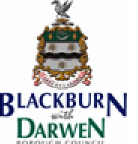
Health Inequalities across the Lancashire sub-region

Executive summary

NHS
North Lancashire



Part of the Lancashire Joint Strategic Needs Assessment (JSNA)
Health & wellbeing of children, adults and older people

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Directors' Foreword

People in the most deprived parts of the Lancashire sub region are 7 times more likely to die from chronic liver disease than those in the most affluent areas of the county. They are twice as likely to smoke, 6 times more likely to say anti social behaviour is a problem in their neighbourhood and they are 5 times more likely to have symptoms of extreme anxiety and depression. These, and many other, health inequalities prevent many of Lancashire's citizens from benefiting from the opportunities, such as working, learning, making the most of leisure time and keeping in touch with family and friends that many of us take for granted.

This report provides a comprehensive analysis of inequalities in health and the causes of poor health, between parts of Lancashire and England and between deprivation groups within the Lancashire sub region. It provides invaluable local evidence of a health gap within Lancashire which we feel all partners will be compelled to act on.

It is clear from this analysis that previous attempts to address inequalities in health in Lancashire have not been successful. It is estimated that 70% of the determinants of health fall outside of health services. Therefore a new approach is needed; one which creates health equity by tackling the social determinants of health. Managing, treating and caring for the poor health and wellbeing of many of Lancashire's citizens is becoming increasing costly. Preventing illness and promoting wellness becomes even more important in times of recession and reducing resources. Addressing the social and economic causes of ill health, including child poverty, is the only way in which we will be able to do this on a sustainable basis.

Informed by the findings of this analysis, we are now working together to develop a strategic framework for health equity for the Lancashire sub region, which will set out a number of key priorities which we will focus on in the coming three years. We will launch this strategic framework in April 2010.

We also want to encourage others living and working in Lancashire to use the findings within this report to develop their own ideas and plans to create health equity. Everybody in Lancashire has an important role to play in tackling health inequalities.

We hope you find this report informative and useful. If you have any comments on this report, or would like support in making sense of its findings, please contact Heather Catt or Gemma Barrow of the Lancashire Joint Strategic Needs Assessment team.

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Introduction

The sub-region of Lancashire, incorporating the 12 districts covered by Lancashire County Council and the two unitary authorities of Blackburn with Darwen and Blackpool, is very diverse, with some of the most deprived and affluent parts of England located within the area. This social and economic diversity is reflected in the health experience of the citizens of the county, with persistent health inequalities between different groups and areas. People in the most deprived parts of Lancashire experience significantly poorer health than those in the most affluent parts of both Lancashire and the rest of the UK.

Health inequalities are most often measured by the differences in average life expectancy between those living in different areas; however there is a clear socio economic gradient in the determinants of health, health behaviours, access and uptake of health services and in patterns of disease and death. It is unfair that people who live in certain circumstances are more likely to have certain diseases and to die earlier than others. This strategic needs assessment includes social as well as medical epidemiology to measure the full extent of inequalities. It is the intention that all Lancashire joint strategic needs assessments will include social data from now on to ensure that they consider needs in relation to the determinants of health.

Origins of the report

In late 2008 the Lancashire Health and Wellbeing Partnership made a request to the joint strategic needs assessment steering group for an analysis of health inequalities across the County, and their wider determinants such as employment, housing, education and crime. Its purpose was to identify actions across a range of organisations which would contribute to a reduction in health inequalities in Lancashire. Difficulties in obtaining agreement on what data to examine and what methodology to use stalled the project, which was resurrected when the development of a health inequalities framework and action plan became a key responsibility for the newly formed Joint Health Unit in 2009.

In between the original request and the creation of the Joint Health Unit, the recession took hold and has created an environment of reducing resources. A probable red flag for health inequalities in the Comprehensive Area Assessment for Lancashire County Council area and a national agenda for joint working means that there is been an increased desire to work together to tackle health inequalities. As such, it makes sense to complete the report based upon the sub-region of Lancashire, including Blackburn with Darwen and Blackpool, rather than the County of Lancashire and identify the health inequalities that persist and the scale of them.

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Partners in Lancashire are working together to reduce these inequalities in health and will be setting out the main priorities to tackle them in a strategic framework. The analysis in this report, put together through the joint efforts of the intelligence staff at the PCTs and local authorities across Lancashire, represents the first stage of this framework which will also involve a review of the evidence of the actions that are most likely to narrow the particular health inequalities gap within this sub region.

Context

In August 2008 the World Health Organisation published the results of a global commission on the social determinants of health chaired by Sir Michael Marmot[1]. This commission reviewed the global evidence on the social determinants of health and Sir Michael Marmot is now chairing a review of health inequalities post 2010 for the UK government[2], due to be published in January 2010. The interim report from this review argued that previous attempts to reduce inequalities in health have failed because:

- They have not addressed increasing inequality in society;
- National inequalities targets focused on death and disease rather than the social determinants of health;
- They identified 'spearhead' areas at local authority level, ignoring pockets of health inequality in many other areas; and
- They targeted the most deprived rather than providing universal interventions across the social gradient.

Using the evidence from the global review the Lancashire Joint Health Unit developed a framework to organise the analysis of and actions to address health inequalities in Lancashire (see figure 1).

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[1] September 2009, http://www.who.int/social_determinants/thecommission/en/, www page
[2] September 2009, http://www.ucl.ac.uk/gheg/marmotreview, www page

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Figure 1: Causal pathway of the relationship between social inequality and health inequality: Key intervention points[3]

Economic and social inequality

Address material deprivation

Income maximisation programmes

Improve housing

Reduce homelessness

Support the local economy

Increase employment

Promote resilience to inequality and deprivation

Increase social capital (people feel they are connected and can contribute to the everyday life of society)

Improve community cohesion (people feel different communities get on together, they feel they are accepted and treated fairly)

Promote personal well-being (people feel happy, fulfilled, valued, positive and in control)

Increase satisfaction with the local environment (people feel comfortable with their surroundings)

Increase community safety (people feel safe)

Increase skills (people are able to make a positive contribution)

Make healthier behaviours easier

Enforce smoke free legislation

Urban planning for active communities

Improved access to affordable nutritious food

Use opportunities within the licensing law

Implement healthier working practices

Enforce responsible alcohol sales

Social marketing

Provide behaviour change support to individuals

Providing accessible, equitable and effective support services

Prevention, treatment & support services reach, and are effective for, those in greatest need and are equitably resourced

Develop integrated one-stop shops

Provide accessible advice services

Commission effective health and social care services

Undertake equity audits

Reduced health inequalities

Gestation time before interventions will have an impact on health outcomes

[3] Based upon the article on the World Health Organisation's Global commission: Fran Baum, 2008, The Commission on the Social Determinants of Health: reinventing health promotion for the twenty-first century, Critical Public Health Vol. 18. No. 4:457-466

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This framework shows the causal routes between social inequality and inequalities in health outcomes. Interventions to reduce the impact that social inequalities have on health take various times to impact and intervening at each part of the causal pathway will be necessary if health inequalities are to be reduced in a timely and sustainable way. The causal pathway has the following stages:

Social and economic inequalities - global evidence suggests that in rich countries with greater social and economic equality, people tend to live longer[4]. This applies to all people in society and not just those who are disadvantaged – inequality is bad for rich and poor alike. Partners in Lancashire have limited opportunities to reduce inequalities in society, so intervening at other points in the causal pathway will be necessary if we are to have an impact on inequalities in health.

Addressing material deprivation – the Global review of the Social Determinants of Health recommended that measures to improve the material living conditions of those at the lower end of the social gradient should be a priority. Poverty, unemployment, cold and damp housing and homelessness all cause poor health, both physical and mental, among the least well off.

Promoting resilience - however, the research has found that some deprived communities seem to have characteristics that protect local people from the health affects of deprivation and social inequality. These characteristics, that seem to make people resilient to the way deprivation affects health, include social capital; community cohesion; personal wellbeing; good quality local environment; safe communities and opportunities to learn and develop new skills.

Evidence suggests lower socio economic groups have poorer health partly because of their material living conditions and partly due to the stress of being 'lower down' the social scale and feeling excluded from what is perceived to be the normal life of society. It is likely that these resilience factors provide alternative ways to feel valued within society. If we are to effectively intervene to address inequalities in health, we need to increase these resilience factors as well as address material deprivation.

Making healthier behaviours easier - smoking, poor diet, lack of physical activity, substance misuse and overweight and obesity are often more prevalent among those that live in deprived areas. There are a number of reasons for this. The stresses of living in material deprivation can affect the choices we are able to make about healthy behaviours. How safe we feel outside in the neighbourhood and the design of the built environment have both been found to predict levels of

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[4] Richard Wilkinson and Kate Pickett, 2009,The Spirit Level: why more equal societies almost always do better, Allen Lane

physical activity. Personal qualities such as skills and feeling in control of things that affect our lives seem to enable us to live healthier lives. Health is not obtained for its own sake but rather to enable individuals to take part in employment, leisure and other activities. If such activities are not available or are not valued people may not be living within a context that encourages them to choose behaviour to maximise health.

Partner organisations in Lancashire can intervene to improve this context and make healthy choices easier, for example through enforcing smoke free legislation, using planning processes to design active communities, enforcing responsible cigarette and alcohol sales, implementing healthy working practices, working with specific groups of the population to find out what would make them change their behaviour and providing targeted support to help people change.

Providing accessible, equitable and effective support services - the public sector in Lancashire invests significant resources in the commissioning and provision of services to tackle the social determinants of health and improve health itself. However, studies have found that those who need these services most often find them hardest to access or benefit from. Equity audits can be used to ensure that prevention, treatment and support services are equitably resourced and that they reach, and are effective for those in greatest need.

In summary, essentially the model says that reducing social inequality and the material deprivation experienced by those living in the more deprived areas will ultimately reduce inequalities in health outcomes. Resolving inequalities due to material deprivation is a long term process, and some of these interventions will take many years to take affect. Partners in Lancashire should in fact look to develop interventions at all levels of the model to have the greatest impact in the short, medium and long term.

Methodology

The analysis examines the inequalities that exist between Lancashire and England (the external inequality), between the districts of Lancashire and within the Lancashire sub-region between deprivation quintiles.

To highlight the relationship between deprivation and an indicator of interest across Lancashire and examine whether there are any inequalities externally or internally (externally where places in Lancashire show inequality against the rest of the country, and internally where there are differences within the sub-region) scatter plots were produced. The graphs plot deprivation against the indicator of interest (for example, mortality rates, child wellbeing or hospital admissions for stroke) and plots a line of best fit for Lancashire authorities and England. This allows comparison

of the pattern across deprivation but also makes it possible to highlight any districts experiencing inequality.

Examining data by deprivation quintile enables us to examine health inequalities across the social gradient, rather than comparing data at district averages. The social gradient for Lancashire is based upon small area data (either ward, middle level super output area or lower level super output area), which have each been ranked using the Indices of Deprivation 2007 and split equally across the five quintiles. This method of ranking has been used rather than using the national ranks as Lancashire is relatively more deprived than the national average, and it is important to have similar size populations in each category to observe significant findings.

To assist in prioritising which inequalities to focus on, summary statistics have been created, which measure the size of the inequality. They measure the size of the external inequality, that between England and Lancashire, and the size of the internal inequality, that between the most and least deprived quintiles within the Lancashire sub-region. Using this method means that it is possible to say where inequalities are greatest to provide a focus for priorities in creating health equity.

Data

Data for this report has been taken from a variety of sources. The Lancashire profile web pages, which include the JSNA pages, have been the main source of data for the determinants of health and contain data from the 2001 Census and Office for National Statistics. Data on crime was provided by MADE (multi-agency data exchange). Place Survey 2008 and Wellbeing Survey 2009 provided the majority of data around resilience and health behaviours.

Data on death rates and disease incidence is from the NHS Clinical and Health Outcomes Knowledge Base compendium of clinical indicators. Small area health outcomes data was provided by CaLCIS, the shared intelligence service funded by Lancashire PCTs, who provided the quintile data for Lancashire. GP level data was obtained from the Quality Outcomes Framework (QOF), the NHS comparators website and LaSCA. CaLCIS produced deprivation scores for GP surgeries across the Lancashire sub-region, which allowed for analysis under the services chapter.

Data used is for the latest possible date and where available is drawn for the Lancashire sub-region (Lancashire County, Blackburn with Darwen and Blackpool). The report can only measure inequalities where there is data. For the purposes of monitoring progress, it has been decided to focus on those inequalities which are measurable. Some gaps in data are there because the data simply isn't collected. However, some gaps are there despite data being collected and improving shared access to this data across the Partnership makes up one of the recommendations to this report.

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Findings

Lancashire is a geographically large, diverse and complex sub-region. There are 12 district councils, two unitary councils, one county council and five primary care trusts within the sub-region, all with responsibility for the improving health of the population. Lancashire experiences a greater share of deprivation than the national average and performs relatively badly in terms of health outcomes compared to other areas of the country. Therefore partners need to be more effective in addressing the causes of poor health in Lancashire, especially in meeting the health needs of people living in the more deprived areas of the sub region. The analysis conducted here provides a local evidence base of the scale of inequalities in health and the determinants of health, to be used by partners to inform interventions. Generally, the analysis shows that the biggest health gaps are those between deprived and affluent populations within the sub-region, rather than between the Lancashire and the national average.

Indicators of income and poverty show that Lancashire performs below the national average. The internal inequalities are greater than the external inequalities with average annual incomes in the least deprived areas 50% higher than the average income of the most deprived households. Indicators on economy and employment highlight strong internal inequalities. Those in the most deprived areas have the lowest levels of employment despite the majority of jobs being available in their areas. Barriers to employment need to be understood and overcome if these inequalities are to be narrowed. Low skills levels are likely to be part of the problem and will make it difficult for Lancashire to attract the inward investment required to close the material deprivation gap with the national average. It is important that plans are put in place as soon as possible to develop the skills base that will support continued investment by existing Lancashire businesses and attract new businesses, to ensure that Lancashire is competitive in the long term.

The recession is likely to be putting people in Lancashire under more pressure financially and the worry about losing a home or job will have health impacts. Many people in Lancashire are struggling to live on their current income and are worrying about money, especially in the most deprived areas. Those in the second least deprived areas are also highlighted as a group among which financial worries are common. This may be related to over-extending in financial terms in the years running up to the recession, to maintain position in the social hierarchy. Ensuring that support and advice services are available and accessible for all groups of people struggling to cope will have immediate impact upon wellbeing.

Lancashire performs well against national benchmarks in terms of resilience factors. The most deprived groups also fare well, which may be the result of successful regeneration interventions targeting the most areas. The second most deprived areas perform badly across a range of

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resilience indicators and partners may wish to employ the successful engagement methods used in previous regeneration interventions to target this group. Increasing volunteering opportunities would support improved social capital and should also have impact upon employment due to skills development. Partner organisations have a particular role to play in offering volunteering opportunities within their own organisations.

Many of the indicators of resilience used are based around perceptions of the population, whether this be perceptions that services listen and respond to their opinions, perceptions of safety or perceptions that people do not treat each other with respect. The need to base interventions in an area on evidence leads organisations to undertake analyses, such as this one, identifying all the problems in an area. Constantly telling people all the worst characteristics of their area is bound to lead to negative perceptions and it is suggested that another approach be taken. Asset based community development provides an alternative model of engaging residents in identifying strengths in their area and empowering them to build upon them. Such an approach might be appropriate for interventions at a neighbourhood level. The results are likely to have medium to long term affects on physical health indicators but should help build communities to support themselves and therefore will lead to shorter term impacts on indicators of social capital and mental wellbeing.

Actions to support improved health behaviours need to be sensitive to the context within which Lancashire residents live their lives. Methods to encourage individuals to stop smoking or not to smoke in the first place, take more exercise, eat a healthy diet or drink less alcohol appear to have had limited effect in the most deprived areas. Partners, particularly local authorities, should exploit the opportunities that are within their control in order to change the environmental context, such as planning and designing attractive and safe environments. Actions to support people into employment will have indirect effects in reducing health inequalities but actions with more direct impacts could include tighter regulation of smoking and alcohol restrictions, improving the quality of public realm to encourage greater pedestrian movement and ensuring access to affordable and nutritious food.

At the same time, actions to break the inter-generational cycle of unhealthy behaviour will be necessary and services to support individuals change their behaviour should continue to be targeted at pregnant women and their families, and those with small children. Preventing children growing up observing unhealthy behaviour as the norm might be the most effective way to prevent them following the pattern. There is currently not a standard healthy lifestyle dataset across the sub region, as each PCT uses different questionnaires and methodologies to monitor health behaviours among their population. It is recommended that one questionnaire be adopted across

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the sub-region and a single methodology be used to provide and comparable dataset if we are to fully understand these behaviours and work together to tackle them.

There are a number of ways in which the quality of primary care in deprived areas can be improved. The National Support Team for Health Inequalities has visited spearhead areas across England over the last three years identifying good practice in improving access to, and quality of, primary care in deprived areas. Much of this has focused on preventing and managing coronary heart disease, stroke and diabetes and encouraging early symptom recognition and intervention in relation to cancer. The benefit of such actions is the immediate impact they can have on health outcomes. Reducing the proportion of patient exceptions from disease registers will ensure that more patients receive the care management they need and will prevent exacerbation of conditions which currently lead to avoidable hospital admissions. Improving screening uptake rates will also have positive and short term impacts on health outcomes. In both cases focussing on the deprived areas will improve both the internal and external inequalities. The high numbers of mental health related emergency hospital admissions suggests that mental health services are not currently meeting the needs of many people with mental health problems . Physical access to services might be an issue for those in the most deprived areas as they are the least likely to have their own car. This needs to be considered in the commissioning of services and may require more services to be delivered as close to patient's home as possible. The vast majority of service data in this report has related to health services, simply due to the unavailability at this stage, of high quality data for social and other support services that is available to be analysed by deprivation quintile. Improving the quality of this data would enable us to gain a better understanding of the contribution that these services can make to reducing health inequalities.

Health inequalities are present within the sub-region and analysis of life expectancy highlights a ten year gap for males and a seven year gap for females between the most and least deprived deprivation quintiles. Analysis of the number of preventable deaths in Lancashire demonstrates the extent of the external inequality – 2,600 male deaths and almost 1,000 female deaths over 2005-07 would have been prevented if Lancashire experience the same patterns of mortality as England. Of further concern is that the life expectancy gap between England and Lancashire is widening over time.

In terms of specific health outcomes, inequalities are present across most of the indicators with the residents of the most deprived areas more likely to suffer or die from particular disease. Quality of life issues are also important elements of health inequalities. People in the most deprived areas have the greatest chance of suffering problems getting dressed or walking and are most likely to be living in extreme pain. Social services and access to services to assist in managing pain should be targeted in these areas.

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Specific recommendations

There is a need for strategic and joined up interventions to impact upon the determinants of health and health outcomes. A framework for doing so is discussed in the next section. However, the summary highlights some immediate recommendations which could have a positive impact on health inequalities. Specific recommendations from the analysis include:

- Identifying the key barriers to employment in the most deprived areas and provide support to reduce them.
- Develop plans to ensure the skills base of the population will meet the future needs of existing and new employers. This should involve further and higher education institutions in providing courses to provide qualifications that local employers are likely to need
- Ensure support and advice services are made available to those who are suffering the greatest impacts from the recession. In particular, services need to be flexible and sensitive enough to effectively meet the needs of people from across the deprivation gradient who are experiencing financial worries.
- Partner organisations should provide volunteering opportunities within their own organisations to support the process of getting people back into work and improving social capital.
- Invest in asset based community development to empower communities develop their own solutions and resilience to the health effects of deprivation and inequalities.
- Local authorities should exploit opportunities to make healthy behaviours easier:
    - Investigate opportunities to introduce minimum unit price for alcohol
    - Implement 20 mph speed limits in all residential areas
    - Enforce smoke free legislation, reduce underage sales and combat illicit tobacco
    - Improve the quality of the public realm and green space in the most deprived communities
    - Improve access to affordable and nutritious food and restrict the availability of fast food takeaways near schools
- Focus support for health behaviour change on pregnant women and first time parents

- Adopt a single sub-regional lifestyle survey
- Reduce Quality and Outcomes Framework exception reporting, particularly in the most deprived areas
- Increase uptake and coverage of national screening programmes across the sub-region with a particular focus on the most deprived areas
- Ensure the availability of effective community based mental health services for those in crisis.
- Provide services at local venues or use other methods to target services for the most deprived communities by sharing public sector assets across agencies
- Conduct equity audits of health and social care services to ensure vulnerable groups have equitable access and outcomes from the services there to support and care for them
- Target stop smoking services and tobacco control measures at women in the most deprived areas
- Put in place processes to access small area data which is collected on early access to maternity services, breastfeeding and smoking whilst pregnant. Ensure data is collected with postcodes to support deprivation group analysis.
- Monitor inequalities in the indicators included in this on a regular basis – annual or more frequently where available.
- Repeat the analysis every three years to ensure monitoring of the strategic view and to inform strategic plans, e.g. community strategies, local area agreements, multi area agreements and PCT strategic commissioning plans.

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Strategic process recommendations

Evidence suggests that previous attempts to reduce inequalities in health have failed for two reasons. Firstly a lack of focus – instead of tackling a small number of priority areas as a partnership, each organisation has identified their own priorities and worked on them. Each has had success in their own area but the bigger picture across Lancashire is one of widening inequalities. The second issue has been that health inequalities targets have focused on reducing death and disease rather than the social determinants of health. This has encouraged agencies to concentrate on short term clinical interventions to reduce inequalities in health at the expense of action to address the root causes of health inequalities. If action had been taken to improve housing or build social capital 25 years ago, it is likely that many health inequalities would have been reduced today.

The purpose of this report has been to provide the evidence base to inform a Lancashire sub-regional strategic framework for health equity. In order to do this it has been necessary to make judgements on what we mean by health inequalities, that is, what do we want to impact upon. Such indicators of health inequalities need to be measurable so that we can monitor progress. Although not perfect, we have been able to measure inequalities in a range of health outcomes and in the determinants of those health outcomes.

It was always the purpose of the report to provide a small number of priorities and to support joint working it is recommended that ten evidence based health equity goals based on health outcomes are focused on by partners across Lancashire. These ten goals were determined by measuring the scale of internal inequalities and ranking them, then grouping into categories.

The ten health equity goals are listed in the table below along with the indicators used to identify them. There are likely to be other health outcomes where there are large inequalities but it is only possible to analyse those where data is available. The benefit of this method is that the indicators can be used to monitor progress over time.

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Goals to reduce health inequalities in Lancashire

Goal rank	Goal	Indicator
1	**Narrow the gap in Liver disease**	Premature mortality from chronic liver disease (DSR per 100,000 population)
		Mortality from chronic liver disease (DSR per 100,000 population)
2	**Narrow the gap in Mental health and wellbeing**	Extremely anxious or depressed (% of participants)
		Anxious or depressed (% of participants)
		Generally satisfied with life (% of participants)
		Self reported good health and wellbeing (Place Survey)
3	**Narrow the gap in Diabetes**	Premature mortality due to diabetes (DSR per 100,000 population)
		Mortality from diabetes (DSR per 100,000 population)
4	**Narrow the gap in Quality of life**	Experiencing extreme pain or discomfort
		Problems with self care
		Problems performing usual activities
		Mobility problems
5	**Narrow the gap in Infant mortality**	Mortality in infancy (rate per 1,000 live births)
6	**Narrow the gap in Coronary heart disease**	Premature mortality from coronary heart disease (DSR per 100,000 population)
		Mortality from coronary heart disease (DSR per 100,000 population)
7	**Narrow the gap in Lung cancer**	Premature mortality from lung cancer (DSR per 100,000 population)
		Incidence of lung cancer under 75 (DSR per 100,000 population)
		Mortality from lung cancer (DSR per 100,000 population)
		Incidence of lung cancer (DSR per 100,000 population)
8	**Narrow the gap in Stroke**	Premature mortality from stroke (DSR per 100,000 population)
		Emergency admissions for stroke (DSR per 100,000 population)
		Mortality from stroke (DSR per 100,000 population)
9	**Narrow the gap in Child health and wellbeing**	Child (<15 years) mortality from all causes (DSR per 100,000 population)
		Child wellbeing, health and disability index
10	**Narrow the gap in Accidents**	Mortality from accidents (DSR per 100,000 population)
		Hospital episodes for serious accidental injury (DSR per 100,000 population)

These goals are the outcomes that a strategic framework for health equity will aim to achieve. Measures and successful intervention by partners should see reductions in these inequalities over time. The interventions that partners take, the means of achieving the goals, will be in one of the four categories of the model – material deprivation, resilience factors, health behaviour and accessible, equitable and effective services. Using evidence from a wide range of sources we have identified the causal routes for each of the ten goal health outcomes. This enables us to highlight the means to address the goals. By grouping the causal routes, we identify 23 means of achieving the evidence based goals. These are summarised in the causal route below and a summary of the means.

Means to achieve our ten evidence based goals to reduce health inequalities

Address material deprivation	Promote resilience to health effects of inequality and deprivation	Improve health behaviour	Commission accessible, equitable and effective support services
Increase Income / reduce child poverty	Increase community cohesion	Reduce alcohol misuse	Improve the quality of primary care
Improve housing and reduce homelessness	Improve community safety	Improve the design of the built environment	Improve social support (including social care)
Address fuel poverty	Improve the environment / green space	Reduce drug misuse	Improve health and social care rehabilitation services
Reduce unemployment / worklessness	Increase healthy working practices	Improve food and nutrition	
	Develop personal wellbeing	Reduce overweight and obesity	
	Improve skills, lifelong learning and educational attainment	Increase physical activity	
	Build Social capital	Reduce smoking	
		Reduce teenage pregnancy / improve sexual health	
		Maximise the health effects of transport planning / policy	

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The need for focus suggests that partners should prioritise a limited number of these means, ensuring that at least one is focused on in each category. Action is needed in each category to ensure that the impact on health inequalities is maximised over the short, medium and long term.

This process of prioritisation took place at the Lancashire Call to Action on Health Equity on Friday 6th November 2009 where 100 stakeholders from across partnerships in the sub region prioritised a limited number of means. Partners were provided with reviews of the evidence of what works in addressing the selected determinants of health inequalities to inform their selection. The six prioritised means were:

- Increase income and reduce child poverty
- Reduce unemployment and worklessness
- Build social capital
- Improve skills, lifelong learning and education
- Address alcohol misuse
- Improve social support (including social care)

At the event, partners developed plans of action within each means. The means and actions will form the basis of a Lancashire strategic framework for health equity and action plan, which is being developed by the Lancashire Directors of Public Health. The outcomes from the event will be included in a later version of the report.

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