Variations between 'Spearhead' areas in progress with tackling health inequalities in England

Executive summary for the National Institute for Health Research Service Delivery and Organisation programme

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Executive Summary

Background

Targets for narrowing health inequalities in England were adopted in 2001, with NHS Primary Care Trusts in ‘Spearhead’ local authority areas expected to narrow inequalities by 2010. Spearheads are the 20% of local authority areas with the poorest health and deprivation indicators. Progress towards the targets has varied from area to area. This study explores this variation for three outcomes: premature deaths from cancer and cardiovascular disease (CVD), and teenage conceptions. There is currently no systematic, comparative evidence about how the attributes of these areas may be related to the degree of progress they have made. The study uses Qualitative Comparative Analysis (QCA) to address this issue.

Aims

The aim of the study is to establish what conditions in Spearhead areas were associated singly or in combination with better or worse outcomes regarding progress with narrowing health inequalities. This entailed establishing the recent trend in each outcome indicator relative to the national average; deriving a list of conditions and descriptors regarded as likely to be associated with these outcomes; gathering data on these conditions from secondary sources and a survey of Spearhead PCTs; analysing these data using QCA to identify patterns of association between conditions and outcomes; and exploring causation further by engaging practitioners in workshops to discuss results from the analysis and identify how PCTs might learn from each other.

About this study

Comparable data about conditions in each Spearhead area were gathered using secondary sources and questionnaires. These conditions included ways of working, types of programme and contextual attributes such as level of deprivation. The data were explored using the Statistical Package for the Social Sciences (SPSS) and analysed using QCA. QCA is a method for comparing cases (Spearhead areas in this study) on the basis of their membership of sets (configurations of conditions) that have patterned similarities and differences regarding outcomes. These sets can be viewed as different paths to narrowing, or failing to narrow, health inequalities. ‘Crisp set’ QCA is used in this study, based on Boolean algebra and binary data (that is, conditions were coded as present or absent for each case).
Key findings

A narrowing cancers gap was associated with a local working culture of individual commitment and champions, together with a higher level of spend on cancers. Beyond a basic level, a higher standard of public health workforce planning was found to be associated with the cancer gap not narrowing. Together with a similarly surprising result for more frequent monitoring and developed commissioning, this suggests that too much effort expended on these types of task may deflect from actions that have a direct impact on the cancers gap. A higher level of deprivation compared with other Spearhead areas, a higher crime rate and a lower NHS primary care trust performance rating were also associated with the cancer gap not narrowing.

A narrowing CVD gap was associated with smoking cessation and primary care services that were assessed as better than a basic standard. A high PCT budget allocation relative to target was also important along with, in other configurations, good or excellent leadership, lower internal migration, and pursuing many smaller projects or an integrated systematic approach. Conditions that were associated with the CVD gap not narrowing were pursuing a few major programmes, a lower PCT budget and higher internal migration.

A narrowing teenage conceptions gap was found to be associated with pursuing a few major programmes and interventions taking place all or mostly in community settings. Contextual conditions were also important including a higher level of GCSE passes compared to other areas, a lower level of deprivation, a higher percentage of under 18 year olds in the population, and a lower number of people receiving drug treatment services. Favourable contextual conditions were associated with a narrowing gap in some areas regardless of the types of programme pursued. Commissioning and leadership were found to be more likely to be associated with not narrowing the teenage conceptions gap if ranked higher than other areas, suggesting a negative bureaucracy or management effect similar to the finding for cancers.

Conclusions

The conditions associated with ‘narrowing’ and ‘not narrowing’ outcomes occurred in particular configurations which are described in the report. By looking at how conditions combined, the study identifies the importance of local contexts for tackling health inequalities as well as local approaches and ways of working. The findings are based on associations interpreted as likely to be causal using substantive and theoretical reasoning. Follow-up evaluation should be part of the learning process in implementing findings from the study. As future data on outcomes become available, it will be possible to explore the effects of these configurations on outcomes over longer timescales.