HEALTH INEQUALITIES IN ENGLAND: POLICY CONTEXT AND TARGET SETTING

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Finance to address SDH
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The situation in England

SLIDE 1:
Background

Although life expectancy and well-being indicators in England are higher than the EU average across the board, analysis of the situation reveals that there is a significant and widening gap between higher and lower social economic groups. Therefore, inequalities in health is the priority for England in the context of the social determinants of health agenda.

The widening mortality gap between social classes

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<tbody>
<tr>
<td>1930-32</td>
<td>I - Professional</td>
<td>100</td>
<td>80</td>
<td>63</td>
<td>50</td>
<td>40</td>
<td>30</td>
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<tr>
<td>1949-53</td>
<td>V - Unskilled</td>
<td>1.2 times greater</td>
<td>63</td>
<td>50</td>
<td>40</td>
<td>30</td>
<td>25</td>
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<tr>
<td>1959-63</td>
<td>Average of all men of working age in England and Wales</td>
<td>2.9 times greater</td>
<td>50</td>
<td>40</td>
<td>30</td>
<td>25</td>
<td>20</td>
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<tr>
<td>1970-72</td>
<td>I - Professional</td>
<td>40</td>
<td>30</td>
<td>25</td>
<td>20</td>
<td>15</td>
<td>10</td>
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<tr>
<td>1979-83*</td>
<td>V - Unskilled</td>
<td>1.2 times greater</td>
<td>25</td>
<td>20</td>
<td>15</td>
<td>10</td>
<td>5</td>
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<tr>
<td>1991-93</td>
<td>Average of all men of working age in England and Wales</td>
<td>2.9 times greater</td>
<td>10</td>
<td>5</td>
<td>5</td>
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*1979-83 excludes 1981

England and Wales. Men of working age (varies according to year, either aged 15 or 20 to age 64 or 65)

Note: These comparisons are based on social classes I & V only.

Source: Office for National Statistics (see References Section)

[Note: This data is from 1990 Census. Social classes have since been re-formulated and updated data not currently available.]

Although the problem of health inequalities was articulated in 1980 in The Black Report, there was not a fit between the findings presented in this and the political ideology of the day. The fact that only 1,000 copies were published and that it was launched on a bank holiday when most people in England are not at work signals how this report was viewed.
2. CHANGING THE POLICY DIRECTION

However, the issues of inequalities in health and the health gap have increasingly been the focus of cross-government policy development since a change of government in 1997 gave inequalities a central location on the political agenda.

In 1997 an independent inquiry on health inequalities was commissioned by the Department of Health and this was chaired by Sir Donald Acheson. The report he produced formed the foundation for a suite of policies to address inequalities in health. The key elements of this were that:

- All policies likely to have an impact upon health are evaluated.
- Families with children should be given priority.
- Income inequalities should be reduced and the living standards of poor households improved upon.

It was also identified that policies which improve average health may have no impact on inequalities.

This articulated the need for cross-government action and resources to be committed to address health inequalities.

www.archive.official-documents.co.uk/document/doh/ih/ih.htm

The publication of this report was timely and new government policy, which was under development at the time, took evidence from it.

Two subsequent reports were commissioned by the Prime Minster, The Chancellor and the Secretary of State for Health from the former group chief executive of the NatWest Bank, Derek Wanless. The reports (2002 and 2004) looked at the resource requirements and population health implications of three scenarios which provided for varying degrees of investment and reform by government and for involvement by the community and individuals in health issues. From this, the HM Treasury asked for the further extrapolation of the “Fully Engaged Scenario”. This scenario requires investment from across government with a high level of community/citizen involvement and has long term cost benefits. These reports have been influential in developing thinking in the area of health and inequalities.

http://www.hm-treasury.gov.uk/Consultations_and_Legislation/wanless/consult_wanless_final.cfm

3. CONSOLIDATING SUPPORT

While Acheson and Wanless identified the problem and suggested broad approaches, the government signalled a serious commitment to addressing the issue in The NHS Plan (2002). In this, for the first time ever, local targets for reducing health inequalities were reinforced by the creation of national health inequalities targets. These were announced by Alan Milburn, former
Secretary of State for Health, in February 2001 in the areas of life expectancy and infant mortality.

In 2003 a Cross-cutting Spending Review which looked at spending across government to see how it could be applied to the greatest effect on health inequalities, proved another milestone in developing action orientated policy and it led to binding proposals for modified and new spending for the period 2003 - 7 across most government departments. It is interesting to note that this review was led by the HM Treasury with technical support by the Department of Health.

www.hm-treasury.gov.uk/spending_review/ spend_ccr/spend_ccr_index.cfm

4. FOUNDATIONS FOR ACTION

As a consequence of the spending review, Tackling Health Inequalities: A Programme for Action was published, also in 2003. This provides targets to 2010 for closing the health gap between social economic, ethnic groups and geographical areas by cross-government action. The actions that are likely to have the greatest impact over the longest term are identified as:

- Improvements in early years support for children and families.
- Improving social housing and reducing fuel poverty among vulnerable populations.
- Improved educational attainment and skills development among disadvantaged populations.
- Improved access to public services in disadvantaged communities in urban and rural areas.
- Reduced unemployment and improved income amongst the poorest.

The themes that underpin this are:

- Preventing health inequalities getting worse by reducing exposure to risks and addressing the underlying causes of ill health.
- Working through the mainstream by making services more responsive to the needs of disadvantaged populations.
- Targeting specific interventions through new ways of meeting need, particularly in areas resistant to change.
- Supporting action from the centre by clear policies effectively managed.
- Delivering at the local level and meeting national standards through diversity of provision.

This programme was developed in partnership between the: Office of the Deputy Prime Minister, The Cabinet Office, HM Treasury, Department for Work and Pensions, Department for Trade and Industry, The Home Office, Department for Transport, Department for Environment, Food and Rural Affairs, Department for Education and Skills, The Department for Constitutional Affairs and the Department for Culture, Media and Sports.
5. PROGRESS, IMPLEMENTATION AND MONITORING
The progress in implementing this is measured against 12 national headline indicators. The process is overseen by reference and scientific committees, the later being chaired by Sir Michael Marmot. In 2005 the process demonstrated that there has been significant progress in absolute health improvement terms, but less in reducing the health gap. However, it is anticipated that more will be achieved by the target date of 2010.

Complimenting the above policy process, the government published its public health strategy in 2004. *Choosing Health: Making Healthy Choices Easier* has the need to address health inequalities as an underpinning concept to chapters on; health in the consumer society, children and young people, local communities, health as a way of life, health promoting NHS and work and health. It also has a specific chapter on taking action on health inequalities. It provides mechanisms for national and local delivery and illustrates this with a range of case studies of good practice from across England.

On October 10th, Health Challenge England was launched. This gives the next steps for the implementation of Choosing Health. It provides health profiles on the neighbourhoods that people live in and fact sheets on key issues.

The Office of the Deputy Prime Minister has recently reviewed delivery of the health inequalities targets agenda. It has acknowledged that narrowing the inequalities gap is a major challenge, but it is achievable. For the first time ever, health inequalities is one of the Department’s top six priorities for the NHS as set out in *The NHS in England: the operating framework for 2006/07 (January 2006)*. This reflects a growing recognition of the impact of social disadvantage on the health of the population. The focus now is on strengthening of the delivery chain for health inequalities across local, regional and national government with greater emphasis on effective communications and community engagement, and more robust performance management against the achievement of targets with stronger lines of accountability.
10. Key learning points/conclusions:

- A supportive political environment is a necessary precursor to getting evidence into policy and practice.

- Evidence on problem definition and achievable actions is necessary to shift political will into policy.

- The process from evidence to policy to practice is a long one.

- Targets not only focus work on achievable deliverables, but clarify the contribution across sectors.

- No one government department can tackle health inequalities alone.

- Measures to address inequalities and associated targets need to be located in a cross government delivery agenda, and not an add on and unmeasurable suite of activities.