Developing the evidence base for tackling health inequalities and differential effects
Foreword

This seminar on developing the evidence base for tackling health inequalities is organised by the Economic and Social Research Council (ESRC) and the Department of Health (DH) Research and Development Directorate. The seminar explores how research can contribute to a better understanding of the factors that determine health inequalities and to the development of effective policies to combat them.

Tackling health inequalities is now a priority on the policy agenda for international organisations and governments around the world. The World Health Organisation, the Organisation for Economic Cooperation and Development, the European Union and many national governments have moved beyond the goal of improving the health of populations to the explicit aim of reducing the health gap between people who are vulnerable and socially disadvantaged and those in more privileged social positions.

It is clear that many health problems can be attributed to the social conditions in which people live. Inadequate housing, poor education and high unemployment all contribute to standards of public health and improved clinical care is not enough to meet today’s major health challenges and overcome health inequities.

It is a matter for growing concern that the health gap appears to be growing, despite unprecedented global wealth and technological progress in recent decades. In Britain the general population is healthier than it has ever been. Life expectancy is higher and some of the great killer diseases are in retreat. At the same time the health of the least and less well off is either improving more slowly than the rest of the population or in some cases getting worse.

Paradoxically, some initiatives designed to improve health seem to have a greater beneficial effect on those who are already better off. This booklet aims to provide some insights into how intervention can impact positively on all sectors of society.

This seminar is designed to encourage dialogue between the research and policy community to explore ways of developing evidence based policy and policy relevant evidence to tackle inequalities in health more effectively.

Professor Ian Diamond
Chief Executive
Economic and Social Research Council
Developing the evidence base for tackling health inequalities and differential effects


The researchers

PROFESSOR HILARY GRAHAM is Professor of Health Sciences at the University of York and is leading the Department of Health, Public Health Research Consortium. The PHRC brings together senior researchers from ten UK institutions in a new integrated programme of research. Its aim is to strengthen the evidence base for interventions to improve health, with a strong emphasis on tackling socio-economic inequalities in health. The consortium is funded by the Department of Health Policy Research Programme for a five-year period from October 2005.

PROFESSOR MIKE KELLY is Director of the Centre for Public Health Excellence (CPHE) at NICE. The CPHE is responsible for the production of evidence based public health guidance for the NHS and local government and others in England. The public health guidance from NICE will attempt to attend to questions of effectiveness, cost effectiveness and equity.
Executive Summary

Introduction

The past decade has seen a widening of the remit of public health policy in rich societies. Increasingly, governments are looking beyond improving overall health to a broader and more challenging set of policy goals. Tackling the unequal distribution of health is central to this broader vision. The European Health for All strategy has made equity its primary objective, with targets set for countries to reduce inequalities in health between socio-economic groups. This objective forms a cornerstone for UK health policy.

Evidence about the fact of health inequalities is straightforward enough. We know that the risk of death is greater for poorer groups, at all stages of the life course and for all causes of death. According to an NHS briefing paper by Hilary Graham and Michael P. Kelly on Health Inequalities: concepts, frameworks and policy, most of the major killer diseases, (except for breast cancer) affect the poorest rather than the richest. There are marked social class gradients for obesity, hypertension and accidents and rates of smoking are also class related with higher numbers of smokers in the lower social classes. The health of some minority ethnic groups is poorer than the rest of the population.

Dealing with health inequalities is considerably more of a challenge. For several decades it has been the subject of a debate that swings between the view that health is a function of an individual’s behaviour; (such as choosing what to eat, drink and smoke) or is the consequence of social factors which lie beyond the reach of individuals and require action from Government. Current policy takes a two-pronged approach, setting targets for reductions in smoking rates and obesity, for example, but also aims to integrate health considerations into a range of other policy initiatives relating to poverty, education, employment and housing.

Figure 1: Proportion of 23 year-olds with a degree by parental income group at age 16, Britain 1980-2000

Source: Machin et al, 2005

Widening social inequalities may work against interventions to reduce health inequalities
The part that evidence should play in informing public health policy and in reducing health inequalities is a topic which has prompted debate among both researchers and policymakers. We need greater clarity over what ‘evidence based policy’ actually means and how best to apply academic approaches to the reality of policy decision-making.

Evidence about what works to reduce inequalities is so far very limited. Much of the research that has been done is rich on explanation and pointers for policy. But research evaluating solutions is thin on the ground.

Researchers working on inequalities point out that effective evaluation of interventions requires information on people’s health and social circumstances. This means that evaluation needs to be ‘on the agenda’ from the early stages of policy planning.

Strengthening the bridge between research and policy is an urgent priority if evidence based policy is to become the norm, rather than the exception.

**Key insights and implications**

- Over time, the health of the population has improved, according to data on life expectancy, mortality rates and infant deaths.

By the same criteria, the health of the poorest has improved, but there is little sign of progress on health equity. This is because the rate of improvement is lower for the poorer groups in society.

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**Figure 2: Life expectancy at birth, all women and women in social class V, England & Wales, 1972-2001**

![Life expectancy graph](Image)

The risk of death is greater for lower socio-economic groups, at all stages of the life course and for all causes of death.
Children’s circumstances have long-term effects both on their future circumstances and their future health. Inequalities in socio-economic position are passed from one generation to another.

Mortality rates among children in unskilled manual households fell between the late 1970s and the early 1990s, but they were still twice as likely to die between their first and 16th birthday as children in professional households. It is never too early and never too late to intervene: children who escape from poverty have better health in adulthood than those who remain disadvantaged throughout their lives.

Most major killer diseases affect the poorest rather than the richest. Morbidity is also greater for the lower socio-economic groups. Mortality is greater for men than for women. There are also significant variations between and within regions.

For obesity, hypertension and heart disease there are marked social class gradients.

The health of some minority ethnic groups is poorer than the rest of the population.

Social position is affected by a number of complex social factors. For example, while education is linked to higher living standards, some ethnic groups benefit more than others. A Bangladeshi with a degree has the same risk of poverty as a white person with no qualifications.

Tackling the social determinants of health inequalities is about tackling the unequal distribution of the major factors that influence health. Although overall living standards, smoking prevalence and other determinants have improved over time, they have not improved as rapidly in poorer groups as in the rest of the population.

Figure 3: Cigarette smoking among women aged 16 and over by socio-economic group 1958-2000, Britain

Source: Wald and Nicolaides – Bouman, 1993; Bridgewood et al, 2000
Smoking among the proportion of women who smoke has declined sharply but the gap in prevalence between poorer and better off groups is widening.
Because the rate of improvement is lower for the poorer groups, policies appear to have a greater beneficial effect on those who are already better off. This points to the importance of policies which have greater beneficial effects on disadvantaged groups.

Evidence on its own does not provide a complete recipe for success, or an imperative for action.

Knowledge transfer does not happen according to a simple cause-and-effect model. Making information available to practitioners does not necessarily or automatically lead to its application to practice.
Thinking about policy options

Hilary Graham on the distinction between the idea of health disadvantage, health gaps and health gradients and the implications for policy

The major drivers of people’s health and the inequalities in health between the poor and better off extend far beyond the health service. Tackling inequalities must also involve non-health policies including housing, education, social protection etc.

It is first important to distinguish between:

The social determinants of health — usually taken to mean the non-genetic and non-biological influences on health – which include individual risk factors such as diet and smoking as well as wider influences such as income, education, housing and the environment and:

The social determinants of health inequalities, which include inequalities in these health determinants and, particularly, inequalities in people’s position in the social hierarchy.

The policy responses to these inequalities in social determinants can take different forms. They may be:

- **To improve the health of poor groups**, for example through interventions to help children from poor families improve their educational performance, to improve housing in poor groups (eg by installing central heating, insulation etc) and to promote smoking cessation, healthy eating and activity among specific disadvantaged groups.

- **To narrow the gap** between the health of disadvantaged groups and health in the population as a whole – or the health in the most advantaged group.

- **To improve the health gradient** with the greatest improvement for the poorest groups, and the rate of gain progressively decreasing for higher socio-economic groups. Policies not only target the disadvantaged minority – but also extend to the larger majority of people who are not socially excluded, but are relatively disadvantaged in health terms. Interventions might include the introduction of a progressive income-related benefit which gives the greater percentage increase to the poorest groups, with the percentage increase declining for higher income groups; a smoking cessation intervention which is available to the whole population but which is actively promoted via additional services for less advantaged groups, with the most intensive support for the most disadvantaged groups.

‘In practice, interventions that improve the health of poor groups may not reduce the health gap between them and better-off groups; and what works to close the gap may not reduce the wider social gradient in health.’ Hilary Graham
The Evidence Challenge

In her presentation, Hilary Graham explains the importance of building evidence linking the effects of wider social policies on health outcomes and identifies ways in which the policy and research communities can work together more effectively.

To develop evidence-based policies to tackle health inequalities, we need information on the effects of policies on the unequal distribution of the major factors which influence people’s health. Evidence tracking the effects of existing policies on inequalities in health determinants is required. This provides an important baseline from which to evaluate the effects of policy changes and new interventions. As yet there is little evidence about the effectiveness of either existing policies or new initiatives.

A major challenge is therefore to marshal evidence tracking the effects of policies on inequalities in wider determinants (like inequalities in education), risk factors (eg inequalities in smoking) and health outcomes. It is important to be aware that changes along this causal chain may well take time to show their effects. This means that policies introduced ten, 20 or even 50 years ago will be influencing the effects of initiatives introduced today.

The way forward

The policy and research community can tackle the evidence challenge in a number of ways. Important strategies include working together to:

- Increase awareness across Government and across academic disciplines of the centrality of non-health policies and interventions for improving health and tackling health inequalities – and what this means for policy evaluations.

- Encourage funding bodies to include measures of health determinants along the causal chain in evaluations of policies and interventions. This expectation should extend beyond clinical and public health interventions to policy evaluations in the fields of education and young people, employment and crime, housing and child protection etc. Key measures include social position (eg socio-economic position), risk factor status (eg smoking status) and health status (eg self-assessed health). Reliable and straightforward indicators are available – and provide potentially-useful intermediate outcomes for evaluating the effects of policies and interventions in these policy fields.

- Ensure that funding bodies routinely require analyses of sub-group effects on health determinants and health outcomes in evaluations of policies and interventions. Standard practice should be to measure not only overall impact but impacts by socio-economic position, ethnic group etc.

- Invest in the development of research designs and evaluation strategies to better capture the effects of policies on health determinants and health outcomes. One key challenge is to track multiple policy impacts across a range of determinants. We must be willing to invest in methodological development – and, as in the world of policy, anticipate that some approaches will work better than others.
Developing policy-appropriate evidence

Mike Kelly on the development of the public health evidence base and evidence based guidance

There is a recognition that the scientific methods developed for the field of clinical medicine are not necessarily entirely appropriate for building the evidence base for public health. The evidence base for public health needs to embrace data and evidence drawn from a variety of methodological traditions and disciplinary approaches. The gaps between evidence, policy and practice also need to be addressed.

Initially the Health Development Agency and now NICE have developed new methods and approaches to do precisely this. The methods which both organisations evolved attempt to deal with ways to include data drawn from sources other than systematic reviews of clinical trials. They also are based on the principle of combining the best available evidence from academic research with the grass roots experience of health practitioners and others. This enlarged concept of evidence will be used as a basis for producing NICE guidance about the effectiveness of public health interventions (NICE 2006a, 2006b).

From 2000 to 2005 (when the HDA was merged with NICE) the HDA produced a series of Evidence Briefings to review the evidence on health inequalities and the effectiveness of interventions. These consisted of summaries and syntheses of review-level evidence on a range of topics including:

- the prevention of low birth weight social support in pregnancy
- the prevention of drug misuse
- sexually transmitted infections and HIV
- the promotion of physical activity
- accidental injury prevention
- the management of obesity and overweight
- the prevention of alcohol misuse and smoking
- the promotion of breastfeeding
- the prevention of teenage pregnancy.
At the same time a number of major gaps in the evidence were uncovered:

- The evidence relating to reductions in inequalities is actually very thin. There is a huge literature which describes the problem of inequalities. There is a very much smaller one describing evidence-based effective interventions to reduce inequalities.

- The amount of funded research on interventions to reduce inequalities is also very small.

- There is little agreement as to what changes in inequalities would be regarded as a success, or what effect sizes of interventions would be regarded as desirable.

- The conceptual apparatus to describe inequalities in health is used in a limited way. The basis for most of the data is a measure of socio-economic status, while the more discrete dimensions of social difference like ethnicity, gender, disability, place, age and geography are underdeveloped empirically and theoretically. Consequently the relationships between the different dimensions of inequality and the ways they interact with each other to produce health effects, is hardly to be found in the extant evidence at all.

- It is clear from the evidence that does exist, that different segments of the population respond very differently to identical interventions. The differential response to smoking education among different social classes is a case in point.

- There is a dearth of studies at topic level where inequalities and measures of inequality are part of the research questions with which researchers are concerned. So evidence about inequalities remains strongest at aggregate population mortality level, and much more diffuse at the level of individual topics like HIV or accidental injury. The epidemiological data clearly show the social class gradient in many of the topics analysed, but the researchers producing evidence focusing on these particular things, seldom address inequalities per se.

- There are some surprising gaps in the evidence. For example there is very little review level research on
the sexual behaviour of young heterosexual men and its impact on rates of teenage fertility. There is little work on social exclusion and the transmission of AIDS/HIV and there is very little evidence about cost effectiveness of interventions (with the significant exception of road transport). In general the evidence base is much stronger with respect to downstream rather than upstream interventions.

- The nature of scientific research designs means that critical process and implementation variables, of vital interest to practice, are frequently excluded from consideration.

The next generation of the evidence base will therefore include data drawn from sources other than reviews, such as observational epidemiology, social scientific investigations (including those using qualitative designs), grey literature, and eventually data from practice (Kelly 2006).

**Developing and disseminating guidance**

NICE is now developing a more integrated, systematic and empirical way of involving practitioners in producing guidance.

> ‘While evidence derived from scientific studies is important and vital, it is best understood as providing scientifically plausible frameworks for intervention, rather than guides to detailed action at local level’. Mike Kelly

In order to determine whether an intervention is likely to be successful, mechanisms are being established to draw on the expertise of such groups as health visitors, school nurses, teachers, medical and related practitioners, managers, and civil and other public servants, for each topic under consideration. Their role will be to test the validity and reliability of research messages and to examine ways in which the findings can be turned into practice in the fieldwork stage of guidance production.

Once the best and potentially useful findings have been identified, they will be tested with practitioners to discuss how to get the evidence working at local level, in the light of the problems they are familiar with in their day-to-day practice.

The practitioner groups also consider current organisational and professional barriers to change, in order to identify drivers, triggers, opportunities and pressure points relevant to making the evidence work on the ground. This phase is critical in informing where and how the evidence can be used, and the type of activities that are likely to be effective in changing practice.

The mechanisms and structures described here provide an initial attempt to improve precision both in the scientific basis of attempts to reduce health inequalities, and in the effectiveness of the methods used to support innovation and development.
## Action on Health Inequalities

Maggie Rae and Ray Earwicker (DH) on the Government’s approach to tackling health inequalities

The appointment of Sir Donald Acheson to undertake a review of health inequalities in 1997 underlined the determination of the recently elected new Labour Government to tackle health inequalities. This review resulted in the *Independent Inquiry into Inequalities in Health* report (*Independent Inquiry into Inequalities in Health* 1998), published in November 1998.

The Acheson Report included 39 recommendations for a wide range of cross Government action and highlighted the interaction between upstream (the wider determinants) and downstream (more specific health interventions). The report set the context for the development of health inequalities policy. In 1999, the public health White Paper *Saving Lives: Our Healthier Nation* (*Secretary of State for Health* 1999) and the Department of Health report on action to tackle inequalities (DH 1999b) began to set out the Government’s response.

The NHS Plan (*Secretary of State* 2000) made a commitment to develop national targets on reducing inequalities in health on infant mortality and life expectancy. The subsequent targets (Department of Health 2001) made it clear that closing the gap was as important as achieving a minimum level of health. Further progress has been made in developing a suite of related targets with a health inequalities dimension. These included the target on smoking prevalence drawn from the tobacco White Paper (*Secretary of State for Health* 1998) which set a population-based target for adult smokers, and the NHS Cancer Plan 2000 (DH 2000a) which set more specific targets relating to inequalities in health. The latest version of these targets is shown in Figure 5.

### Figure 5: Department of Health – Public Service Agreement targets (2004)

**Aim**

Transform the health and social care system so that it produces faster, fairer services that deliver better health and tackle health inequalities.

**Objective 1**

Improve the health of the population. By 2010 increase life expectancy at birth in England to 78.6 years for men and to 82.5 years for women.

1. Substantially reduce mortality rates by 2010:
   - from heart disease and stroke and related diseases by at least 40 per cent in people under 75, with at least a 40 per cent reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole;
   - from cancer by at least 20 per cent in people under 75, with a reduction in the inequalities gap of at least six per cent between the fifth of areas with the worst health and deprivation indicators and the population as a whole; and
   - from suicide and undetermined injury by at least 20 per cent.

2. Reduce health inequalities by ten per cent by 2010 as measured by infant mortality and life expectancy at birth.

3. Tackle the underlying determinants of ill health and health inequalities by:
   - reducing adult smoking rates to 21 per cent or less by 2010, with a reduction in prevalence among routine and manual groups to 26 per cent or less;
   - halting the year-on-year rise in obesity among children under 11 by 2010 in the context of a broader strategy to tackle obesity in the population as a whole. Joint target with the Department for Education and Skills and the Department of Culture, Media and Sport; and
   - reducing the under-18 conception rate by 50 per cent by 2010, as part of a broader strategy to improve sexual health. Joint target with the Department for Education and Skills.

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1. [http://www.hm-treasury.gov.uk/media/70320/sr04_psa_ch3.pdf](http://www.hm-treasury.gov.uk/media/70320/sr04_psa_ch3.pdf)
In 2002, the Cross-Cutting Review (CCR) on Inequalities in Health (DH/HMT 2002) set the framework for the national cross-Government health inequalities strategy, *Tackling Health Inequalities: A Programme for Action* (2003) to start focusing action on the target and laying the foundation for a long-term, sustainable reduction in health inequalities. The review developed its conclusions on the basis of the Acheson report and, like Acheson, emphasised the paucity of evidence in relation to specific interventions that would help to narrow the gap; that is evidence that could direct further action to address the policy goal. The CCR report goes on to say that the situation is compounded by:

- An emphasis on research directed at changing single risk factors.
- The fact that more complex, multifactoral socio-economic and environmental socio-economic and environmental determinants are much less well researched and the evidence supporting interventions based upon them much less solid.
- Intervention research is scant compared to the much larger body of evidence that describes inequalities.
- Where interventions have been evaluated, they have been mainly concerned with the overall effects on health rather than with what is effective in reducing inequalities.

The debate on the evidence base for public health interventions has gathered momentum in the last couple of years. The release of the Wanless review (HMT 2004b) has added impetus. As well as highlighting the need for research which can assess issues of equity, the report calls for the development of the evidence base for public health interventions, technical development and capacity building. The recent Public Health White Paper, *Choosing Health* builds upon these themes (SoS 2004).

In 2005 *Tackling health Inequalities: Status Report on the programme for Action* (2005) set out a system for reporting developments in relation to the target, including the 12 national headline indicators based on programmes, policies and interventions expected to make a significant impact on the problem. On progress the report found:

- A continuing widening of inequalities as measured by infant mortality and life expectancy at birth in line with the trend.
- An inconclusive picture on the indicators but with progress against two important headlines, child poverty and housing, and some signs of a narrowing of the gap in other areas, notably in circulatory (heart) disease mortality (in absolute terms) and, to a much lesser extent, cancer; as well as flu vaccinations and educational attainment. Other areas, like smoking, remain less susceptible to change.

On the evidence base, the report reiterates that the urgent need to address the issues of what works reflects the poorly developed nature of the evidence base on health inequalities.

The findings of the Status Report underline the persistence of health inequalities and emphasises that tackling health inequalities is a continuing policy challenge. Action is continuing to tackle health inequalities by promoting cross-Government support to narrow the gap on a long-term and sustainable basis, including working with the NHS to meet the more immediate demands of the 2010 PSA target engaging the Government’s wider policy and systems agenda - such as the identification of health inequalities as a top six NHS priority - including through the delivery of mainstream services targeting of groups and areas to improve the health of the disadvantaged faster than other groups, such as the spearhead group of local authority areas with the worst health and deprivation indicators covering around 28 per cent of the population.

The most pressing policy issue is delivery of the 2010 target. This will require leadership from the NHS and engaging a wider range of partners and interested bodies. This approach will also need to be underpinned both by better data about health needs and what is happening, as well as improved evidence and research about what works and can both improve the health of disadvantaged groups and areas and narrow the health gap.
Inequalities in health: Developing the evidence base – examples of innovative approaches

Over the last few years, a number of research teams have made efforts to develop the evidence base on what interventions might tackle the ‘gap’. The examples below demonstrate some of the different approaches being taken.

Example 1 – Evaluation of Stop Smoking Services

The evaluation of Stop Smoking Services was commissioned in response to the cessation services implemented as part of the Tobacco White Paper (Secretary of State 1998). Assessing the potential to impact on inequalities in health was written into the brief at an early stage. The resulting project built upon monitoring data being collected by the DH Statistics Division. In brief, an analysis of clients showed that equity of access to the services was favourable although quit rates among more disadvantaged groups were below average. Further analysis showed that the effect of the volume of clients from disadvantaged areas outweighed the poorer quit rates.


Example 2 – Systematic overview of population tobacco control interventions and their effects on social inequalities in health

The aim of this recently commissioned review is to assess the differential effects of population tobacco control interventions on individuals and groups with different socio-economic characteristics. To assess which interventions, in which contexts, are likely to be effective in reducing smoking-related health inequalities, and to identify reasons why other interventions may be ineffective – to answer the questions: ‘What works? What might work? For whom? In what contexts?’

Further information: Dr Amanda Sowden – Centre for Reviews and Dissemination, University of York

Example 3 – Health inequalities impact assessment of New Deal for Communities – scoping study

In 2004 the DH funded a scoping study to explore how data being collected as part of the national evaluation of the New Deal for Communities (NDC) combined with other sources of data might be used to inform policy on health inequalities. The scoping study aimed to:

- Define health inequalities in the context of the NDC and how secondary analysis of data can be used to explore health impacts and health gains associated with NDC over time.
- Consider the extent to which it is possible to explore differential changes in inequalities in health.
- Explore suitable comparators against which changes in NDCs can be judged.
- Undertake interim analysis to examine narrowing/widening of differences in health and the determinants of health between social groups (defined by age, sex, SES and ethnicity) across NDCs and in comparison with control areas.
- Develop new, theoretically informed classifications and related variables of the NDC strategies and their local contexts.

Further information: Professor Jennie Popay, University of Lancaster

2 The examples are taken from the Department of Health’s Policy Research Programme.
Example 4 – An examination of the differential social impact of national tobacco control policies

As part of the Public Health Research Consortium’s programme of work, further analysis of the International Tobacco Control Policy Evaluation Study (ITC) will be undertaken. The study seeks to provide evidence of behavioural and other effects of key tobacco policies and the psycho-social processes by which they work. The additional funding through the Consortium will support modelling to look at potential differential impact of policies.

Further information: Professor Hilary Graham (University of York) and Professor Gerard Hastings (University of Stirling)

Example 5 – Tackling inequalities through the social determinants of health: building the evidence base

The aim of this project (supported by the Public Health Research Consortium) is to identify priorities for new systematic reviews, and for new primary studies addressing inequalities in health. In particular, the projects will explore what systematic reviews have been done so far which address the main (non-healthcare) social determinants of health (eg education, housing, transport, income, crime, employment etc). One of the objectives will be to assess what are the conclusions of these reviews in relation to the (health-related) effects of interventions in different subgroups. This will allow for the further exploration of the potential of social interventions to influence inequalities in health.

Further information: Professor Hilary Graham (University of York) and Dr Mark Petticrew (University of Glasgow)

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3The Public Health Research Consortium (PHRC) brings together senior researchers from ten UK institutions in a new integrated programme of research. Its aim is to strengthen the evidence base for interventions to improve health, with a strong emphasis on tackling socio-economic inequalities in health. The consortium is funded by the Department of Health’s (England) Policy Research Programme (part of the Research and Development Directorate) for a 5-year period from October 2005.
References


Special reports commissioned for the UK Presidency of the European Union Health Inequalities: Europe in Profile by Professor Johan Mackenbach and Health Inequalities: A Challenge for Europe by a team led by Professor Ken Judge are available at www.dh.gov.uk/eupresidency.
Resources

The UK Clinical Research Collaboration http://www.ukcrc.org/ brings together the NHS, research funders, industry, regulatory bodies, Royal Colleges, patient groups and academia to a UK-wide environment that facilitates and promotes high quality clinical research for the benefit of patients.

EuroHealthnet http://www.eurohealthnet.org is a network of health promotion and public health agencies in Europe which coordinates the work of 31 national and regional agencies in Europe providing a platform for information, advice, policy and advocacy on health issues at EU level.

The Commission on Social Determinants of Health (CSDH) http://www.who.int/social_determinants/en/ supports countries and global health partners to address the social factors leading to ill health and focus on health inequities. It draws the attention of society to the social determinants of health, such as unemployment, unsafe workplaces, urban slums, globalisation and lack of access to health systems that are known to be among the worst causes of poor health and inequalities between and within countries.

The Eurothine project http://mgztb4.erasmusmc.nl collects and analyses information from different European countries that will help policymakers at the European and national level to develop rational strategies for tackling socio-economic inequalities in health.
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Economic and Social Research Council
Polaris House
North Star Avenue
Swindon SN2 1UJ

Telephone: 01793 413000
Fax: 01793 413001
E-mail: comms@esrc.ac.uk
www.esrcsocietytoday.ac.uk