

Consultation response

The King's Fund response to the Strategic Review of Health Inequalities in England post 2010 (Marmot Review)

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The King's Fund is a charity that seeks to understand how the health system in England can be improved. Using that insight, we help to shape policy, transform services and bring about behaviour change. Our work includes research, analysis, leadership development and service improvement. We also offer a wide range of resources to help everyone working in health to share knowledge, learning and ideas.

Introduction / General Comments

This is a formal response by The King's Fund to the Marmot Review Consultation. The King's Fund seeks to understand how the health system in England can be improved. Using that insight, we help shape policy, transform services and bring about behaviour change. Our work includes research, analysis, developing leaders and improving services. We also offer a wide range of resources to help everyone working in health share knowledge, learning and ideas.

The Marmot Review Consultation document provides a comprehensive analysis of practical proposals to reduce health inequalities and provides a range of evidence to underpin future policy and action. This is welcome as guidance on how the NHS can achieve reductions in health inequalities is often vague, and leaves people unclear as to what actions to take (Smith et al. 2009: 232).

The consultation also helps to clarify the role of the Department of Health (DH) and the NHS in reducing health inequalities. The DH has a role in coordinating action across government departments at a national level. At a local level, the NHS has the capacity to lead through PCTs. Both have a legitimate role in reducing health inequalities and should aim to steer policies and actions. The focus on the wider determinants of health does not undermine the role of the NHS as a provider or commissioner of health care services, but does require the NHS to act as a leader, and to work in partnership with, for example, local authorities and education to coordinate policies that have a significant impact on health.

The Marmot consultation finds itself reporting to government during a difficult financial period after years of economic growth. During the growth period, the Labour government committed to reduce income inequalities (by, for example, committing to the eradication in childhood poverty) and to reduce health inequalities. However, health inequalities have continued to widen during a period of economic growth. The current financial period may lead to widening income inequalities, which may have repercussions for both the widening of health inequalities and the reduction in budgets available to address these issues. The Consultation therefore finds itself with a difficult message at a difficult time.

We outline our response to the Review Consultation document:

Section 1. Overview of evidence on health inequalities and their social determinants

Question 1: Are the Principles and values of social justice the right approach to addressing the social determinants of health inequality?

The principles of social justice are an admirable long-term approach to address the social determinants of health; however, the political reality is that many politicians will not agree with this approach. There is value in having social justice as an underlying principle as research shows a more equitable society is a more healthy society (Wilkinson and Pickett 2009) but more practical approaches may also be required. There may be value in targeting 'vulnerable groups' across England, particularly if the current economic situation continues. As stated, despite policies to reduce income inequalities, these have increased; therefore this approach alone is not sufficient. In addition, as income inequalities may take a number of years to change, in the meantime, people from poorer groups will continue to have poor health and die earlier; therefore, there is still a need to directly address health inequalities by targeting health.

Question 2: Are there any significant gaps in the evidence presented in the task group reports?

The review provides an extremely useful outline of available evidence. There are two areas where the evidence is more limited and which may be worthy of further consideration. Firstly, to overtly address the role and responsibilities of the commercial sector in reducing health inequalities. Working with industry to improve health requires firm commitments with industry; relying on voluntary guidelines is often not enough. For example, the alcohol industry has failed to voluntarily comply with a new labeling scheme, only 3% of alcoholic products have fully complied (Public Accounts Committee 2009). In addition, the length of time spent by the current government to seek agreement to front of pack food labeling demonstrates the difficulty of working with industry. These types of work and relationships are also under-researched and therefore it may be difficult to assess what is good and most effective practice.

Secondly, due to the nature of evidence, many proposals concern gains which will occur in the long term. There may be value in outlining the evidence in terms of the short/medium and long term gains, to demonstrate how the inequalities gap can be reduced in a generation if proposals were implemented. We feel it would be useful to clarify what 'a generation' means, to assign it a specific number of years in order to help create practical targets/monitoring systems.

In addition, given the continuing role of the NHS to reduce health inequalities, our own research found a paucity of evidence about which interventions work and for whom (Boyce et al. 2008).

Question 3: Is there additional alternative evidence available which the review should be considering?

Unfortunately, implementing evidence based policy is, at the best of times, haphazard. The review may also wish to consider how and whether evidence based policies are implemented, as well as the underlying evidence of what works. In addition to lack of evidence, several barriers to good practice have also been identified such as the impact of the difficulty of recruiting and retaining staff in disadvantaged areas, constant reorganizations, challenging partnerships and agreements, competing priorities in NHS plan, and resource issues (Marks 2006: 65).

Section 2. Key strategic themes
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Question 4: Are these the most relevant themes?

The nine themes well reflect the work of the tasks groups and demonstrate that national programmes need local policies which are shaped and owned by local communities. Local Area Agreements provide this local ownership, and these policies should be evaluated as to

their effect on health inequalities and their role in improving partnership working. The Review proposes that local and national partners should develop local public sector performance measures of inequality; however, this is easier to state and much more difficult to carry out. This type of partnership work can take years to develop and agreeing what these shared objectives will be may prove difficult. Localities may need direction in developing these shared objectives and could learn from a similar approach adopted in the *NHS Next Stage Review*. Local visions were developed at Strategic Health Authority level but all documents covered the same thematic areas and included the same headings.

Question5: Do the themes provide a sufficiently comprehensive and appropriate framework through which to develop the review's proposals?

The themes cover a range of areas, and most adequately collate the proposals and key ideas raised in the task groups' reports. The theme 'Public sector performance and responsibility' contains a number of important proposals and perhaps some subthemes could be identified as themes in their own right, such as working in partnerships. In this theme, we would recommend emphasising the role of partnerships and the specific role of the NHS, in particular, the leadership role the NHS should play. A great deal of emphasis is placed on partnership working to reduce health inequalities, the operating framework emphasised the value of working in partnerships. It takes years to see the effects of good working partnerships (Glasby and Dickinson 2008). Evaluating the 'success' of partnerships is difficult as little research examines the effect of partnerships and instead concentrates on the processes (Smith et al. 2009). A systematic review of partnerships found 'little evidence of the direct health effects of public health partnerships' (Smith et al. 2009: 218). Direct health effects may not be the most appropriate way to measure success, thus it may be helpful if the review were to recommend such measurements.

This theme also identifies 'mainstreaming equity issues'. Ultimately health inequalities should be mainstreamed, however, more specific policies may be required which address health inequalities until mainstreaming of health inequalities in all policies is genuinely achieved. The Department of Health believes it has already mainstreamed health inequalities into all policies, claiming, '(a) necessary objective **has been substantially achieved** by moving health inequalities from a peripheral concern characterized by small-scale, uncoordinated project work to a place in the mainstream as an established policy priority, forming part of the planning and performance systems of health services and local government' (DH 2009: 9). However, evidence that this has occurred is unclear and policies continue to be launched which do not mainstream health inequalities from the beginning of an initiative, yet later claimed to do so. For example, reducing health inequalities was not one of the original aims of the Quality and Outcomes Framework (QOF) but it was subsequently claimed as making a 'huge contribution to tackling HI' (Johnson 2008). Initial evidence suggests QOF may be reducing health inequalities, however, whilst the gradient is small, after 3 years spearheads still contained most of the poorest performing practices (Doran et al. 2008). Had health inequalities been mainstreamed at the beginning of the policy process, QOF may have had a more substantial impact on health inequalities.

Examining the WHO's views on mainstreaming gender may be useful when considering mainstreaming health inequalities. Health care systems are required to adequately respond to problems caused by gender inequality. Gender is not simply 'added in' late in a given project's development, and the WHO recommends "Research, interventions, health system reforms, health education, health outreach, and health policies and programs must consider gender from the beginning". They further state gender should not 'be consigned to 'watchdogs' in a single office' and that health professionals need to be made aware of how gender affects health. Applying this to health inequalities would mean building health inequalities into policies from the beginning, making it part of performance objectives, consistently including it in the Operating Framework and increasing knowledge and awareness amongst all health and other relevant professionals.

Question 6: Are there alternative themes which need to be explored and what evidence exists to support their inclusion?

One of the themes stressed in the report from the Priority Public Health Conditions task group is the close interplay between physical and mental health, and the importance of this interplay in understanding health inequalities. Given the strength of evidence demonstrating the role of psychological pathways in generating and maintaining health inequalities (Marmot 2005, 'Status Syndrome') it is surprising that this has not been given more prominence in the consultation document. Some reference to the issue is made within the theme 'protecting vulnerable groups', but this misses the point - it is not simply a question of paying attention to the physical health of 'vulnerable' people with mental health problems, but one of recognizing the profound interdependence of the mental and the physical within the general population.

In addition, the Bradley report highlighted the particular needs of those with mental health problems or learning disabilities in the criminal justice system and the review may seek to consider the specific inequalities which might arise from this population.

There is a question as to whether themes should be prioritised. In the current economic climate, and with so many themes, it may be helpful to identify proposals where stronger evidence exists, or where the impact may be greater.

Section 3. Cross cutting challenges

Question 7: What are your views on the challenges raised?

1. Reducing the gradient

We agree with the Consultation, that a progressive universal approach, which uses both universal and targeted programmes, are most likely to reduce health inequalities. Universal preventative activities are important to reducing health inequalities, for example, setting a minimum price on alcohol or early childhood interventions.

The impact at different positions of the social gradient is equally important.

We agree there is a need for research to create tools to:

- understand the impact of complex upstream interventions
- measuring long term health gains
- differing impact of interventions on different vulnerable groups

2. Beyond mortality: Inequalities in "being well" and "well being"

We also agree that the NHS needs to move beyond treating illness and value preventative activities. Both the current and previous Secretary of State for Health regarded prevention as a key priority for the NHS. Recent programmes such as *Change4Life* have demonstrated the government's willingness to take prevention seriously.

The current life expectancy targets emphasise long-life, regardless of state of health. Policies should aim to help people live longer and in better health. New policies or targets should also emphasise the prevention of ill health and could build on current policies such as World Class Commissioning (WCC). WCC seeks to support the shift from treatment and diagnosis to the prevention and the promotion of well-being. New policies could include more of a focus on early childhood development and mental health as they focus more on the outcomes that precede mortality. The evidence of the link between mental ill health and health inequalities, as the Consultation points out, is substantial, with the causal relationship going both ways, and likely to be exacerbated in a recession. In this context, the *New Horizons* strategy, currently out for consultation by DH, and which will replace the mental health National Service Framework that comes to an end in 2009. *New Horizons* presents an opportunity to ensure inequalities in mental health are reduced.

3. The role of resilience

We agree that resilience is a powerful tool in reducing health inequalities. Research needs to identify and understand where people survive and thrive, where the relationship between adverse social and health outcomes is weak. These findings should be shared widely, with

those making policies, and working on the ground in the NHS, local governments and the third sector.

4. Public services – creating the conditions that foster change and the role of regulation

Conditions that foster change will be where funding is available long-term, where partnerships are integrated and where the public demand these services.

Along with meeting the population's health care needs and improving health generally, the NHS has an explicit role in reducing health inequalities. Part of the basic information set needed to carry out these tasks is accurate accounting of the resources devoted to these aims. To date, however, there is little understanding of the expenditure the NHS actually commits to reducing health inequalities (Johnson, 2008). While we recognise that there are not just practical but theoretical difficulties, we would suggest that the feasibility of generating an account - at PCT level - of expenditure on health inequalities reduction activities (analogous to the National Programme Budget accounts) should be explored.

Perhaps one of the most longstanding and consistent health inequalities reduction policies in the NHS has been the methods and criteria by which local (i.e. PCT) budgets have been determined. For over thirty years resource allocations have been based on (an evolving) population needs-based capitation formula with the explicit aim of ensuring that those in equal need have equal access to health care services. As a result, over time, billions of pounds have been shifted around the country from low to high need areas. However, recent evaluation of the impact of this allocation process has shown however that it has made little contribution to the main aim of the policy (Sutton and Morris 2008). We would suggest that a formal review be undertaken of the extent to which the allocation formula has met its goals in practice, and if not, what modifications to the formula and the way it is applied are needed to improve its effectiveness in helping to reduce access inequalities (and by implication, health inequalities).

Such a review would also need to assess the latest changes to the allocation formula (applied to the 2009/10 and 2010/11 allocations), particularly the new health inequalities criterion whereby 15% of the total allocation to PCTs is distributed on the basis of variations in PCTs' population's average disability free life years (Resource Allocation Team 2008). Of note, however, is the fact that while this element of the new formula has had a big individual impact on PCT target allocations this year and next, overall, changes in other parts of the formula (in particular the needs element) have served to largely counteract the impact of the inequalities element.¹

An overriding issue that needs to be considered concerning the potential impact on access and health inequalities over the next five to ten years however, is the extent to which the (or indeed any) weighted capitation formula will have any impact on actual PCT allocations given the likelihood of little or no real growth in NHS funding. Under such circumstances it is hard to see any room at the margin to move PCTs to their target allocations. In effect, the target allocations implied by one of the world's most sophisticated formulas for allocating public money will be ignored.

Conditions that will foster change will see public services work together across departments. This partnership working is not new, so the challenge is to how to make it attractive. One way to do this might be to incentivise working in partnerships and rewarding those partnerships that are effective. We agree that the NHS needs to break out of silos and work together across primary, secondary and tertiary care to prevent illness. The NHS also needs to work in partnership with those outside the NHS. Numerous government departments, in addition to the Department of Health, can address health inequalities. With so many government departments able to address health inequalities, there is a need for a leader to steer policy, the Department of Health should hold this role.

¹ Across all PCTs there is a strong inverse correlation ($R^2=0.86$) between the gains/losses due to the new inequalities element and the gains/losses due to the new needs elements of the formula.

To create conditions to foster change, the public need to support these proposals. Governments may not wish to risk being seen as nanny state, however, there is evidence that the public support such policies (Jochelson 2005). For example, public support for the smoking ban and using mobile phones whilst driving grew after they were introduced. Governments will have to argue the case strongly for intervention and demonstrate changes will improve the health of the population.

5. Prioritising proposals

In light of the King's Fund's remit, we are particularly concerned with the priorities related to what the NHS can achieve. We support prioritizing the following areas which have an extensive evidence base, and are areas where the NHS is able to make a difference, or provide a strong leadership role:

- early child development and education
- reinforcing policies throughout life, through good work and continued education
- addressing both physical and mental health needs in workplace and outside
- Include health in measuring the success of policies on social determinants
- Better employment practices within the NHS
- 'Hitting the target but missing the point' should cease - either by creating more effective targets and/or monitoring systems or by dropping targets entirely
- Local leadership to improve multi-sectoral work on social determinants of health
- Shared targets on shared objectives
- Workforce development on determinants of health

The current economic constraints may require trade-offs between short term solutions and investment in long term strategic improvements. Long term goals are ideal, but they will have to be accompanied by short term milestones. Therefore, to increase the likelihood of providing short term outcomes, we propose that the Review prioritise those proposals which have an established evidence base, such as:

- Focus early child development services on deprived children and families.
- Improve infant and maternal nutritional status
- **All proposals** under the 'Adequate prevention and treatment for vulnerable groups'
- Larger proportion of NHS budget on primary care, prevention, public health
- Physical healthcare for people with mental health problems and vice versa
- Early detection and treatment among susceptible groups
- Direct some PCT funding at reducing avoidable health inequalities
- Promote healthy behaviour and inequity reduction in performance regime
- Enhance the psycho-social wellbeing of lower socioeconomic groups

The current economic climate may limit the number of proposals government is willing to support, however we would suggest that the following proposals where the NHS can take a stewardship role and which are likely to have wide-ranging effects are given consideration:

- Ensure community infrastructure and development to support public health campaigns
- Funding sectors beyond health to reduce health inequalities
- Addressing the crisis in key workforce areas including midwives, health visitors and social workers
- 'Ethnic proofing' of policies focussed on social and health inequality
- Improve prevention and treatment of childhood mental health problems
- Empowering people giving them real control over the decisions that affect their lives
- More nutritious and sustainable foods in public sector
- Make it easier for lower SEGs to engage in physical activity
- Reintegrating sick, disabled and unemployed people
- Greater involvement of public health in the planning system
- Safeguard and enhance ability of system to take population health perspective
- Introduce a minimum price per unit for alcohol.
- New planning developments must demonstrate health outcomes
- Promote healthy behaviour in transport
- Extend awareness and training of refugee and asylum seekers' health issues across the NHS

- NHS and Social Services to be held to account for improving the public's health and health equity.
- Take account of effectiveness and inequalities in allocating local health inequality funding
- Introduce equity weights into NICE methodologies
- Appraisal of effects of preventative interventions on different social groups

We also support the call for further research, particularly in the following areas:

- A better understanding of "what works" in particular contexts
- Develop evidence-based policy options in the field of ethnic inequalities in health
- Further research on income and health behavior
- Need for evidence of what works and of good practice in mental health field
- Culture of evaluation needs to acknowledge need for a range of methodologies for complex in interventions and service modifications
- Efforts be made to strengthen the impact of NICE recommendations on sectors beyond the NHS
- More studies on interventions on socio-economic health inequalities.
- What does not work?
- Appraisal of effects of preventative interventions on different social groups
- Research into resilience.

Question 8: Are there other significant challenges the review needs to address?

1. Costs

Many interventions with long term effects may seem costly in current period of fiscal restraint. Beyond 2011, and for at least 5 years afterwards, NHS spending will be facing a tough fiscal environment (Appleby et al.2009).

The final report of the Review needs to demonstrate that spending more on prevention will be the least costly option in the long run. When Sir Derek Wanless was commissioned by the Treasury to analyse healthcare funding, he envisioned a fully engaged scenario, where levels of public engagement in health are high, leading to high life expectancy, health outcomes, efficient uses of resources. This scenario was estimated to be the least expensive in the long-run, saving the NHS around £30 billion by 2022/23 (Wanless 2002). However, simply demonstrating that the NHS can save money by investing in prevention is not enough. Some of Wanless' recommendations have not been implemented. Spending on prevention is still relatively low compared to spending on acute care. 90% of NHS resources continue to be allocated to acute care and 'only around 1% of health resources are allocated to health prevention measures' (Hunter 2008: 146). Shifting funding from health care to prevention is needed if prevention is going to play a serious role in reducing health inequalities. Based on Wanless' scenarios and the evidence provided in the Consultation documents, we agree that the percentage of expenditure on prevention and public health services should be increased over the next 10 years. Long term commitments to funding are needed, but they may not be realistic in the current economic climate, therefore, the Review should link long term spending with short term gains that are able to demonstrate they are improving health and reducing costs to the NHS.

2. Public support

The low level of public support to reduce health inequalities is a concern. Contrast this issue with that of waiting times or MRSA in hospitals, which attracts a great deal of public and media attention, health inequalities in comparison, fails to raise the ire of the public. This means when politicians or chief executives have to make difficult decisions about where to put funding, they may not choose to support health inequalities if it does not appear to be an important topic for the public. If budgets are tight, this is potentially a large challenge.

3. Evidence

One of the key challenges is the lack of evidence, particularly that this may have an impact on the length of time to reduce health inequalities.

Regardless of the difficulty of collecting evidence, this should not stop interventions or actions being adopted which are based on a 'strong suspicion that they will deliver a beneficial outcome' (Morris et al. 2006: 892). Whilst evidence might not be available which proves a causal relationship between an intervention and improved health outcomes, many of these interventions will not make situations worse. For example, creating accessible green spaces or reducing air pollution will not necessarily improve health, but it is extremely unlikely to make it worse.

Methods of translating evidence to policy makers and those creating policy on the ground also needs to improve. Currently, evidence infrequently filters from academics to front line workers or the reverse. The SDO can improve how it communicates its findings, as well as the new UKCRC Public Health Research Centres of Excellence and the National Institute of Health Research's Public Health Research programme.

4. Workforce

With regard to the NHS, there is a need to understand who the public health workforce is. Health professionals can adopt a range of roles with regard to health prevention. For example, Yorkshire and Humber SHA have introduced the policy of 'Making every contact count' which aims to view every contact in the NHS as an opportunity to offer advice and support to improve health and offer training to a range of NHS staff. As well as integrating well-being into the NHS, these types of programmes have the potential to be cost-effective as existing workforce can be used. There is an issue of how to incentivize these types of interventions, which may be an additional cost to the NHS or take up more time.

Question 9: Are the current systems for delivering reductions in health inequalities the most appropriate? What would improve them?

For most policies, there has not yet been adequate time to assess whether they are delivering reductions in health inequalities. More time is needed to assess the value of, for example, the National Support Team on Health Inequalities, or the Health Inequalities Intervention Tool.

The question of whether to replace current targets with new targets is a key question. We recommend some set of monitoring targets or indicators. These new monitoring systems will need to be cross-government and not just aimed at PCTs. They should also be capable of monitoring cross-sector working.

The current targets are very specific targets, and there is a concern that some issues have been left off the policy agenda (e.g. breastfeeding, age related inequalities, ethnicity, disability, alcohol). However, targets have raised the profile of the topic of health inequalities. Future monitoring systems should use both universal and targeted measures and consider impacts at national and local levels.

We also believe there may be a need to reconsider the emphasis on geographically based inequalities, and the creation of spearheads. We have carried out research into the extent to which practices in Spearhead PCTs and those in non-Spearhead PCTs differ in their achievement on key clinical indicators (which evidence suggests result in health gain). Using the first two years of QOF data (2004/05 and 2005/06) small but statistically significant differences in reported achievement between practices in Spearhead and non Spearhead PCTs in the first year of QOF were observed, narrowing the second year. In general the more deprived practices across England performed worse but improved more. Practices serving the most deprived populations have similar patterns of performance regardless of whether they are in a Spearhead PCT or not. The least deprived practices in Spearhead PCTs performed significantly worse than similar practices in non Spearhead PCTs.

The lack of a substantial difference in performance among the most deprived practices between those in Spearhead PCTs and non Spearhead PCTs suggests that Spearhead status and its associated policies have not yet had an observable impact on the performance of deprived practices in these areas. Spearhead activities only really began in 2004 so there may be a time lag. This might suggest that future efforts to tackle health inequalities should focus on deprived practices, regardless of the area in which they are located (Dixon et al. 2009). By addressing intra-area inequalities, every PCT / Local authority will then be seen as responsible for tackling inequalities in all areas, at different gradients.

Any new monitoring systems or targets should include both short and long term goals. Many changes in societal behavior have taken years to change for the worse, and may take years to change for the better.

As the Consultation review documents, 'equity starts at home' and the NHS is in an excellent position to portray itself as a good employer, able to contribute to the reduction of health inequalities. The recent announcement that the NHS is trebling the number of apprenticeships is welcome in providing employment opportunities. In addition, through its employment and procurement strategies at local levels, the NHS has a real potential to play a significant role in reducing health inequalities.

In conclusion, the Marmot Consultation provides a range of evidence on proposals which will reduce health inequalities. Improved partnerships and working across services will be extremely valuable in reducing health inequalities. There is a real opportunity for the DH, nationally, and the NHS, locally, to use their experience and knowledge to act as leaders in reducing health inequalities in England.

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