EC EXPERT WORKING GROUP ON THE SOCIAL DETERMINANTS OF HEALTH INEQUALITIES, 2-3 March 2006

Tackling Health Inequalities – The UK Situation

Introduction

1. The UK Presidency of the EC held between July and December 2005 featured health inequalities as one of two health themes. Two interim reports on the state of health inequalities in the EU were commissioned and published during the Presidency. A summit conference *Tackling Health Inequalities – Governing for Health* was held on 17/18 October and emphasised the importance of action to deliver change through effective polices and governance, drawing on models of policy and good practice across member state governments.

2. It also raised health inequalities as an issue for the EC, proposing a separate group to explore health inequalities, and closer working with WHO, particularly with the new Commission on the Social Determinants of Health.

3. This paper sets out the UK situation in tackling health inequalities as a case study for the first meeting of the Expert Working Group. Taking account of the political make-up of the UK and drawing primarily on the example of England, it highlights the value of

   - an independent, scientific review on the evidence of health inequalities
   - a strategic approach that encompasses the social determinants of health underpinned by a cross government partnership
   - national targets to galvanise action at all levels, supported by an outcomes based performance framework and focus on delivery

National Context

4. The UK consists of four countries England, Scotland, Wales and Northern Ireland. Health responsibilities are devolved from the UK government to each of the four countries: to the Westminster Parliament for England, to the Scottish Parliament and the Welsh Assembly for Scotland and Wales respectively. Although the Northern Ireland Assembly has devolved health powers, Northern Ireland business is currently run directly from Westminster.

5. Despite these differences in governance, all UK countries have recognised the need to tackle health inequalities and have a common approach, working with regional and local structures of government as necessary. This approach involves a focus on both health (health care and health behaviour) factors, and on the wider, social determinants in health that are crucial to a long-term, sustainable reduction in health inequalities.

Profile of health inequalities in the UK

6. In 1997, a scientific review of health inequalities in England was undertaken by an independent inquiry into health inequalities chaired by Sir Donald Acheson, a former CMO. This inquiry also looked at possible policies to address these inequalities. It found that the health gap had grown significantly since the 1970s, and reported that

in the early 1970s death rates among men of working age were almost twice as high for unskilled groups as they were for professional groups, by the early 1990s, death rates were almost three times higher among unskilled groups

7. This long-term trend of a growing health gap continues to pose a major challenge. The Status Report for England (2005) acknowledged this challenge and showed that the gap in life expectancy and infant mortality continues to widen, despite overall improvements in population health.

8. Currently, average life expectancy at birth in 2001-03 was 76.2 years for males and 80.7 for females in England, the average life expectancy for the fifth of local areas with the lowest life expectancy was 74.2 and 79.1 respectively. The gap between the local areas with the highest and lowest life expectancy rates at birth was 8.3 years for males and 7.2 for females. Scotland shows a bigger and growing gap between the best and worse areas. For male life expectancy, the gap increased from 7.8 years (1991) to 13.7 (2001), based on parliamentary constituencies. A lesser gap would be shown for local authority areas.

9. The Status Report shows that life expectancy gap had widened between areas by almost 2% for males and 5% for females in 2001-03 since the 1997-99 baseline. The infant mortality rate among the 'routine and manual' group in 2001-03 was 19 per cent higher than the total population, compared with 13% since the baseline, and 69 per cent higher than the rates in the higher social groups.

<u>Policies and action</u>

10. The national health inequalities strategy for England is set out in the *Programme for Action* (2003) covering around a third of the population, not just socially excluded groups. It outlines a twin track approach with a national target to

    reduce health inequalities by 10% as measured by infant mortality and life expectancy at birth by 2010

    This approach combines action to achieve a long-term, sustainable reduction in health inequalities through the National Health Service (NHS), and through other government departments. The strategy identified 77 commitments from 12 government departments

11. The aim is to improve the health of people in disadvantaged groups and areas faster than the rest of the population. This includes reversing the 'inverse care law' where those with greatest health needs have least access to services.

12. This requires action on a broad front and is reflected in the strategy themes
    - supporting families, mothers and children
    - engaging communities and individuals
    - preventing illness and providing effective treatment and care
    - addressing the underlying determinants of health

13. Delivery involves action at local, regional and national level. Local government in England has new responsibilities for the health and well being of their

communities as well as responsibility for a range of services covering the wider determinants such as education and housing. Working with local NHS bodies will also help deliver this strategy.

14. A different focus is required to deliver the 2010 target part of the strategy. On reducing the life expectancy gap, the specific interventions required are
    - reducing smoking in manual social groups
    - preventing and managing other risk factors, such as diet, and obesity, physical inactivity and high blood pressure
    - improving environmental health, including housing conditions and reducing accidents
    - targetting the over-50s –among whom the greatest short-term impact will be made, as well as

    UK action also includes reductions in suicide rates and teenage pregnancy.

15. All UK countries share a commitment to tackling health inequalities through addressing the wider, social determinants of health, as well as with targets although the targets are framed slightly differently in each country.

16. In Scotland, targets to tackle health inequalities were set in *Building a Better Scotland* (2004) and seek a 15% improvement in the health of the most deprived communities. This is based on reductions in the rates of six indicators: adults smoking, smoking during pregnancy, CHD and cancer mortality in the under 75s, suicide in young people (10-24) and teenage pregnancy (13-15).

17. The Scottish Executive's *Closing the Opportunity Gap* anti-poverty strategy supports cross-governmental action including on education, housing, employment and health, and there is a specific NHS contribution to tackling health inequalities. *Prevention 2010* a new programme of anticipatory care seeks to strengthen primary care in the most deprived areas to prevent chronic disease and deliver better health outcomes.

18. The Welsh Assembly Government launched *Health Challenge Wales* (2004) to co-ordinate sustained improvements in health. Action on health inequalities has been shaped by an independent review, *Targeting Poor Health* (2001) that recommended a 'dual strategy' of action within and outside the NHS. This included pilot work with health professionals to help them make changes in the way they work, prior to wider roll out 2006/07.

19. A Welsh health inequalities fund was also established to stimulate local action across the most disadvantaged communities, focusing on heart disease and supporting 62 projects. An interim report, *The Inequalities in Health Fund – making a difference* was published in February 2006. The programme is being evaluated independently.

20. A further update taking account of these developments, *Inequalities in Health: The Welsh Dimension 2002-2005* was published in November 2005.

21. Similarly, Northern Ireland's cross-departmental strategy, *Investing for Health* sets out to tackle the wider factors which adversely affect health and perpetuate health inequalities, with a particular focus on the most disadvantaged.

The role of targets

22. Targets help focus energies and resources on health inequalities and drive change. They have been set across the NHS in England to make the service more effective and responsive to need, as across other public services. They form part of a contract between individual government departments and the rest of government, an arrangement overseen by the Treasury. Extra resources are awarded to departments in exchange for meeting agreed goals or targets.

23. Since 2004, a health inequalities dimension has featured in other health targets, including the targets for heart disease and cancer. It encourages action in disadvantaged groups and areas necessary to meet other health targets. This approach is already showing results – the death rates from both diseases are falling fast but the health gap between different social groups is falling faster – by 24.7 per cent in heart disease and 9.4 per cent in cancer in absolute terms over six years.

24. Winning hearts and minds for the 2010 target is challenging, not least because the health gap continues to grow, albeit slowly. While it has been easier to win support for addressing health inequalities on a broad front, getting a clear focus on the target has been more difficult. This is partly cultural for some of the key stakeholders who have a greater interest in the social determinants of health rather than a 'medical model' suggested by the target. This preference is made stronger in a context where the target is seen as hard to achieve. A key task is to win recognition among local staff and communities that the target is achievable.

25. A recent Department of Health/Treasury review concluded that the target can be achieved. This will require
    - a clear local plan and timescale for delivering the target
    - the engagement of key players in health and local government
    - greater clarity about the actions needed to address health inequalities, including an assessment of the impact of different interventions
    - action to address the low expectations about their health by people living in disadvantaged groups and areas, and
    - a clear performance management framework focused on outcomes and tracking delivery

26. In January 2006, the NHS in England announced that tackling health inequalities is to be one of the top six priorities for the service. This will strengthen and support delivery of the target at local level.

27. In Scotland, the new targets for NHS performance management includes the six indicators on health inequalities referred to earlier, including action on smoking and other factors. NHS Boards must account for delivery in their Local Delivery Plans from April 2006. Action on health improvement is supported by NHS Health Scotland, the national delivery agency.

Outcomes

28. Much has been achieved in political and process terms in raising the health inequalities profile since 1997. The Acheson inquiry paved the way for embedding health inequalities into the business of government. This has been consolidated by the development of a national target and national strategy based on partnership working, cross government reviews to promote ownership of the issue as well as clarification of who does what for the strategy, and the adoption of health inequalities as a criteria of policy and performance at local, regional and national level.

29. It has been harder to demonstrate quantitive change, especially at national level. The *Status Report on the Programme for Action* noted improvements headline indicators reflecting the wider, social determinants of health – such as reductions in child poverty and improvements in housing quality among disadvantaged communities - and the successful implementation of departmental commitments addressing them. Like improvements in heart disease and cancer, these changes will contribute to a long-term reduction in health inequalities but are unlikely to make an impact on the target by 2010.

30. There are examples of progress at local level, such as the Sheffield city-wide initiative for reducing cardiovascular disease. It shows how clinical services can help reduce health inequalities and have an impact on the health of people living in disadvantaged areas.This programme targeted the most deprived fifth of areas in the city and saw a faster decline in heart disease than in the city – mortality declined by 23% in these areas compared to 16% in the city as a whole.

Next steps

31. The national health inequalities strategy for England is recognised and well established. Delivering change to meet the 2010 target is the next step. This will require

- a stronger focus on achieving the target among key players
- being clear about what action is necessary and what interventions work, clarifying need, evaluating initiatives and monitoring delivery
- mobilising NHS and local government so that health inequalities issues are embedded in local service delivery, and build partnerships
- developing the spearhead group of deprived areas (covering 28% of the population) as a focus for new initiatives – this group is key to improving the health of disadvantaged groups and areas faster than other areas
- continuing to work across government – and with cross government programmes for long-term, sustainable reduction in health inequalities

Issues for the EC and member states

32. The UK situation in tackling health inequalities emphasises on delivering effective action on a broad range of areas to a large part of the population, and delivering it in a way that can specified by a targets and outcomes measured. This experience raises issues for the EC and other member states, including

- being clear about what's happening on health inequalities, quantifying inequalities and measuring change, identifying barriers, opportunities and scope for action, learning lessons from elsewhere
- moving from analysis to delivery, a crucial but difficult step if anything is to change, identifying needs and what works, who are the key players and stakeholders that need to be involved
- developing a dual approach, compatibility of a social determinants and health targets approach, short-term and long-term issues, showing success
- winning support for action and for new approaches, cultural issues for stakeholders, ownership

Conclusion

33. The group is invited to consider the issues raised by this paper and whether it provides a useful model for case studies from other member states

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