

Consultation response

The King's Fund response to the Mayor of London's draft health inequalities strategy

Introduction

The King's Fund is an independent health charity whose [Royal Charter](#) stipulates our work should include the promotion of health and alleviation of sickness, to confer benefit, whether directly or indirectly, for the health of Londoners. We interpret this broadly, and our national work has relevance to London, but we also undertake work and seek to influence in ways issues that will directly benefit Londoners' health. As such we welcome the Mayor's consultation on his future health inequalities strategy and the opportunity to comment.

The King's Fund's response to the consultation is set out below. We group the 11 points into four linked reflections on: the scope and focus of the strategy; the Mayor's role versus that of others; accountability; and finally views on specific proposals.

Our overall view is that the strategy needs to follow both a broad approach (reflecting the complex causes and solutions to health inequalities) and a tightly focused one (narrowing down on interventions that have inequality reduction as their core aim). The draft strategy ticks the box on the first, but doesn't sufficiently do so on the second. In sum, this is a good start, but we believe as the strategy is finalised its commitments need to be more tightly focused on inequality reduction than they currently are.

Scope and focus of the strategy

1. Taking a holistic view of health

We congratulate the Mayor for the holistic understanding of health and health inequalities that this consultation document clearly demonstrates. The broad areas it focuses on do justice to the complex interplay of factors that influence the health of Londoners and that also leads to avoidable inequalities in health between different groups of Londoners whether defined by geography, gender or other personal characteristics and life events.

2. A greater focus on inequalities is needed that is different to 'health for all'

We believe the Mayor's final health inequality strategy will require a tighter focus on tackling health inequalities than it currently has.

While we congratulate the Mayor for his commitment to 'health for all' which is clearly expressed in this consultation document, we believe conflating 'health for all' and tackling health inequalities will cause confusion and lack of clarity about the core goals of the strategy, and muddy assessment of whether it is a success.

The Mayor and his partners need to be constantly on their guard that their actions do not inadvertently contribute to widening inequalities in health. For example, we know that many broad public health campaigns have higher take-up among already healthier people, hence improving overall public health but *widening inequalities* between groups. There is a clear danger that this strategy and its proposed dual aims of tackling inequalities and promoting the health of all Londoners could fall into this trap which is why we believe it needs a much stronger and focused set of objectives on inequalities reduction, given this is what the strategies core purpose.

For example, on mental health, we support the Mayor's ambitions for London to have 'the best mental health in the world' (p 10). But this is a health inequalities strategy, not a population mental health one. As the former, it needs to be more specific, challenging and ambitious about *narrowing gaps* in the experience and risk of mental health of Londoners. It is not clear that the goals around mental health in the strategy are specific enough to achieve that (see below). If they are, then the Mayor needs to be clearer about the evidence that supports it.

We therefore disagree with his proposed ambitions for the strategy to 'reduce this unfair variation while also improving the overall health of Londoners' (p 9). The focus needs to be much more firmly on the former.

The Mayor's role versus that of others

3. The Mayor's role versus that of others in London

We recognise the Mayor has different levels of power and influence across the holistic drivers and determinants of health. He has stronger direct powers to influence his 'own' policy areas, such as transport, than he has over others he does not 'own', such as health care. We also recognise the complex array of participants and organisations in London, including its boroughs, the cross-London structures of relevance (for example, sustainability and transformation partnerships) and wider policies of relevance (such as devolution).

This means the Mayor cannot – and should not – act alone to tackle health inequalities in London. As the draft strategy states he can act in one of three ways: directly through the policy areas he leads on; through championing work from others; and through directing support from City Hall.

The Mayor also has a duty to challenge and hold to account in a stronger way than implied here. This is clear from the legislation, helpfully referred to in the consultation document. That is, the inequalities strategy must, 'c) specify priorities for reducing those inequalities; d) describe the role to be performed by any relevant body or person in terms of implementing strategy' (p 22).

The legislation therefore places a duty on the Mayor to do more than deliver through his other policies, champion and direct City Hall. And more than ask for contributions from his partners, he has a duty to set out and describe what he views they should do. This therefore gives him the responsibility to move beyond voluntary contributions and to be clearer about where he expects more action as appropriate. We look forward to the Mayor setting out his views on this in the final strategy as well as welcoming voluntary contributions.

Finally, we believe that PHE London, as the main source and guardian of much data and analysis about London's health, should have a clearer direct and transparent role in helping to hold partners to account (including the Mayor's actions) and in supporting the Mayor to do that in relation to others. This may be in hand via the London Health Board (see below), but the final strategy needs to set out how this will happen.

We say more about accountability below.

4. Sustainability and transformation plans (STPs) and devolution

While not expressed as a commitment directly, we welcome the Mayor's statement that through STPs, '...future health and care in London best addresses health inequalities and prevents ill-health. As such, these plans should be developed with local communities through continuous engagement, including with marginalised groups' (p 90).

We support this and our and The Nuffield Trust's joint [review of London's STPs](#) states, that their 'Ambitions to prioritise prevention and reduce inequalities need to be backed up by more detailed proposals on how this will be done. The role of the NHS in addressing people's non-medical needs and reducing inequalities should be more clearly defined.' (p 7)

London has also recently announced its [next steps on health and care devolution](#). We look forward to seeing how the benefits of this devolution will be focused on tackling health inequalities, and expect to see an explicit focus on this in the final strategy.

The STP and devolution processes are operating in parallel in London. The Mayor's strategy is an opportunity to ensure they are aligned and synergistic in their impact on reducing health inequalities. We expect the final strategy to show how this will happen.

5. Over-dependence on shrinking local government public health budgets

There is a danger that too much will be expected of London's local government public health budgets in contributing to the strategy, and of those budgets in supporting the other mechanisms that need to support the strategy, such as STPs.

As we set out in our and The Nuffield Trusts joint [review on London's STPs](#), recent and further planned cuts in funding for public health and other local authority services will make any ambitions on moving towards prevention harder to achieve. The table below is drawn from that report and shows (on a comparable basis) that London's local authorities will have less cash in 2020/21 to spend on public health than they were budgeting in 2013/14 for the same functions.

London local authorities' public health raw and comparable budget cash values (stripping out services for children under five), forecasts to 2020/2021

Financial year	Budget (£)	'Comparable' budget (£)	% change raw budget	% change 'comparable' budget
2013/14	£558,712,000	£558,712,000		
2014/15	£587,566,000	£587,566,000	5.2	5.2
2015/16	£664,002,000	£575,100,000	13.0	-2.1
2016/17	£690,782,000	£529,443,000	4.0	-7.9
2017/18	£673,512,450	£516,206,925	-2.5	-2.5
2018/19	£656,001,126	£502,785,545	-2.6	-2.6
2019/20	£638,945,097	£489,713,121	-2.6	-2.6
2020/21	£638,945,097	£489,713,121	0.0	0.0

Under this scenario the contribution of local government public health budgets to the health inequalities strategy will be severely strained.

6. Sub-regional inequalities in health

There needs to be a stronger focus on sub-regional inequalities in health. In London's current system responsibilities and accountabilities for factors that influence health inequalities tend to cluster at either the GLA level or the borough level (putting aside the role of the NHS). This means action can be taken by boroughs (including on tackling within borough health inequalities) and at London level where appropriate (eg, through the planning of the transport system).

But, as is well known, London also experiences between borough health inequalities, historically been 'east' and 'west' and between 'north' and 'south'. More recently as London has been changing, there are also challenges between 'inner' and 'outer' London. The strategy appears to have nothing directly to say about this. It sets out no specific goal to narrow these longstanding health inequalities that are about actions at the level between London-wide and borough level. The final strategy needs to be clear about how these sub-regional health inequalities will be closed.

Accountability

7. Measurement and monitoring – is not enough

Tackling health inequalities is clearly a long-term task. In order to achieve it we need monitoring and measurement to track progress. We therefore welcome the commitments made in the consultation document to do that. We also note the London Health Board will be an important mechanism for reporting on the strategy over time. This is welcome, as is the new London Prevention Board.

However, measurement and monitoring – and reporting – are necessary but not sufficient. The final strategy must be clearer about where accountability lies and how that is distributed between partners for each of the final commitments.

For all commitments we need to answer the following questions (with a focus on inequality reduction): a) who is mainly responsible? b) how should we measure progress? c) what should we seek to achieve in 'closing gap x'? and d) who should we hold to account and how?

Otherwise, there is a danger that a well-written and conceptualised analysis of London's health inequalities will not make a real impact.

8. Making the connections with other mayoral policies and plans – timing and assurance

The consultation makes the connection between the health inequalities strategy and other mayoral plans and strategies such as the London Plan. This is highly welcome.

However, most of these strategies are in development and while the consultation gives assurances that these connections will be made, it presents no, or very little, detail on what these will be, how strong they will be, and how they will be monitored and governed.

For example, the Mayor's [draft London plan](#) was launched one day before this consultation closed. It contains a welcome commitment on health inequalities that those involved in planning and development must 'assess the potential impacts of development proposals on the health and wellbeing of communities' including on health inequalities, and through the use of health impact assessments (p 35).

However, it is clearly hard for anyone responding to the health inequalities consultation to fully consider the impact of the London Plan or how they might need to be strengthened, given the timing.

The final strategy therefore needs to be much clearer on how the Mayor's various plans stack up and the process that has taken place to focus on health inequalities, given that these plans are the key direct mechanisms the Mayor can use directly to influence health inequalities.

The final strategy needs to include relevant impact assessments on health inequalities of the measures the Mayor is taking through his other strategies and plans.

Views on specific proposals

9. A clearer justification for the specific commitment and areas chosen

While we congratulate the Mayor on the holistic breadth of his vision on tackling inequalities in health, it is less clear about how the individual areas have been chosen, and the relative scale and impact on health inequalities of the proposed individual commitments and interventions. It is not explicit how evidence based these choices have been.

The consultation mentions an Integrated Impact Assessment (IIA) document which has been produced, which in our view would help bring transparency to this issue. However, the IIA does not appear to have been published alongside the strategy, as the consultation document says it would be. We know it has been [commissioned](#). If it is publicly available it is hard to find, and we have not been able to. In its absence, it is hard to judge the extent to which the proposed commitments and their scale and timing will act to meaningfully tackle the challenge of health inequalities in London.

10. Our perspective on a small number of specific policy areas

We set out below, a small number of comments on specific areas.

- a. HIV. We welcome the focus on stigma reduction and the intention of the Mayor to support HIV prevention and treatment in London (p 97). [Our report earlier this year](#) showed that, despite successes such as DoIt, London's HIV system is overly complex and lacks clear co-ordination and leadership. We also welcome that the Mayor will 'explore' Fast-Track Cities, but we urge him to sign up with relevant partners. Sharing and learning from other major cities is a clear 'no-brainer' and London should now commit.
- b. Alcohol, tobacco and drug misuse.
 - i. It is unclear to us whether the target that 'smoking, alcohol and drug misuse are reduced among all Londoners especially young people' (p 109) is challenging enough. Trends in smoking and alcohol use are generally falling in the population, especially in young people. Setting an ambition that simply matches this trend is unambitious. The Mayor should be more specific, and focus his ambitions on reducing inequalities in those who smoke.
 - ii. If the Mayor believes that tobacco accounts for around half of London's health inequalities (p 105) then his commitment to '...support partnership work across the city...' (p 112) is not enough or specific enough. He needs to be much more ambitious, given the huge pay-off in reducing health inequalities that could flow from success.
 - iii. In reality Londoners often experience lifestyle behaviours in combinations. [This is very bad for health and is highly correlated with inequalities in health](#). Therefore, London needs to tackle lifestyle behaviours *together* as well as seeing them as separate issues. The Mayor's health inequalities

policy needs to take this more into account. We know for example from [analysis of the Well London intervention](#) that in London's most disadvantaged communities it is those who are male, white and unable to work who have the most risk of multiple poor behaviours. To tackle future inequalities in health, 'London' needs to be better at identifying and targeting different groups at risk of these multiple poor behaviours, not just broad-brush approaches focused on behaviours one by one.

- c. Mental health. As intimated above, the strategy needs to be more focused on inequality reduction. It should be clearer about how it will address the facts that:
 - i. some groups in the population (eg, black and minority ethnic groups or low socio-economic status groups) experience higher rates of mental health problems than others as a result of multiple social determinants
 - ii. people with severe and enduring mental health conditions then go on to experience health inequalities in relation to physical health and access to care, leading to a 15 to 20-year gap in life expectancy
 - iii. people with mental health conditions are also experience other forms of inequality which lead to health inequalities (eg, through less access to employment) largely as a result of stigma and discrimination.

11. A firm commitment to health equity impact assessment

Given our view (see section 2) that the strategy needs to be more focused on inequality reduction and that success will partially depend on other mayoral strategies that have not yet been finalised (see section 7) we believe that all the draft final commitments need to pass a stringent health equity impact assessment test before being finalised.

The King's Fund offer

Finally, the consultation document asks for partner commitments. As The King's Fund we are committed to helping to tackle inequalities in the health of Londoners. We do this in several ways including our analysis and reports on the London health and care system. For example, in the past year we have published reports on [London's STPs](#) (commissioned by the Mayor) and [HIV care in England, with a special focus on London](#).

We also provide leadership and development support to London's health and care system and have worked with many voluntary and community sector organisations in London, including through the GSK IMPACT Awards programme. More informally, we seek to help improve Londoners' health and tackle inequalities through our membership of relevant advisory bodies in London.

We will continue to do all this and ensure that our work is relevant to London and to tackling health inequalities within London. Of particular relevance will be our work on [Governing for health in global cities: lessons for, and from, London](#), reporting in the new year.