Equally Well – Tackling Poverty

Introduction

This report will look at the main ways that the Equally Well Framework approach can have an impact on tackling poverty in Scotland. Equally Well is informed by the understanding that to reduce inequalities in health and wellbeing it is necessary to develop interventions which target the underlying causes, of which poverty and deprivation are central.

The report brings together the findings of a brief review of relevant policy and research literature. Where possible, the impact of Scottish initiatives that have been informed by Equally Well have been explored. It should be acknowledged that the Equally Well Framework is relatively new so there is a limited amount of research evidence for its impact on outcomes for reducing inequalities in health and wellbeing. The report has drawn upon UK-wide and international evidence, where possible, of the impact on tackling poverty from the approach set out in Equally Well.

This report understands the main ways Equally Well will help to tackle poverty to be:

- Developing interventions committed to early intervention and prevention at various stages of a person's life cycle.
- Helping to develop the individual and collective capacities and assets of people and communities for leading healthy lives.
- Ensuring there is an improved synergy between our universal public services and the community and voluntary sector.
- Fostering an enhanced understanding amongst our service delivery professionals about the relationship between poverty and health outcomes, ensuring the individuals whole life circumstances are taken into account when addressing health and wellbeing.

The report will begin by describing the main features of inequalities in health and wellbeing according to income and area deprivation[1] measures in Scotland. The report will continue by discussing the approach set out by Equally Well to tackle these inequalities, and the way poverty is being addressed by the Equally Well Framework. The report will conclude with a discussion of some of the health initiatives driven by Equally Well, highlighting the main ways these initiatives address poverty.

1. Context setting; the relationship between poverty and health outcomes.

This section will explore the relationship between poverty and health outcomes, drawing upon a selection of the data[2] available on the key characteristics of health inequalities by income and area deprivation[3].

[1] Area deprivation measures have been used where data on income was not available.

[2] In the main, the data in this section has been drawn from: *Equally Well Overview of Statistics on Health (2008c)*

It is important to note that most of the statistics available on health inequalities are simple breakdowns by a single determinant which do not take into account the influence of other factors associated with the health indicator concerned. In reality, there will be complex interactions between factors that contribute to the initiation or exacerbation of particular conditions or the lifestyle choices people make.

The key measures of population health are; life expectancy at birth[4], healthy life expectancy[5] and overall mortality.

Life Expectancy and Healthy Life Expectancy

There have been improvements over time in Scottish life expectancy and healthy life expectancy. Nevertheless, healthy life expectancy is increasing at a slower rate than life expectancy; meaning that people are living longer but that more of these years are spent in ill health. Latest figures on male life expectancy in the 10% most deprived areas in Scotland is 13.5 years lower than male life expectancy in the 10% least deprived areas. For females, the gap in life expectancy between the most and least deprived is 9.1 years *(*General Register Office for Scotland 2010*)*. Further, the deprivation inequality gap in life expectancy appears to be widening over time, particularly for males (see diagram 1). Healthy life expectancy for the period 2007-08 for males in the least deprived fifth of the Scottish population is 15.8 years higher than in the most deprived fifth of the population. For females, the gap is 15.2 years[6].

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http://www.scotland.gov.uk/Topics/Health/health/Inequalities/inequalitiestaskforce/overviewofstatistics, *Key Statistics on Health Inequalities – Summary Paper (2008b)* http://www.scotland.gov.uk/Publications/2008/06/09160103/3, *Equally Well Review; Update on Health and Related Inequalities (2010d)* http://www.scotland.gov.uk/Topics/Health/health/Inequalities/inequalitiestaskforce/ewreview/update/Q/EditMode/on/ForceUpdate/on, *Scottish Health Survey 2008 (2009a)* http://www.scotland.gov.uk/Publications/2009/09/28102003/0, *Long-term Monitoring of Health Inequalities – Headline Indicators (2010g)* http://www.scotland.gov.uk/Publications/2010/10/25144246/0.

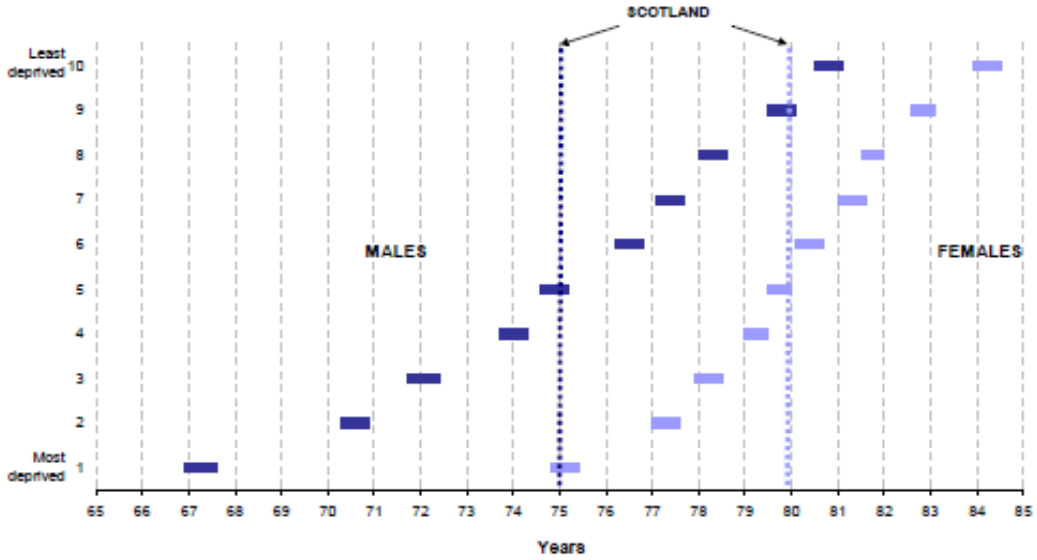
[3] Deprived populations tend to be concentrated in particular geographical areas, hence the use of area based definitions to identify them. However, not all people living in areas defined as deprived are disadvantaged. Area deprivation is measured using the Scottish Index of Multiple Deprivation (SIMD).

[4] Defined as the number of years that a person is expected to live as determined by mortality statistics at the time of their birth.

[5] Defined as the number of years a person can expect to live in good health. Healthy Life Expectancy in Scotland is estimated using people's assessment of their health and/or the presence of limiting long term illness.

[6]Scottish Public Health Observatory, ScotPHO 2010 – link: http://www.scotpho.org.uk/home/Populationdynamics/hle/hle_data/hle_depquintiles.asp.

Diagram 1: Life expectancy at birth, 95 per cent confidence intervals for SIMD 2009 Decile areas, 2006-2008 (males and females)



Source: GROS 2010

Overall mortality

Mortality rates for those aged <75 years in the 10% most deprived areas are three times higher than those in the 10% least deprived areas. Increases in male mortality in the last twenty years are restricted to the more deprived areas. A general pattern of greater decreases in the more affluent areas has led to increasing inequalities for males aged <75 and for women aged 30-74 years.

For males, the biggest deprivation inequalities in mortality are observed for deaths from accidents (when aged 5 years), deaths from suicide, disorders due to use of drugs and assault (when aged 20 years), deaths from disorders due to the use of alcohol, chronic liver disease, coronary heart disease and cancers (when aged 45+) (Scottish Government 2008c).

For females, the biggest deprivation inequalities in mortality are observed for deaths from suicide and disorders due to the use of drugs (when aged 25), chronic liver disease, cancers and heart disease (when aged 45+) (Scottish Government 2008c).

General Health and Mental Wellbeing

People with a 'health problem' are less likely to be in employment than those with 'no health problem' (57% compared with 83%). This difference is even more marked within the most deprived 15% of areas in Scotland, with only 34% of those with a 'health problem' in employment compared with 70% of those with 'no health problem' (Scottish Government 2008c).

Disabled people's income is, on average, less than half of that of people who are not disabled. Households containing at least one person with a limiting long term

condition are twice as likely to have an income of less than £15,000 p.a. than households where nobody has a limiting long term condition (Ibid).

Those who have a low income, find it difficult to manage on their income, or live in a deprived area are more likely to have had experience of mental health problems (personal or of someone close to them), display more signs of psychiatric disorder and have less positive mental wellbeing scores (Ibid).

Across the UK, adults in the poorest fifth of the population are twice as likely to be at risk of developing mental illness as those on average incomes. People with mental health problems are three times more likely to be in debt and less than a quarter of adults with a long-term mental health problem are in employment – the lowest rate amongst disabled people (Ibid).

The results from the *2008 Scottish Health Survey* found that low household income was significantly associated with poor self-assessed health for both men and women. The odds of those in the lowest quintile having poor self-assessed health were 8.03 times higher for men and 2.50 times higher for women than those in the highest quintile. In addition, households in the lowest income quintile were found to have the lowest mean scores on the Warwick-Edinburgh Mental Wellbeing Scale, which measures mental wellbeing (Scottish Government 2009a).

Analysis of the Department of Work and Pensions (DWP) data on Incapacity Benefit (IB) by Brown et al (2009) shows that mental health problems are more often used as grounds for claiming benefits than any other condition, and there has been a decline in claims based on musculoskeletal problems. In addition, those with poorer employment records are more likely to claim on the grounds of mental health. (Scottish Government 2010d).

Health inequalities in the early years

Low birth weight is a good marker of the environment in the womb, and thus of the mother's health. Further, it is strongly associated with socio-economic deprivation, and low birth weight babies can have continuing health and social disadvantages not only in childhood but into adult life, as expressed for example in raised risks of coronary health disease in middle age (Macintyre 2007).

In 2008, babies in the most deprived decile were 2.2 times more likely to have a low birth weight than those in the least deprived decile. Inequality has been stable, however, there are initial signs in recent years that this gap has narrowed in both relative and absolute terms as the percentage of low birth weights has also fallen (Scottish Government 2010d).

Economists have estimated the long term social return on investment in the early years as being between 3:1 and 7:1 (Scottish Government 2010c). Analysis of Scottish data from the Millennium Cohort Study notes a social gradient in cognitive

behavioural outcomes[7] by parental qualification at age 5, and a significant relationship with parental employment status at age 3 (Ibid). There was also a suggestion that persistent poverty was worse for children's cognitive outcomes at age 3 than periodic episodes of poverty (Ibid).

In addition, there is a strong deprivation gradient in teenage pregnancy. In 2008[8], under 20s in the most deprived quintile had approximately ten times the rate of delivery as the least deprived (66.9 per 1,000 and 7.6 per 1,000) and nearly twice the rate of abortion (Ibid). Younger mothers and those from less affluent areas are more likely to find it difficult to know who to ask for help regarding concerns over their children's health or behaviour and are also less likely to ask for help. Younger mothers appear more suspicious of professional help (Scottish Government 2008c)

There is also marked variation by socio-economic group and by maternal age at birth in the proportion of pregnant women attending antenatal classes: two thirds of those aged < 20 years did not attend any classes while three quarters of those aged 30-39 years went to most or all (Ibid).

Big Killer Diseases

Data on first admissions for heart attacks before the age of 75 suggest that inequalities have narrowed in both absolute and relative terms in recent years[9]. Adults under 75 from the most deprived decile are 2.2 times more likely to be admitted to hospital for heart attack than those in the least deprived decile (Scottish Government 2010g) 45-74 year olds in the most deprived decile are 4.7 times more likely to die from coronary heart disease (CHD) than those in the least deprived decile. The large social differential for mortality could be due to the first presentation of CHD being sudden death in more deprived areas due to greater incidence of smoking, exposure to second hand smoke, and poor diet. This suggests that prevention is an important factor as well as care (Scottish Government 2008c).

In 2007, adults under 75 in the most deprived decile were 1.4 times more likely to be diagnosed with cancer than those in the least deprived decile. Although there has been a 5% decrease in new diagnoses since 1996, inequalities[10] have been stable in both relative and absolute terms as these reductions have been observed across the population (Scottish Government 2008c).

[7] As measured by the Strengths and Difficulties Questionnaire.
[8] 2008 Teenage pregnancy information is provisional
[9] http://www.scotland.gov.uk/Publications/2010/10/25144246/0
[10] It should be noted t hat within the overall figures, however, there are different patterns by deprivation for different types of cancer. See http://www.scotland.gov.uk/Topics/Health/health/Inequalities/inequalitiestaskforce/overviewofstatistics,

Alcohol and Smoking

In 2008, the alcohol related death rate in the most deprived decile was around 10 times higher than the rate in the least deprived deciles in Scotland (Scottish Government 2010g).

It has been estimated that smoking accounts for about 24% of all deaths in Scotland, rising to as much as 34% in some areas. There is currently a clear relationship between smoking and deprivation (Scottish Government 2008b). Smoking rates have dropped much faster in affluent areas than in deprived areas. Recent Scottish Health Survey findings show that 44% of men and 39% of women in the lowest household income quintile were current smokers compared with 18% of men and 16% of women in the highest income quintile. Prevalence in the most deprived areas was 39% for men and women compared with 15% of men and 14% of women in the least deprived areas (Scottish Government 2009a).

Obesity

Recent findings from the Scottish Health Survey showed there was a clear relationship between male and female obesity and household income, albeit a different relationship for each sex. Obesity prevalence was highest among men with the highest incomes but, for women, obesity was highest among those with the lowest incomes. Some experts attribute this "reverse social gradient" in overweight/obesity in men to the effects of strong social gradients in smoking in men, together with the higher physical demands of many men's jobs in lower income groups (Scottish Government 2009a).

Measuring the Costs of Health Inequalities

Despite the difficulties in putting a financial cost on the health inequalities within Scotland, Equally Well produced a paper reviewing current evidence on the cost of inequalities in Scotland (see Scottish Government 2008c). Diagram 2 summarises some of the work that has been carried out.

Diagram 2[11]

Cost by topic area	NHS Scotland Costs	Wider economic/social costs
Alcohol[1]	• £ 110.5m in 2002/03	• 417m - Economic
		• £223m – Human
		• £96m – Social services
Smoking[2]	• £96m - Resource Savings	• £58m - Reduced sickness absence • £ 1474m - Productivity gains as a result of reduced smoking breaks - • £333m - Reduced fire hazards, cleaning and decorating costs - • £2354m - Health benefits (measured as the economic vales of lives saved
Obesity[3]	• £171m - 2003	
Mental Illness[4]	• £1520m (Health and social care including NHS, local authorities, and informal care) • £54.8m (Gross ingredient cost of anti depressant medicines 2005/06)	• £2378m (Output losses) • £4693m (Human Costs)
Teenage Pregnancies[5]	• £13.4m	
Asthma[6]	• £900m (UK and Republic of Ireland)	

Source: Equally Well, Overview of Statistics in Health 2008

Various studies have been conducted to estimate the impact of health on potential earnings and wages. Luft (1975) for example showed that bad health accounts for a loss of 6.2% of total earnings. More recently, Fuki and Iwamoto (2003) carried out research on 30-54 year old Japanese men and found that about 1% of total earnings are lost due to bad health (see Scottish Government 2008c).

Human capital theory predicts that more educated individuals are more productive. Children with better health can be expected to reach higher educational attainments and be therefore more productive in future since good health enhances cognitive functions, reduces school absenteeism, and early drop-outs. A large body of literature has provided evidence of a strong positive correlation between adult health and education (Freedman and Martin 1999 in Scottish Government 2008c).

[11] Sources, taken from Equally Well, Overview of Statistics in Health 2008: 1: Alcohol Misuse in Scotland (2005) http://www.scotland.gov.uk/Publications/2005/01/20541/50225; 2: Regulatory Impact Assessment, Analytical Services Department, All cost savings over a 30 year period; 3: Dr A. Walker (2003) The Cost of Doing Nothing – The Economics of Obesity in Scotland; 4: Scottish Association of Mental Health commissioned study http://www.scmh.org.uk/80256FBD004F6342/vWeb/pcKHAL6VSEU3; 5: Scottish Needs Assessment Programme – Teenage Pregnancy in Scotland http://www.phis.org.uk/PDF.pl?file=publications/teenage.PDF; 6: Global Initiative for Asthma http://www.ginasthma.com/ReportItem.asp/11=2&12=2&intId=94.

In 2006 the employment rate in the most deprived[12] quintile was 60.2% compared to 82% in the least deprived quintile. If those in the most deprived quintile had the same employment rate as those in least deprived quintile then potentially an extra 128,838 people would be in employment. Even if those in the least deprived quintile had an average employment rate (calculated across all quintiles) then there would potentially be an extra 85,458 people in employment (Scottish Government 2008c).

Similarly, if the employment status of the most deprived in Scotland were raised to that of the next quintile the mean salary for full time employees would increase from £20,164 to £22,012. With a total of 269,000 people in full time employment within the most deprived quintile annual salaries would increase by £497m (Ibid).

2. Equally Well: An Approach to Tackling Inequalities

This section will discuss the approach set out by the Equally Well Framework for tackling health inequalities in Scotland with an emphasis on the impact of this approach on tackling poverty.

Equally Well sets out a dynamic approach to tackling health inequalities in Scotland. A key principle underpinning this approach is that the underlying causes of inequalities in healthy life expectancy and wellbeing need to be targeted. Subsequently, many of the recommendations for action set out in Equally Well are to address the underlying causes of adverse health outcomes, including a sub-set of recommendations aimed at tackling poverty and increasing employment. Therefore, developing initiatives that address poverty are central to Equally Well.

The Framework has been informed by an understanding that rather than focusing on what a person is doing wrong, it is important to *"promote and foster people's assets and capacities for health and wellbeing"* (Scottish Government 2010c). The assets based approach has in turn been informed by Antonovsky's concept of *sense of coherence*, which:

> *"expresses the extent to which one has a feeling of confidence that the stimuli deriving from one's internal and external environments in the course of living are structured, predictable and explicable, that one has the internal resources to meet the demands posed by these stimuli and, finally, that these demands are seen as challenges worthy of investment and engagement"* (Antonovsky in Scottish Government 2010c).

Therefore, underlying Equally Well is a commitment to develop interventions that help support all of Scotland's people to develop a *sense of coherence* in order that they have the necessary assets and capacities required to invest in their health.

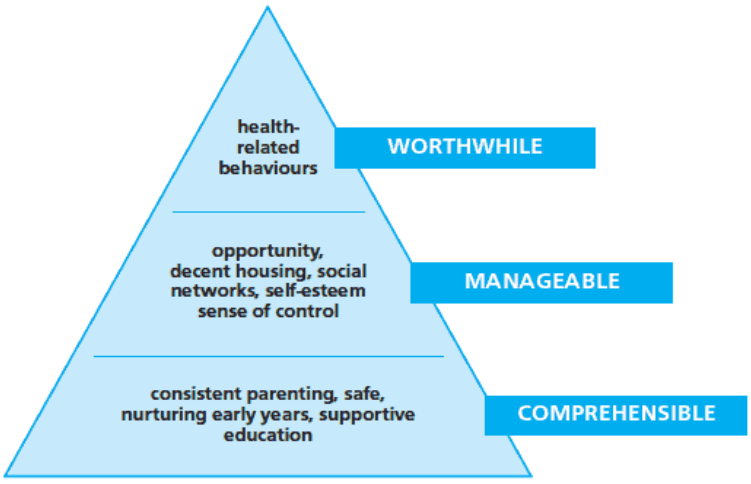
[12] Calculated using the SIMD.

This understanding of the complex interplay of factors that impact on health inequalities necessitates a holistic approach. The approach set out in Equally Well is designed to ensure that interventions to tackle health inequalities are designed to focus on the factors that support human health and wellbeing. This explains why many of the recommendations from Equally Well are not directed at health care services. Rather, it is understood that in order to target the underlying causes of health inequalities the full range of services must be involved. As referred to in Equally Well

> *"there is international agreement that reducing unfair and unjust inequalities in health needs a cross-government approach. It cannot be achieved through health policies and health care systems alone"* (Scottish Government 2008a).

In addition, Equally Well understands the relationship between the distribution of poverty and that of adverse health outcomes. The key priority areas identified by Equally Well to reduce inequalities in healthy life expectancy and wellbeing are areas where there is strong evidence to suggest poverty is a powerful driver of the most significant health inequalities[13], namely children's very early years, mental illness, drug and alcohol problems, and the "big killer" diseases; cardiovascular disease and cancer.

Diagram 3



Source: Equally Well Review, 2010.

Diagram 3 helps demonstrate why Equally Well has focused on initiatives which address the bottom and middle tiers of the triangle, which represent the underlying causes of inequalities in healthy life expectancy and wellbeing. In particular, Equally Well acknowledges the importance of addressing the wider social environment in which people live, in particular whether people have enough money to live and understanding that employment is a key determinant of health. It is by ensuring people understand the world as comprehensible and manageable that they will see adopting health related behaviours as worthwhile.

[13] http://www.scotland.gov.uk/Publications/2008/06/25104032/0

Redesigning of services.

Alongside setting out a new model for understanding the underlying causes of health inequalities, Equally Well sets out a new approach for delivering public services to tackle inequalities in health life expectancy and wellbeing.

This new approach acknowledges the complexity of health inequalities and thus requires enhanced synergy and collaboration across different public services, the voluntary and community sector, and the active engagement of service users. Equally Well is committed to the principle of redesigning universal services to be more responsive to those who are less likely to access them. This commitment is informed by the 'inverse care law' proposed by Hart (1971) which states that in order to be truly universal, a service cannot merely claim to offer 'equal treatment' to all. Rather, that there is evidence to support targeted interventions to disadvantaged groups in order to reduce inequalities (see Macintyre 2007).

Equally Well is committed to local government and others as equal partners in developing national policy and agreeing how that can be delivered in practice. It is understood that a redesign of public services requires cross-professional and integrated working that brings together in partnership local authorities, health boards, as well as community and voluntary organisations to secure a "whole system" approach (Scottish Government 2010c).

An example of the commitment to collaboration across sectors, shared learning and innovation underpinning Equally Well can be seen in the work being taken forward by Macmillan Cancer Support. Macmillan have developed an income maximisation model to support people affected by cancer which has been rolled out across the 5 tertiary cancer centres in Scotland. The model encourages clinicians to consider the risk of poverty to people affected by cancer and where necessary make referrals to Macmillan and other partner organisations for welfare rights advice. Macmillan have recently received additional funding to see whether this model can be extended to people who have other long term health conditions including stroke, dementia, and chronic obstructive pulmonary disease (COPD).

The approach set out under Equally Well has been informed by complexity theory; that the causes of health inequalities are complex, and can adapt and change making the challenge of solving the problem considerable. This recognition of the complexity of the challenge posed means seeking to understand and respond to health and other inequalities as 'wicked' rather than 'tame' problems:

> *"A 'Wicked Problem' is more complex than complicated – that is, it cannot be removed from its environment, solved, and returned without affecting the environment. Moreover, there is no clear relationship between cause and effect. Such problems are often intractable"* (Grint, in Scottish Government 2010c).

Equally Well Test Sites

It is understood that solutions must be innovative and must start somewhere. The Equally Well test sites were informed by this commitment to a new way of delivering public services, as well as the new and dynamic model for tackling health inequalities. The test sites have been designed to begin the process of developing a new approach to delivering and mainstreaming services that tackle the underlying causes of inequality without the worry about the service failing. The test sites have been encouraged to function using the simple rules approach. Examples of simple rules adopted by the test sites include:

- We will try to do different things and do things differently;
- We will decide the innovations we want to progress and try to avoid the need to repeatedly seek approval for testing ideas and approaches;
- We will not be afraid of making mistakes or experiencing 'failure', but rather learn from them and try new approaches;
- We will seek out and celebrate successes, however small.

A central feature of the test sites is the adoption of a shared learning approach. Shared learning was informed by improvement methodology which places central importance on learning cycles, implementing what has been learnt into the next phase of the service delivery. The test sites are members of a learning network which meets 6 weekly. The meetings encourage team members to come together in action learning sets in an attempt to problem solve together. The network exposes the members to new emerging theories with an agenda led by the members.

As discussed earlier, Equally Well recognises the importance of tackling poverty as a key social determinant of health inequalities and the critical roles income maximisation, financial inclusion and capability, and employability have in tackling poverty. A key outcome of Equally Well is for services to mainstream the dynamic approach to address inequalities in healthy life expectancy and wellbeing. In relation to the recommendations to tackle poverty and increase employment, public services are to consider financial inclusion and income maximisation when assessing a person's wider life circumstances, and ensure their needs in relation to these areas are addressed. This will be explored further by examining some of the initiatives being progressed by Equally Well which embody this commitment for public services to mainstream tackling poverty considerations.

Each of the test sites are committed to tackling the social determinants of health inequalities. In addition, each test site is informed by the assets based model approach which attempts to develop the assets and capacities of people and communities to empower them to deliver the changes required to improve their outcomes. The test sites are developing innovative ways of implementing a co-production approach of including community members and professional in the design and delivery of services.

The central importance placed on tackling poverty to address inequalities in health is particularly evident in the Lanarkshire test site. The principal aim of the Lanarkshire test site is: 'to work with partner services not traditionally engaged with the employability needs of clients/patients such as NHS, Social Work and Housing with a view to developing onward referrals to support clients/patients claiming Incapacity Benefit, or at risk of claiming Incapacity Benefit, to enter or remain in the labour market'. Service delivery professionals who are likely to have regular contact with people at risk of claiming, or in receipt of Incapacity Benefit, are being encouraged to consider referrals to employability services as a routine part of their service provision. Training sessions have been delivered to public delivery professionals highlighting the importance of work as a determinant of health. Professionals are encouraged to consider employability when assessing their clients/patients needs, and to refer them to a centralised phone-in service staffed by personnel who will assess and refer the person to an employability service depending on their needs.

Equally Well is committed to evidence informed policy development[14]. This evidence has informed the design of the interventions driven forward by Equally Well. In her report titled, *'Inequalities in health in Scotland: What are they are what can we do about them?'* Macintyre (2007) draws out some of the main findings from the evidence into the most effective policy principles to reduce inequalities in health and wellbeing. Diagram 4 summarises these policy principles. In particular, the evidence supports the approach of Equally Well; in particular that interventions must address inequalities in life circumstances with a focus on education, employment and income (Macintyre 2007).

Diagram 4

Principles for effective policies to reduce inequalities in health
• maintain and extend equity in health and welfare systems • address 'upstream' and 'downstream' causes • level up not down • **reduce inequalities in life circumstances (especially education, employment, and income)** • prioritise early years interventions, and families with children • address both health care and non health care solutions • target, and positively discriminate in favour of, both deprived places and deprived people • remove barriers in access to health and non-health care goods and services • prioritise structural and regulatory policies • recognise need for more intensive support among more socially disadvantaged groups • monitor the outcome of policies and interventions, both in terms of overall cost effectiveness and differential cost-effectiveness

[14] For a list of supporting papers see http://www.scotland.gov.uk/Publications/2008/06/09160103/0

- ensure programmes are suitable for the local context
- encourage partnership working across agencies, involvement of local communities and target groups

Source: Macintyre, S. (2007) Inequalities in health in Scotland: What are they and what can we do about them?

In addition, Equally Well is committed to developing new approaches to outcome and impact evaluation of the test sites. The evaluation design was developed in February 2010 and is currently underway. There is a national evaluation being carried out which will report in March 2011. The national evaluation has an integrated iterative learning approach, with learning notes being produced throughout the evaluation period. The first learning notes were completed in September 2010, outlining the early lessons about partnership working and community engagement. In addition, each test site is being evaluated, with findings due March 2011. The local evaluations aim to report on the interim findings and short term outcomes from the test sites.

3. Health Initiatives: Tackling Poverty

This section will discuss a selection of the initiatives[15] that help demonstrate the approach being promoted by Equally Well with a focus on tackling poverty. The section will discuss 3 initiatives being driven forward by Equally Well:

- Early Intervention in the Early Years (e.g. Family Nurse Partnership)
- Early Intervention and Anticipatory Care (e.g. Keep Well)
- The Health Works strategy

The initiatives help to highlight the main ways poverty is being addressed by Equally Well set out in the introduction. In addition, each of the initiatives have been informed by the evidence on the characteristics of policies likely to be effective in reducing inequalities in health (see diagram 5 below).

Diagram 5

Characteristics of policies more likely to be effective in reducing inequalities in health
Structural changes in the environment (e.g. area-wide traffic calming schemes, separation of pedestrians and vehicles, child resistant containers, installation of smoke alarms, installing affordable heating in damp, cold houses) **Legislative and regulatory controls** (e.g. drink driving legislation, lower

[15] It is important to note that these initiatives have not necessarily all progressed as a direct outcome of Equally Well, rather, they have all been informed by Equally Well.

speed limits, seat belt legislation, smoking bans in workplaces, child restraint loan schemes and legislation, house building standards, vitamin and folate supplementation of foods)

Fiscal policies (e.g. increase price of tobacco and alcohol products)

Income support (e.g. tax and benefit systems, professional welfare rights advice in health care settings)

Reducing price barriers (e.g. free prescriptions, school meals, fruit and milk, smoking cessation therapies, eye tests)

Improving accessibility of services (e.g. location and accessibility of primary health care and other core services, improving transport links, affordable healthy food)

Prioritising disadvantaged groups (e.g. multiply deprived families and communities, the unemployed, fuel poor, rough sleepers and the homeless)

Offering intensive support (e.g. systematic, tailored and intensive approaches involving face to face or group work, home visiting, good quality pre-school day care)

Starting young (e.g. pre and post natal support and interventions, home visiting in infancy, pre-school day care)

Source: Macintyre, S. (2007) Inequalities in health in Scotland: What are they and what can we do about them?

Early Intervention and Early Years

Equally Well set out a commitment to tackling the underlying causes of inequality in the early years. As MacIntyre acknowledges *"some socio-economic status inequalities are generated at or before birth"* (MacIntyre 2007). Equally Well has pulled together a selection of the evidence into the key components of effective interventions to address health inequalities in the early years. Evidence has shown it is easier to improve outcomes for younger children than with older ones (see Hallam 2008, Scottish Government 2010d).

The review of Equally Well published in 2010 further highlighted the importance of early intervention in the early years:

> *"Patterns set in children's early years are more difficult to undo in later life, but it appears that some factors are protective against poor outcomes, despite social disadvantage. Promoting children's cognitive development can counteract the effects of social disadvantage. Action on breastfeeding, diet,*

*parental mental wellbeing and poverty can also be useful" (*Scottish Government *2010d).*

One recommendation proposed by Equally Well was for Scottish Government to lead the development of holistic support services for families with very young children at risk of poor health and other poor outcomes. Equally Well recognises the importance of developing maternity services that are informed by an understanding of the causes of inequalities in health and wellbeing. In a report examining the evidence of effective ways of reducing antenatal inequalities, it was recognised that the role of universal antenatal healthcare is pivotal in assessing women's health and social assets and needs (Scottish Government 2010b). The importance of assessing a family's social needs is supported by the evidence. For example, according to the Centre for Maternal and Child Enquiries (CMACE):

- Women living in families where both partners were unemployed, many of whom had features of social exclusion, were up to 20 times more likely to die[16] than women from more advantaged groups (CMACE 2002).
- Mothers in more deprived areas are twice as likely to have a stillbirth or neonatal death as those in less deprived areas (CMACE 2008).

The Framework for Maternity Services in Scotland reinforces this message further by stating as its central aim 'to strengthen the unique contribution of maternity services to improving health and reducing inequalities in health outcomes which in turn will reduce poor outcomes across a range of later educational, social and economic outcomes' (Scottish Government 2010a). Again, this commitment to mainstream an approach to early years services that recognises the importance of addressing the social needs of children and families offers a considerable contribution for tackling poverty in Scotland.

An example of an initiative being taken forward under the recommendations of Equally Well is the Family Nurse Partnership. The Family Nurse Partnership approach has been evaluated in the United States and is currently being evaluated in Scotland and England. The Family Nurse Partnership is an example of an initiative developed upon the principles for effective policies to reduce inequalities in health (see diagrams 4 and 5). For example, the service targets resources towards more disadvantaged individuals and areas, and offers intensive support to families (see Macintyre 2007). In addition, there is a strong evidence base for specialist programmes (usually targeted work with vulnerable families – such as intensive home visiting) as opposed to universal family support services (Hallam 2008).

The Family Nurse Partnership programme is a nurse-led intensive home visiting programme that enables one family nurse to visit from early pregnancy until the child is two. The programme is targeted at young, first time mothers with the stated

[16] A maternal death is defined as "the death of a woman while pregnant or within 42 days of termination of pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes" (CMACE 2002).

aim to improve the economic self-sufficiency of the family in order to break the cycles of poverty, inequality and poor outcomes through the early years. The programme is being piloted in NHS Lothian and recruited its first cohort in January 2010. The first report from the evaluation of this pilot is due in February 2011.

Evidence from randomised controlled trials in the US has shown a major impact on the life outcomes for socio-economically disadvantaged mothers and their children who took part in the Family Nurse Partnership programme (Hallam 2008). Mothers who received nurse visits spent less time on welfare and had fewer subsequent births (Ibid). In addition, the programme is particularly interesting because outcomes for both mothers and children are most promising for the most disadvantaged groups (Ibid). This reinforces the importance of intensive support targeted at disadvantaged groups and prioritising early years interventions to help reduce inequalities in life circumstances as referred to in diagram 5.

Evidence has also shown positive long term outcomes for children who receive early years interventions in their development with respect to tackling poverty. Evaluations of pre-school education programmes in the US found evidence of a positive impact for mothers' education and employment outcomes as well as for the children, with evidence of long-term beneficial effects in terms of increased employment and earnings (Hallam 2008). As Hallam states

> *"the evidence suggests that investment in screening and support during pregnancy, and parenting and care until children are 5 years old pays off almost immediately as children are better prepared when they arrive at school. Subsequently they are likely to achieve better qualifications and to gain and sustain employment with savings to the health, welfare and criminal justice systems"* (Hallam 2008).

This highlights a further benefit of investing in maternity services; that the interventions affect the lives of both the child and the mother.

There are other examples of early years interventions being progressed under Equally Well such as the Vulnerable Families Pathways[17] and the Triple Ps[18], Positive Parenting Programme. The Triple Ps programme is an example of a universal service that also has a targeted element. The programme is being piloted by NHS Greater Glasgow and Clyde and Glasgow City Council. The programme targets families who have been assessed as at risk according to certain risk factors which include deprivation and poverty. Studies have shown that positive parenting can help ease hardship such as poverty (NHS Greater Glasgow and Clyde 2009).

Further, the NHS Quality Improvement Service are developing a Parent Education Syllabus to support professionals to deliver consistent and evidence based parent

[17] For more information see: http://www.vulnerablefamilies.org/media/CLT/ResourceUploads/21922/(12)%20PS_CL_ReportDraft3.doc

[18] For more information see: http://glasgow.triplep-staypositive.net/

education to all pregnant women and their partners. The education syllabus is informed by the assets-based approach; building on what parents know, and is committed to a holistic approach which considers the wider needs of the family, including financial support.

Early Intervention and Anticipatory Care

In addition to prioritising early interventions that focus on children's early years, Equally Well supports early interventions and preventative care at various life stages. A recommendation set out in Equally Well was that *'universal public services should build on the examples of effective financial inclusion activity, to engage people at risk of poverty with the financial advice and services they need'* (Scottish Government 2008a). This commitment to early intervention in later life for people at risk of poverty is evident in the Keep Well GP health checks.

Keep Well health checks are informed by an anticipatory care approach which aims to:

> *"Address inequalities in health by targeting resources at areas of greatest need, building primary care capacity to deliver proactive as well as reactive care, and preventing serious ill health through early detection and intervention"* (O'Donnell et al 2008).

Although Keep Well predates Equally Well, the initiative has been informed by Equally Well's approach. Keep Well health checks are targeted at deprived communities and those at risk of preventable serious ill-health. A key commitment of Keep Well health checks is to tackle the lifestyle risk factors which contribute to the risk of preventable serious ill-health, of which poverty is a crucial factor. The holistic assessment process requires healthcare professionals to consider whether a patient has money worries or other life stresses which may be affecting their health and wellbeing.

Keep Well is informed by an understanding that:

> *"exposure to socially patterned risks (e.g. to hazardous working environments, smoky environments, poverty) also occurs in adult life. Earlier and later life risks can be cumulative; exposure to damaging environments in both childhood and adulthood is worse than exposure in only one period. Experiences and behaviours in later life can help to reduce risks generated earlier"* (Macintyre 2007).

Again, universal primary care services are being utilised to provide both health care and non health care solutions to health inequalities, and to identify the wider life circumstances to help prevent serious ill-health from occurring. Keep Well demonstrates the holistic approach set out in section 2 and is informed by the assets-based model. Again, Keep Well demonstrates the importance of the link

between poverty and healthy wellbeing, and exemplifies the commitment to service redesign and partnership working discussed in section 2 (see paragraphs XX).

The North Glasgow Keep Well pilot can help to exemplify the importance of partnership working. Partnerships have developed between North Glasgow Keep Well and Maryhill Citizens Advice Bureau (CAB), North Glasgow Advice Centre and Glasgow North Regeneration Agency (Vestri et al 2010). Vestri et al found that the partnerships enabled people with a financial or related problem with fast track access to an established advice service. The people being referred tended to be unemployed or on a low income, and who had debt problems (Ibid). In addition, Vestri et al found that people who were 'hard to engage' and would not normally visit an advice centre, were, through the fast track access, seeking advice for financial related problems (ibid).

In addition, the partnership between North Glasgow Keep Well and Glasgow North Regeneration Agency (GNRA) enabled GNRA to employ an Employment Advisor to work with Keep Well clients. The Employment Advisor and the Keep Well Co-ordinators developed a half day training course deliver to GP practice staff involved in carrying out Keep Well health checks. The training course was based on a course developed for social work services and covered employment law, the reasons why they should be interested in employability[19] for their patients, and the importance of having a job to people's health and wellbeing (Vestri et al 2010).

Health Works

Equally Well is informed by an understanding of the importance of work[20] as a key determinant of health outcomes, recognising the risks to employees who become unwell while working and the poorer health outcomes for those out of work or in insecure or poor quality work (Scottish Government 2008a).

Health Works is another example of an early intervention strategy targeted at the working age population as well as employers and service provider staff. Health Works' strategic direction outlines a commitment to reduce ill health caused, or made worse by work; help people who have been ill return to work; improve opportunities for those currently not in employment due to ill health or disability; and use the workplace to help people maintain or improve health and wellbeing.

Health Works can be understood as targeting:

[19] Employability means the combination of factors and processes which enable people to progress towards or get into employment, to stay in employment and to move on in the workplace (Equally Well 2008).

[20] By work we mean meaningful activity. This could be paid or unpaid work, volunteering, etc

- People who are in work, offering early access to advice for employees and employers;
- Service provider staff, to raise awareness and understanding of the link between health and work;
- The public sector as an employer, to develop the public sector as an exemplary employer for the current workforce and as a recruiter, offering opportunities to those wishing to return to work.

Health Works has drawn upon existing evidence in developing its strategy. In particular, the strong evidence that supports work being generally good for physical and mental health and well-being. Worklessness is associated with poorer physical and mental health and well-being, and individuals who are out of work for long periods of time due to sickness experience a drop in incomes which can result in poverty and social exclusion (Waddell and Burton in NHS Health Scotland 2010a).

Further, there is evidence that employers who invest in promoting the health and wellbeing of their employees see significant benefits in improved attendance, better motivation, increased productivity and better staff retention. For example, research by PricewaterhouseCoopers looked at 55 organisations[21] in the public and private sector with between 50 to over 100,000 employees found returns ranging from £1 to £34 for each £1 invested in a variety of activities to promote and improve health and wellbeing over periods of between 6-12 months (Scottish Government 2009b).

The Workplace and the Individual

The Scottish Centre for Health Working Lives, established in 2004, provides a phone advice line to employers and is committed to particularly target small and medium sized enterprises (SMEs). Waddell, Burton and Kendall (2008) have noted that vocational rehabilitation cannot be delivered by health services alone and employers have a key role to play. The work of The Scottish Centre for Healthy Working Lives is developing the capacity of employers in this.

Advisers from the Scottish Centre for Healthy Working Lives offer site visits to SMEs to provide advice on health, safety and wellbeing in the workplace and Advisers from NHS Health Boards have been liaising with SMEs to provide advice about how to develop healthy workplaces. There is moderate evidence that the duration of sickness absence is significantly reduced by early and sustained contact between the employer and absent workers (NHS Health Scotland 2010a). Further, Health Works is developing information about the 'business case' for health, work and wellbeing; defined as a direct financial return and impact on bottom-line benefits, supported by emerging evidence from a body of case studies in this field to achieve better engagement and commitment from employers to the Health Works agenda (see NHS Health Scotland 2010a and NHS Health Scotland 2010b).

[21] The organisations covered a wide range of industries including: pharmaceutical manufacturing, engineering, financial services, utilities, education, the NHS and local and central government

In addition, Health Works recognises the role of the individual in early detection of ill-health to prevent long-term sickness absence. The model for vocational rehabilitation developed by the Scottish Government identified that a rapid access referral process, through which individuals should be able to secure support and specialist advice from a dedicated vocational rehabilitation team consisting of a range of professionals, is an essential service. The team should adopt a case management approach, considering the wider issues around personal circumstances. This approach has been piloted by NHS Lanarkshire who operate a Scotland wide phone advice line; a central advice line for any health concerns relating to work. The advice line has been offered nationally since May 2010 as part of UK wide programme, Fit For Work with Scottish Government support. The service aims to take a biopsychosocial approach[22] to the health conditions of those working for SMEs without access to in-house occupational health services.

In addition, vocational rehabilitation pilots have been operating in Dundee, Lothian and in the Borders predating the Lanarkshire pilot. These pilots have targeted people with common physical and mental health conditions working for SMEs without access to in-house occupational health. The model uses a telephone triaging approach which allows patients to be referred directly into the appropriate healthcare service. Patients are case managed, and the patient's wider life circumstances are assessed with additional support available to those with non-health issues such as money concerns. An evaluation of these pilots has been carried out and is expected to be available by spring 2011.

The evaluation has considered whether the service offered improved functional capacity and improved rates of, and earlier return to work for patients than if the service was not available. The evaluator has also been asked to estimate the cost savings to the public purse of faster recovery, consequent reduced demand on health services and reduced risk of loss of work and consequent benefit claims.

Service Provider Staff

Waddell, Burton and Kendall found strong evidence that return to work assists recovery from many health conditions. They concluded that healthcare professionals should play a key role in advising and supporting patients in their return to work, and recognise return to work as an important clinical outcome (Scottish Government 2009b). Health Works recognises the importance for those currently not working for health reasons of ensuring that there is a well defined pathway linking health with employability services to help people move as smoothly and seamlessly as possible through the necessary services towards work. It is also accepted that this requires an integrated approach across services, and not health services alone. Many people who have health barriers to work continue to access public services, though not necessarily in the context of employment, for example social services, housing or debt advice services. Such contacts provide an opportunity for staff to establish

[22] This is an approach in which health is understood in terms of a combination of biological, psychological and social factors as opposed to approaches which understand health in in purely biological terms.

whether a person is in work or not and to provide advice on how they can access services to support a return to work.

In addition, Waddell, Burton and Kendall found strong evidence that many GPs and other healthcare professionals feel ill-equipped, and lack training and expertise on work issues (NHS Health Scotland 2010a). The Equally Well test site in Lanarkshire is rolling out key training to frontline staff who may have historically not explored employability needs with clients/patients, e.g. health, housing and social work staff. Health Works is committed to promoting the adoption of good practice and learning from the Lanarkshire employability test site to NHS Boards and local authorities in the rest of Scotland. NHS Education for Scotland (NES) are developing and designing the education and training that workers across Scotland need to access so they are enabled to better support people back to employment (Scottish Government 2009b). Evaluations of employability initiatives suggest the following factors are important determinants of effectiveness:

- Holistic, client-centred, customised provision of training and support;
- Based on assessment of local demographics, social environment and market demand;
- Build on existing service provision;
- Credible with employers and potential clients (Scottish Government 2008a).

A detailed needs assessment is needed for individual clients when they enter the system. This needs to be comprehensive to ensure that all of the potential impacts on a client's ability to return to work are considered. These would include benefit maximisation, debt counselling, housing advice, education and skills appraisal and health assessment. This may be provided by a single point of contact or may involve a number of organisations. There is growing evidence that a case management approach to supporting a client can be beneficial in providing joined-up support for the client, simplifying the process and ensuring an holistic approach. A key worker can develop an activity plan with the client to address those areas where support is needed. Health Works has recommended NES and Scottish Government establish a working group to develop national guidance on needs assessments.

The Public Sector

Health Works also recognises the role the public sector can play as an employer and recruiter. Current figures show that total public sector employment currently accounts for 24.7% of total employment in Scotland (Office of the Chief Statistician 2010). Health Works is committed to the public sector as a whole being an exemplar employer and recruiter. Providing employees with the opportunity to develop their skills and progress with their career and supporting those who are long-term unemployed and on welfare benefits back into the workplace. There are clear links between workplaces that promote health and wellbeing, and improved productivity, motivation and staff retention, and reduced sickness absence (Scottish Government 2010e).

Health Works recognises that sickness absence levels (both work and non work related) have remained stubbornly high, particularly in the public sector (Scottish Government 2010e). Health Works has developed a public sector mandate; an established set of principles that set out what a public body should be aiming to achieve by way of supporting the health, safety and wellbeing of its workforce and how its role as an employer can help improve the health of the community it recruits from (Scottish Government 2010e). Health Works is looking to establish the mandate into the NHSScotland Occupational Health and Safety Strategy and is in discussions with COSLA about taking the mandate forward in local government.

NHS Tayside Healthcare Academy has been developed to prepare people for working in NHS Tayside, offering pre-employment training and further work experience to people on welfare benefits.

> *"The (Healthcare Academy) will target the long term unemployed, those on incapacity benefits, those from socially deprived backgrounds, and aim to implement the philosophy of creating employment to sustain health, by offering opportunities and preparing people for real jobs in NHS Tayside"* (NHS Tayside 2005).

NHS Tayside Healthcare Academy is committed to identifying gaps within essential support services throughout NHS Tayside. It was recognised there was a long term skills gap being faced for plumbers. NHS Tayside Healthcare Academy developed a programme of 4 year apprenticeships over a 10 year rolling programme for plumbing, electrical engineering, joinery and mechanical engineering. In addition, NHS Tayside Healthcare Academy offers 20 week clinical support worker training programmes. The programmes are provided in partnership by the Healthcare Academy partners.

4. Conclusion

To summarise, this report set out to examine the main ways that the Equally Well Framework approach can have an impact on tackling poverty in Scotland. The report has brought together the findings of a brief review of relevant policy documentation and research literature. The impact of a selection of Scottish initiatives that have been informed by Equally Well have been explored for their impact on tackling poverty.

It has been suggested that the main ways the approach set out by Equally Well can have an impact on tackling poverty are by:

- Developing interventions committed to early intervention and prevention at various stages of a person's life cycle.
- Helping to develop the individual and collective capacities and assets of people and communities for leading healthy lives.
- Ensuring there is an improved synergy between our universal public services and the community and voluntary sector.

- Fostering an enhanced understanding amongst our service delivery professionals about the relationship between poverty and health outcomes, ensuring the individuals whole life circumstances are taken into account when addressing health and wellbeing.

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