, 26% of girls and 16% of boys aged 15, smoked regularly.
- Smoking causes 120,000 deaths in the UK each year, and treating smoking related diseases costs the NHS about £1.7 billion a year.

Smoking[6/7] has already provided the Government with a particularly difficult challenge this year, dividing MPs over the issue of a full or partial ban in pubs, bars and clubs – including private members clubs. The problem that the Government faces is balancing the freedom of individuals to make their own lifestyle health choices, as identified in the white paper, with the rights of the general public, who do not wish to be subjected to potential health risks themselves, as a result of smokers. Another aspect the Government needs to address is the economic costs of smoking and the implication these costs can have on already deprived households. In addition to this, smoking is the main cause of lung cancer and contributes to a range of other diseases and conditions, such as heart and respiratory diseases[8].

Drinking Facts

- Almost half of men 47%, and 39% of women, aged 16-24, exceeded the daily benchmark at least once a week.
- 32% of men and 24% of women aged 16-24 were classed as "heavy drinkers".
- Drinkers aged 11-15 in England, doubled their average weekly intake during the 1990s, and in 2004, 45% of 15 year olds drank regularly.
- The cost to the NHS of alcohol misuse has been estimated at £1.7 billion each year. This does not include the £7.3bn in crime and anti-social behaviour costs related to alcohol.

Figures[9/10/11] also suggest that the true cost of alcohol misuse is closer to £20 billion if you add together the costs shown above relating to health harm and crime and anti-social behaviour harm, with the estimated £6.4 billion arising from loss of profitability or productivity (equivalent to 17 million lost working days), and the cost to families and victims of alcohol related crime, costing another £4.7 billion[12].

Long-term alcohol misuse was responsible for 5,500 deaths in 2000, mainly to chronic liver diseases such

[6] Statistics on smoking taken from National Statistics at: http://www.statistics.gov.uk/cci/nugget_print.asp?ID=1327.

[7] According to the Department of Health: (http://www.dh.gov.uk/PublicationsAndStatistics/PressReleases/PressReleasesNotices/fs/en?CONTENT_ID=4085553&chk=PhFbg9

[8] See *Smoking, drinking and drug use among young people in England in 2004*. National Centre of Social Research, Department of Health, London.

[9] Statistics on drinking taken from National Statistics at: http://www.statistics.gov.uk/cci/nugget_print.asp?ID=1328.

[10] As defined by National Statistics, heavy drinking is classed as more than 8 units a day for men and 6 units a day for women.

[11] Cabinet Office (2004). *The Alcohol Harm Reduction Strategy for England.* Prime Minister's Strategy Unit, Cabinet Office, London. Available at: http://www.strategy.gov.uk/output/page3669.asp.

[12] Taken from the Department of Health Statistical Bulletin on Alcohol; England, 2004. Available at: http://www.dh.gov.uk/assetRoot/04/09/53/20/04095320.pdf.

as cirrhosis. But there were also 580 deaths and 2,600 serious injuries attributed to drivers over the drink-drive limit in 2003. At peak times, in many A&E facilities, up to 70% of attendance can be alcohol-related.

Eating and Exercise Facts

- The prevalence of obesity in England has increased markedly since the mid-1990s despite the fact that:
- There is no evidence that the average calorific intake or consumption of foods rich in fat and added sugar has increased in the UK since the mid 1980s.
- There has been a steady reduction in physical activity with the increase in use of cars, and decrease in numbers walking or cycling to work or school being blamed.
- Proportion of children aged 5-10 walking to school fell 9 points to 52% between 1992 and 2002.
- Obesity costs have been estimated at £1 billion on treatment, £1.4 billion on absence from work and another £1-6 billion on state benefits.

Obesity[13/14], especially related to children, has been thrust very firmly into the limelight over the past few months. In light of recent campaigns about the state of school dinners, the Government has been forced to seriously address the issue and come up with viable and effective solutions in a short space of time. This has coincided with the information from the white paper consultation, outlining the general public's desire for the Government to *"exercise a special responsibility for children"*. There is clear evidence that not only is the Government taking this matter extremely seriously, it is actually willing to invest the funds required and develop the long term strategies needed to tackle the problem effectively. There appears to be a clear focus in the Government approach that is allowing it to maintain its promise to allow individuals to make their own choice on lifestyle health issues, but at the same time extend the *special responsibility* to children that was also requested, some of these strategies will be highlighted later.

Sexual Health Facts

- New diagnoses of HIV tripled among heterosexuals between 1998 and 2003, with half of the 37,000 receiving care living in Greater London.
- Chlamydia is the most common STI in the UK. New diagnoses of chlamydia greatly increased between 2000 and 2004 from 116 to 175 per 100,000, this increase was primarily in persons under 16.
- It is estimated that STIs and their consequences cost the NHS around £1 billion annually.

Sexual health problems[15/16] are beginning to see a very steep rise, especially between heterosexual partners. Ignorance of the symptoms - or in some cases not having any symptoms - and a latent embarrassment about dealing with the problems, mean that diseases are often well progressed and much harder to treat as a consequence. There is still

[13] Statistics on eating and exercise taken from National Statistics at: http://www.statistics.gov.uk/cci/nugget_print.asp?ID=1329.

[14] Figures taken from the *Choosing Health: Obesity Bulletin Issue 1 (04/05/2006)*. Obesity Team/Health Improvement Directorate, London. Available at: http://www.dh.gov.uk/assetRoot/04/13/44/73/04134473.pdf.

[15] Statistics on sexual health taken from National Statistics at: http://www.statistics.gov.uk/cci/nugget_print.asp?ID=1330.

[16] According to the Select Committee on Health (2005) *Memorandum by Brook Advisory Centres (WP 08)*. Cabinet Office, London. From: http://www.publications.parliament.uk/pa/cm200405/cmselect/cmhealth/358/358we10.htm.

a wide range of myths that exist regarding the transmission of STIs, the most worrying, and potential most harmful, is the belief that only homosexuals and drug users are at risk from serious STIs. Whilst this may have been true in the mid 1980s it is certainly not the case any longer. Cases of new HIV diagnoses have remained almost constant in homosexual men between 1989 and 2003, while in heterosexuals it has gone from less than a third, to more than double this homosexual rate in the same time period. The other routes of infection, such as injecting drug use or mother to infant affect only a very small number of people.

Policy Interventions

The Neighbourhood Renewal Unit (NRU), the Local Strategic Partnership (LSP) Team within the NRU and individual Local Strategic Partnerships have played vital roles in building the links between private, public and voluntary sectors that are needed to effectively tackle health inequalities. The Choosing Health White Paper gave advice on the nature of contemporary health issues, but it is the LSPs and the PCTs that need to be developed in order to combat the problems.

Development of the PCTs has been pivotal in attempts to reduce health inequalities. In 2004, PCTs were made responsible authorities for health within Crime and Disorder Reduction Partnerships. This was viewed as extremely important since *"effective crime and disorder strategies could impact on a range of national and local NHS priorities such as reducing health inequalities"* but also because *"bed days related to crime and disorder cost the NHS between £1.1 and £2.3 billion per year. An estimated 116,000 NHS staff were the victims of violence and aggression in 2002 - 2003. Property damage, risk, liability or injury to staff costs between £300 million and £678 million per year"*[17]. More recently PCTs have been issued with specific guidelines on the collection of data for measuring childhood obesity.

The Choosing Health White Paper has also called for health inequality interventions to be joined up to wider regeneration and social exclusion agendas. The Health Development Agency (HDA) in particular, also believes that *"regeneration can make a positive contribution to improving the health of those in poorer socio-economic circumstances"*[18]. They propose three key elements to reducing inequalities through regeneration, these being; Employment; Housing; and Transport. While the view that *"changes in employment status have been shown to be linked to changes in health"* and that *"transport has a number of features that contribute positively to determinants of health, by improving access to a range of services"*[6] are widely evidenced and agreed, the effect of housing regeneration is still viewed cautiously. This is because these programmes do not always benefit all local residents equally and can displace social problems rather than solving health inequalities. However, combining these three elements successfully can produce a much greater level of public health, and open the doors to a higher level of social interaction. This last improvement is held in particular high regard by the Cabinet Office[19] who see *"the potential of social capital for generating economic, social and health outcomes as a reason why working with communities and building social cohesion is a prerequisite to tackling deprivation and inequalities"*.

Another area where notable health inequalities can arise is in Black and Minority Ethnic (BME) groups. A key focus of the DoH appears to be on the inequalities arising from mental health within BME groups. They have set up the Delivering Race Equality (DRE) in Mental Health Care in an attempt to curb the rising incidence of BME patients with schizophrenia in particular. The scheme is based around three central tenents:

- More appropriate and responsive services - achieved through action to improve mental

[17] DoH (2004) *Commencement of primary care trusts as responsible authorities within partnerships.* Department of Health, London. Available at: http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4086947&chk=nmHkyR.

[18] Hunter, D & Killoran, A (2004) Tackling health inequalities: Turning policy into practice? Health Development Agency, London.

[19] Cabinet Office (2002) *Social capital: A discussion paper*. Performance and Innovation Unit, Cabinet Office, London.

health care for black and minority ethnic patients, developing a more culturally capable workforce, and finding new pathways to care and recovery.

- Community engagement - achieved by engaging communities in planning services, and supported by 500 new community development workers and the expertise of independent sector BME service providers.
- Better information - from improved monitoring of ethnicity, better dissemination of information and good practice, and by improving knowledge about effective services. This includes the new regular census of mental health patients covering their ethnicity, faith, legal status and more.[20]

Following on from BME group specific interventions the Department for Communities and Local Government (DCLG) also engages the *Supporting People* programme to alleviate health inequalities for other more vulnerable groups in society such as the elderly, teenage parents and young people, ex-offenders, the homeless and a range of other potentially vulnerable groups. The focus of their work is housing related, and they aim to provide people with, or keep people in, their own homes when ordinarilly they would have to be moved in to care or some form of institutionalised housing. The primary objective may not be directly related to health but this form of support can help to make people more independent and will allow them to leave the confines of full-time health care more successfully.

Continuing with the mission to target children's health issues, the Government has introduced a significant number of programmes specifically designed to improve children's health. The use of cross department thinking has helped to develop a number of projects. Noteworthy contributors are the Department of Health, Department for Education and Skills (DfES), the Department of Culture, Media and Sport (DCMS) and even the Department for Transport (DfT).

A key target is the obesity Public Service Agreement (PSA) introduced in 2004. This set down a clear objective to *"halt the year-on-year increase in obesity in under-11s by 2010 as part of a broader strategy to tackle obesity in the population as a whole"*[21]. A number of the programmes introduced to meet the PSA target include:

- £235m invested to transform school lunches;
- £1.5bn invested in school sport;
- Obesity Social Marketing campaign;
- Obesity Care Pathway;
- Obesity Toolkit;
- Your Weight, Your Health;
- DoH *Five a Day* Scheme;
- Audit Commission – *Tackling Childhood Obesity* publication.

Of major importance has been the identification of universal preventative measures and targeted interventions. The use of universal preventative measures is an attempt to *"counter the long running trends that have created an increasingly "obesogenic" environment"*, these include:

- Healthy Schools Programme;
- Children's Centres/Sure Start;
- School Fruit and Vegetable Scheme;
- Food Promotion;
- School Food Trust;
- School Sport Strategy;
- Travel to School;
- Play;
- Breast Feeding and Weaning Support;
- Work with food industry (signposting & reformulation);
- Healthy Start Initiative;

Targeted interventions aim to provide young children and their families with treatment specific to their needs and include the recently published DoH *Obesity Care Pathway*[22]. This seeks to present

[20] For more information on the DoH DRE scheme see: http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/MentalHealth/BMEMentalHealth/fs/en

[21] DoH (2006) *Choosing Health: Obesity Bulletin Issue 1*. Obesity Team/Health Improvement Directorate, London. Available at: http://www.dh.gov.uk/assetRoot/04/13/44/73/04134473.pdf.

[22] More information on the Obesity Care Pathway can be found from the Department of Health at: http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4134408&chk=Sq/wNd.

evidence based guidance to primary care clinicians in identifying and treating obesity, but this is an interim measure due to be updated by the National Institute of Health and Clinical Excellence (NICE) obesity guidance, to be published in November 2006.

The importance of promoting a healthy lifestyle at an early age has been underlined by the introduction of healthy eating standards now being considered by Ofsted during their school inspections. Advice on improving standards can be offered to schools by the School Food Trust. But keeping children active outside of school is also seen as crucial. The School Sports Programme aims to develop children's activity levels by offering 15 sports, including dance, in a bid to engage pupils sidelined by traditional sport. It is also seeking to better link children with their local communities.

A less targeted approach is being developed by the DCMS, who are seen as key in encouraging 'play'. £155m has been provided by the Big Lottery Fund to develop children's play and local authorities have been tasked, as their primary responsibility, with *"engaging with local partners to enhance the local environment with more opportunities to increase physical activity"*. Another £10m has been invested by the DfT to link the existing National Cycle Network to schools with a further £2m being spent to construct new links.

Health Interventions at the Local Level

As discussed earlier, health inequalities are seen as a major barrier to social inclusion and to community development. Local Strategic Partnerships (LSPs) have been fostered around the country in order to help to reduce these and other inequalities, but also to alleviate some of the problems that these inequalities may be causing and to build stronger communities as a result. Local Area Agreements (LAAs) set particular targets and outcomes for a local area to tackle health related issues. Advocating partnership working and having the ability to pool and align resources and negotiate freedoms and flexibilities LAAs present real opportunity for joined up and effective inequality reduction.

A range of local organisations and partnerships have responded to national and local policy and strategy to develop a host of innovative projects. The section below highlights examples of key local health interventions from across England[23]:

Community Action on Health (CAH), Newcastle – Strategic Case Study

Funded primarily by Newcastle Primary Care Trust, CAH was developed from Community Participation in Health, set up in 1994, and tasked *"to tackle inequalities in health by working with local people, to support them to address health related issues and influence policy and service decision-making"*.

The model they use is adapted according to local circumstances but still relies on the existence of local community groups and other community workers. This helps to:

- enhance work already under way;
- build trusting networks between groups;

As a result, CAH aims to assist the NHS with implementation of section 11 of the *Health and Social Care Act 2001 (public involvement and consultation)*, and share knowledge, information, skills and capacity with the VCS. This allows communities to define their own health agenda and create bottom up priorities, rather than those imposed by government – priority is always given to excluded groups and communities, whose voices are least likely to be heard. The programme includes work on a feasibility study on access service for BME communities and a training scheme for basic literacy skills around health.

An evaluation of the programme found that *"with limited resources and great commitment, CAH has made a significant contribution…for community participation in decision making in health…and to the project of tackling health inequalities in Newcastle"*.

[23] More information about the above case studies can be found on the NRU website at: http://www.renewal.net/Nav.asp?Category=:health.

Horden and Eastington Colliery Pathfinder, Sunderland – Project Driven Case Study

This former mining community near Sunderland suffers from high rates of teenage pregnancy, chronic heart disease, cancer, smoking, obesity, and alcohol consumption, and a lower than average life expectancy. According to the 2000 index of Multiple Deprivation, 26 wards in this area are in the worst 10% in terms of health provision.

Initiatives implemented to tackle the problem included; the Handy Van and Handy Man services, providing elderly residents with minor repair work to ensure safety and reduce falls in their homes; the Smoking Cessation Programme, in conjunction with Sure Start, that saw advisers going to peoples homes to provide a recognised psychological approach combined with Nicotine Replacement Therapy; Substance Misuse Development Programme to provide face-to-face sessions on drug education; and a Teenage Parent Programme that provides one-to-one support to help young people make informed choices about pregnancy and parenthood.

Lead by the PCT and with heavy involvement from the Sure Start programme has enabled a level of leadership and expertise to be brought to the programmes. Success with the scheme has allowed the Handy Van programme to extend its services to include financial advice on benefits and pensions, this has helped increase household income and therefore, further reduced health inequalities.

Preston Road New Deal for Communities (NDC), Hull

13 out of the 20 wards in this district of East Hull fall in the 20% most deprived wards in England on the Index of Multiple Deprivation. Compared to nearby East Yorkshire, residents are 60% more likely to die prematurely of heart disease and twice as likely to die from lung cancer.

65% of residents did not exercise, and many believed that if they quit smoking they would put on weight.

Partnership between the NDC, PCT and Tees and East North Yorkshire Ambulance service resulted in:

- The Stay Healthy Live Longer project, providing slimming classes and drop in services that pull together the lifestyle strands that contribute to health and well being, and encourages lifestyle changes.
- Enhanced GP access to residents by reducing the use of GPs for preventative problems and non-medical use, as part of the Support not Pills intervention.
- A community paramedic being introduced to address the issue of difficult access to A&E facilities, and to deal with the high incidence of Ischaemic Heart Disease. This also sought to provide information on dealing with life-threatening emergencies, training residents, and even providing information and opportunities about careers within the ambulance service.

Outcomes of the scheme include; greater access to GPs; reduced anxiety and stress for the sick and disabled, and their carers; and 21 local residents trained as First Responders to provide 24hr additional service to the ambulance service.

Conclusion

The 2004 white paper on health identified a number of key principles that are seen as critical by the general public. Looking at the current array of government initiatives, it appears that they genuinely are taking these key principles seriously. There is an undeniable focus on children, especially in relation to their eating and exercising habits, but there are also preventative measures in place to reduce their potential to be enticed into other negative lifestyle choices that will affect their health badly in the future i.e. smoking, drinking etc. The cross department projects, working together to tackle the growth in childhood obesity and hit the obesity PSA targets, look extremely promising and are highly commendable but it is, as yet, too early to be able to evaluate their success.

Other projects, geared both towards children and adult's health problems, also appear to take on board the key principles identified. Targeted health

care that is being provided is taking a case-by-case approach, allowing health workers to assess each patient individually and to apply varying treatments that can be tailored to an individual or to a specific region. These methods also involve the incorporation of existing local methodologies and as a result, have so far proven to be effective. Individual choice is also catered for and an abundance of advice is given to patients rather than mandatory prescription. This allows the individual to decide what course is right for them and to then contact the health authority to progress their chosen course voluntarily.

Further efforts have very recently been announced to include a health dimension to Social Enterprise. The new Social Enterprise Unit within the DoH will encourage innovation and entrepreneurialism in health and social care and provide services that better serve patients needs. Indeed the voluntary, community and social enterprise sector are seen as key to the future development and delivery of health services. Many local authorities and other bodies are increasingly recognising the role of this sector and particularly the benefits delivery at a more local level and smaller level can bring by commissioning established organisations to deliver services on their behalf. This has been particularly evident in the spend of Supporting People funds. Active encouragement of voluntary, community and social enterprise service delivery is also being actively encouraged in sectors which are also likely to impact on improving health and reducing health inequalities such as; services for older people; homeless hostel provision and correctional services.

One particular example of where a voluntary, community and social enterprise sector organisation has been successful in commissioning a service delivery contract from the local authority is Hendon Community Care in Sunderland. Hendon Community Care provides home support services to older people and disabled people across inner city Sunderland who require assistance with their daily living needs. The organisation has been delivering contracts for Sunderland City Council since 1994, growing out of an established voluntary organisation that began operating in 1973. Hendon Community Care won its most recent contract at the end of 2005, a three year contract from Sunderland City Council to deliver 'Support Services for People at Home'.

While considerable effort is being poured in to combat lifestyle health issues there seems to be a lack of attentiveness towards the diseases that kill the most people in this country each year – cancer and cardio-vascular related diseases. The Spearhead Group identified these as areas to focus resources, in an attempt to tackle the main causes of health inequalities. Local authorities and Local Strategic Partnerships and their associated partners are however beginning to utilise central policy to develop and target more locally defined health interventions aimed at reducing inequality.

For further information on any of the issues raised in this bulletin please contact:

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