Keeping up with the pack: can government reduce health inequality?

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Executive summary

The nation’s health has steadily improved over the last century. However, the gains have not been shared equally throughout society. The poorest in society do not just suffer a deficit of wealth – they are also deprived of years of life.

The quality of an individual’s health and life expectancy are related to income: the poorest usually suffer the worst health. But other less tangible factors – stress levels, social capital, family relations and mental health – contribute to illness and premature death.

The richest countries do not necessarily have the highest longevity – in particular, life expectancy in the US belies its position as the world’s wealthiest nation. However, the extent to which health inequalities are directly related to income poverty, or to more general social inequality, has not been convincingly explained. The link between health and wider social inequality may yet prove a useful explanatory tool. But it is not a meaningful guide to action for hard-pressed governments – and it risks diverting attention from those most in need. The focus should be on helping those who suffer most from health inequalities – invariably the poorest in society.

Labour arrived in office in 1997 with a manifesto commitment to tackle health inequalities. In line with other key policies, the government based its approach on a series of targets and it has adopted a broad range of public health and social justice measures to try and meet them.

It is too early to provide a definitive assessment of the government’s record, but the most recent data show that long term inequalities are not yet diminishing. The gap in life expectancy between the worst performing local authorities and the overall average life expectancy has widened to two years. Similarly, the difference in infant mortality rates between the national average and the routine and manual classes has widened slightly since 1997.
The government’s focus on the average also conceals the stark and rising life expectancy difference between top and bottom. The gap between the very top and very bottom local authorities has increased by 15 per cent since 1997. Similarly, the difference in infant mortality rates between the top and bottom classes has widened.

Critics point to a number of flaws in the government’s approach. For example, it has placed insufficient emphasis on rising public health threats, such as obesity and mental health. Over half the adult population – and a quarter of children – in the UK are now classified as overweight or obese. Obesity is most common in deprived households. The government needs to target its resources at disadvantaged children, and schools need to be at the centre of any campaigns. In particular, all schools should teach some basic cooking skills; the rise in convenience foods has led to a second generation growing up unable to cook. The government also needs to develop more effective ways of reaching parents – this requires a targeted, sophisticated and positive public information campaign.

There is a strong link between poor mental health and reduced life expectancy. The increasing prevalence of mental illness in children is especially worrying. But as the government admits, mental health is not a fully integrated part of its health inequality strategy. The government needs to increase substantially investment in mental health services. But its immediate focus should be on services in deprived areas. In particular, it should target services at those people suffering mental illness who are claiming incapacity benefit.

Overall, the government deserves credit for trying to develop a comprehensive approach to health inequalities. However, too often it has provided only short term responses to long term problems, and not allowed reforms to bed in before changing direction. It has failed to establish a sufficient evidence base for fruitful policy interventions. It is not co-ordinating policymaking effectively. The government’s targets are arbitrary, and they do not convey the full extent of health inequalities. To improve the value of health policymaking, this paper concludes there is an urgent need to:

- **Expand the evidence base:** the government needs to devote far greater resources to health inequalities
research. Given the entrenched nature of the problem, the government also needs to support research projects to examine outcomes over the long term – and allow policies to run their full course.

- **Improve the links between social and health inequalities policy**: the government should conduct a health inequalities impact assessment on all relevant social justice policies. Policies that increase employment, tackle poor housing, raise education levels and heighten social mobility will, over the long term, reduce health inequalities. But in the short to medium term, the primary focus must be on policies that directly tackle the problem, especially targeted public health interventions.

- **Foster a political debate**: at present, the problem of health inequalities is too often the sole preserve of experts and practitioners. It is vital for effective policymaking to encourage a meaningful and competitive political debate on health inequality.

- **Revise the targets**: the target dates should be pushed back from the medium to long term, with 2010 kept as an interim target for assessment purposes. The focus of the headline targets for life expectancy and infant mortality should be the gap in absolute terms between the bottom and top. The difference between rich and poor is the only true measure of the extent of health inequalities in society.

- **Localise delivery**: while central government will continue to provide much of the funding for tackling health inequalities, effective targeted programmes can be delivered only at the local level.

- **Focus on targeted public health measures**: over the medium term, resources should be switched into public health measures which curb the growth in new health risks, such as obesity and mental health problems.
Introduction

The rapid improvement in health and rise in life expectancy is one of the great achievements of modern society. In the last 100 years, average life expectancy has increased by almost two-thirds from 48.2 years in 1904 to 78.5 in 2004. However, these gains have not been shared equally throughout society. The difference in the life expectancy of the richest and poorest has been widening since as far back as the 1930s. Men living in Kensington and Chelsea can look forward to on average 11.5 years more life than those in Glasgow. Or to put it another way, life expectancy in the Glasgow City local authority is still at levels enjoyed by the population as a whole as far back as 1976. In the Calton district of Glasgow, average life expectancy stands at just 53.9 years – a level lower than in most developing countries and the average for the UK in 1920. The poorest in society do not just suffer a deficit of wealth, they are also deprived of years of life.

Health – but especially longevity – is a very good marker of the performance of society as a whole. The quality of an individual’s health and life expectancy are related to income – the poorest (usually) suffer the worst health. But other less tangible factors – such as stress levels, social capital, family relations and mental health – are all important contributory factors to ill health and premature death. Measures of health inequality thus provide concrete evidence of how relative disadvantage affects different groups within society.

In the last couple of years, a debate has begun over whether it is feasible and desirable for government to seek to raise the the overall quality of people’s life, rather than simply focusing on improving prosperity. Most recently, David Cameron, the Conservative leader, expressed his desire to improve the country’s “general well-being”.¹ Politicians are struggling to put flesh onto such abstract concepts. But measures of health inequality, especially life expectancy, provide a proxy guide to the state of ‘well-being’ across society. Governments that are genuinely
interested in quality of life issues should consider making a priority of the battle against health inequalities.

Some critics have questioned the need for governments to intervene to ensure greater health equality, given that all social classes have enjoyed a steady rise in life expectancy. But there are two good reasons why health inequality matters. The first is moral. All humans should have the expectation of a full and healthy life. The second is one of efficiency. Unhealthy people are unable to fully contribute to the economy. Premature deaths rob society of much needed human capital.

It is, therefore, right that governments should be concerned about health inequalities. But finding effective policy measures to tackle such a long-running and complex phenomenon is far from straightforward. Policymakers face major difficulties both in defining the goals of health inequality policies and in choosing the most suitable means of delivery.

First, there is no guarantee that governments can deliver on their health inequality goals, since policymaking in this area remains in its infancy. In particular, there is a complete lack of evidence about what are the most effective means of intervention. Second, there may be tensions between the desire to improve the relative health of the most disadvantaged and the goal of improving that of the population as a whole. Third, since the roots of health inequality lie far beyond the reach of traditional health services, governments need to adopt a very broad array of policy measures, ranging from targeted public health campaigns to measures to improve the socioeconomic circumstances of the most disadvantaged.

Finally, governments face a dilemma about the extent to which they are willing to intervene in pursuit of a reduction of health inequalities. Policymakers could seek to reduce health inequalities through heavy-handed regulation, such as further curbs on bad health behaviour like drinking and smoking, and large-scale redistribution. At an extreme, it would be possible to achieve greater equality by ensuring that the health of the best off is made worse. As one academic has written: “It is taken as an article of faith that it should be the overriding aim of public policy to narrow, if not eliminate, health inequalities. The proposition is not self-evident. What if this aim conflicts with another goal of public policy, which is to improve the health of the population as
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a whole? Does reducing inequalities trump improving the population’s health? If so, engineering a deterioration in the health of the best-off, for example, by encouraging them to smoke, would do the trick even if the health of the worst-off did not improve.”

Governments need to be certain that the level of intervention is justified by the results and does not conflict with the equally valid goal of improving the health of the population as a whole. Governments also need consent, and not just to redistribute resources away from the wealthy. One of the problems of even the best-meaning government intervention in the area of public health is a failure to secure the support of the people it is trying to help most.

As this paper shows, the UK as whole – but England in particular – has adopted a relatively bold approach to tackling health inequalities over the last decades. However, the government’s efforts have so far met with disappointing results – on key measures of health inequality, such as life expectancy, the gap between rich and poor is continuing to widen. Most worryingly, the government is only slowly facing up to a series of new public health challenges – especially the dramatic rise in obesity – which could have a profoundly negative impact on health inequalities in the coming decades.
What are health inequalities?

It has long been recognised that the poor endure worse health and die younger than the wealthy. The great Victorian public health reforms, for example, were driven by a philanthropic desire to reduce the gaping chasm in life expectancy between the best and worst off. The founders of the National Health Service (NHS) in the mid-20th century were also concerned with reducing health inequalities. They rightly believed that the provision of a universal health service would diminish the ill health and premature mortality caused by the lack of access to a doctor.

However, the creation of the NHS has failed to fulfil the hopes of its founders that everyone could enjoy similar levels of good health. Average life expectancy has risen steadily over the last 60 years, reflecting increasing prosperity and improvements in healthcare. However, as the table below shows, unskilled workers are now nearly three times as likely to die prematurely as professionals, compared to just 1.2 times more in 1930.

Table 1: The widening mortality gap between the social classes

Source: Office of National Statistics (ONS), Decennial supplements
The gap in overall life expectancy between the richest and poorest in society also has widened substantially. As table 2 shows, the difference in life expectancy between the highest social class (Class I) and lowest (Class V) grew from 5.4 years in the early 1970s to 6.5 years by the turn of the century – an increase of 20 per cent.

Table 2: Differences in life expectancy according to social class

By the 1970s, it had become clear that the establishment of the NHS was not itself sufficient to eradicate health inequalities. Policymakers gradually began to develop a more sophisticated analysis of the problem, exploring potential causes that went far beyond the traditional focus on curbing specific killer diseases, or remedying the lack of access to health services.

This renewed interest in health inequalities culminated in the publication of the Black Report in 1980. The Black Report concluded that socioeconomic factors were the most important cause of health inequalities – just three out of the report’s 39 conclusions directly referred to health services. The majority of the
recommendations centred on measures to improve the material conditions of poorer groups, most notably advocating the “abolition of child poverty... as a national goal for the 1980s”. However, the immediate practical impact of the Black Report proved limited as the Thatcher government baulked at the potential costs of implementing the proposals.

The contemporary debate

The Black Report suggested four possible causes of health inequalities: artefact, selection, behaviour or material factors. The idea that health inequalities derive from artefact or ‘selection’ – that is ill health causes poverty rather than the reverse – has been thoroughly disproved. Most experts now accept that the problem derives from the last two of Black’s suggested causes: the complex interplay between material deprivation and individual behaviour.

However, there remains stark disagreement about the extent to which individuals should be held responsible for their health-related behaviour and, consequently, how far the state should intervene to try and redress inequalities. This fault-line is clearly exposed in the debate over smoking: the British government has agonised over whether and how to introduce a ban in public places (in England and Wales).

Many public health experts argue that the government should shrug off ‘nanny state’ criticisms when there is a case that intervention could save lives. However, there is currently a dearth of evidence about the impact of interventionist public health measures on health inequalities. For example, some experts have raised concerns that a ban on smoking in public places can have a counter-productive effect in poor areas. Research in America has shown that smoking bans tend to increase the exposure of poorer individuals to smoke – because the poor smoke more at home while the rich give up. There may be reasons why a government wishes to take action despite potential inequality problems, such as protecting the health of non-smokers. But governments should take much greater account of the impact on health inequalities before proceeding with interventionist measures.

A controversy also has developed between those who argue that governments should concentrate primarily on alleviating the worst
forms of material deprivation, and others who claim that the focus of policy should be on reducing inequality in general. Academic Richard Wilkinson, for example, emphasises the importance of ‘psycho-social’ factors in causing health inequalities in rich countries. In Wilkinson’s view, ill health and premature death cannot be simply ascribed to income poverty. Rather, health inequalities are caused by a complex array of factors such as the strength of family and friendship networks (social capital), a person’s position within the social hierarchy, the extent to which a lack of control over a person’s life generates extra stress and so on. These inequalities run right across the social gradient: for example, a study into Whitehall civil servants found the quality of an individual’s health declined every step down the social ladder – even those in senior management positions on average suffered worse health than those at the very top.

However, other academics – such as Johan Mackenbach – continue to stress the prime importance of income poverty, rather than general inequality, as a cause of health inequalities. It remains the case that it is the poorest who (almost) always suffer the worst health. They also question whether, as Wilkinson and others have argued, there is a strong correlation between general levels of inequality within a country and health inequality. They fear that by emphasising inequalities right across the social spectrum, policymakers could be diverted from helping those most in need.

The relationship between health, wealth and inequality in developed countries is highly complex. The table below shows there is no strong correlation between wealth and life expectancy among developed countries. The richest countries do not necessarily have the highest longevity – in particular, life expectancy in the US belies its position as the world’s wealthiest nation.
Some experts have consequently argued that it is not absolute levels of wealth that matter but general levels of inequality within developed countries. The table on page 15, which compares life expectancy with the Gini coefficient measure of income inequality, provides some superficial support for this argument (the lower the Gini coefficient, the more equal the distribution of income). It shows that the country with the greatest income inequality, the US, had the lowest average life expectancy in 1995 and second lowest in 2000. Similarly other relatively unequal countries such as Ireland and the UK rank towards the bottom. On the other hand, Sweden – which is the most equal country – ranks second top in terms of life expectancy.

However, there are a number of anomalies within the data. Japan has only middling levels of equality but has the highest life expectancy. Similarly Italy is the second most unequal country but in 2000 had the third highest life expectancy. Just as importantly, there appears to be no relationship between a change in inequality and life expectancy – over the short term at least. Japan, for example, enjoyed the second largest rise in longevity between 1995 and 2000 despite income inequality growing sharply. On the other hand, Ireland experienced a large decline...
in inequality during the same period but only a modest rise in life expectancy.

Table 4: Changes in Gini coefficients and life expectancy, 1995-2000

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sweden</td>
<td>21.1</td>
<td>78.8</td>
<td>24.3</td>
<td>79.7</td>
</tr>
<tr>
<td>Netherlands</td>
<td>25.5</td>
<td>77.5</td>
<td>25.1</td>
<td>78</td>
</tr>
<tr>
<td>France</td>
<td>27.8</td>
<td>77.9</td>
<td>27.3</td>
<td>79</td>
</tr>
<tr>
<td>Germany</td>
<td>28</td>
<td>76.5</td>
<td>27.7</td>
<td>78</td>
</tr>
<tr>
<td>Canada</td>
<td>28.3</td>
<td>78.3</td>
<td>30.1</td>
<td>79.3</td>
</tr>
<tr>
<td>Japan</td>
<td>29.5</td>
<td>79.8</td>
<td>31.4</td>
<td>81.2</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>31.2</td>
<td>76.6</td>
<td>32.6</td>
<td>77.9</td>
</tr>
<tr>
<td>Ireland</td>
<td>32.4</td>
<td>75.7</td>
<td>30.4</td>
<td>76.5</td>
</tr>
<tr>
<td>Italy</td>
<td>34.8</td>
<td>78.1</td>
<td>34.7</td>
<td>79.6</td>
</tr>
<tr>
<td>United States</td>
<td>36.1</td>
<td>75.7</td>
<td>35.7</td>
<td>76.8</td>
</tr>
</tbody>
</table>

Source: OECD

Over the last 50 years, the debate about the causes of health inequalities has become increasingly sophisticated. However, the extent to which health inequalities are directly related to poverty, income or more general social inequality has not been convincingly answered. The American example below (see box) suggests that, even in the medium term, income inequality alone does not explain widely differing standards of health within a society. The link between health and wider social inequality may prove a more useful explanatory tool, although the evidence is far from conclusive. Moreover, this approach has not yielded policy solutions, and does risk diverting hard-pressed government attention from those most in need. Consequently, governments should focus their efforts on helping those who suffer most from health inequalities – which invariably are the poorest in society.
The American paradox

The US is not only the world’s richest country but also spends the most on healthcare, as Table 5 shows. However, its average life expectancy of 77.2 years considerably lags behind other developed countries such as Japan at 81.8 years and Sweden at 80.2 years.

Table 5: Health expenditure per capita, 2004

<table>
<thead>
<tr>
<th>Country</th>
<th>Purchasing power parity (US$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norway</td>
<td>6000</td>
</tr>
<tr>
<td>Sweden</td>
<td>5000</td>
</tr>
<tr>
<td>Germany</td>
<td>4500</td>
</tr>
<tr>
<td>France</td>
<td>4000</td>
</tr>
<tr>
<td>Japan</td>
<td>3500</td>
</tr>
<tr>
<td>New Zealand</td>
<td>2500</td>
</tr>
<tr>
<td>UK</td>
<td>2000</td>
</tr>
<tr>
<td>Canada</td>
<td>1500</td>
</tr>
<tr>
<td>USA</td>
<td>1000</td>
</tr>
</tbody>
</table>

Source: OECD

Experts have traditionally sought to explain this paradox by reference to the absence of universal health care and entrenched poverty within ethnic minority groups. However, new research suggests that these factors are only part of the reason for the US’s relatively poor health. The authors found that even when ethnic minorities are excluded, the health of US citizens is worse than their counterparts in England across all social classes.

Americans record higher levels of morbidity, sometimes much higher – with the sole exception of cancer. Most strikingly, wealthy and highly educated Americans had comparable levels of major diseases, such as diabetes and heart disease, as those in the bottom of the income and educational strata in England. This wealthy US group had almost universal access to high quality
US healthcare, thus lack of access cannot be blamed.

What lies behind this transatlantic health gap is not immediately obvious. One possibility is that Americans have worse health due to the earlier onset of a childhood obesity epidemic, which is strongly linked with ill health in adulthood. The English results could look far worse in a decade’s time as the country is rapidly catching up with US levels of obesity (see ‘New Threats’, page 35). However, the research rules out a straightforward link with higher levels of income inequality in the US. Income inequality has increased rapidly in the US over recent years, but there does not appear to have been any worsening in the position of those at the bottom. Nor would income inequality explain the relatively poor health of educated and wealthy Americans. Rather the research suggests that the more complex interplay of lifestyle, rank, and status are causing Americans greater stress, and therefore greater illness, than their English counterparts.

An equitable system?

It is important to distinguish the debate about reducing health inequalities from the separate, albeit related, question of whether a health system is equitable. An equitable system is one where citizens can access health workers and treatments on an equal basis without distortions caused by social or economic factors, such as the ability to pay or geographical location.¹¹

The question of whether the NHS delivers equitable care has long exercised health workers and academics. People of low socioeconomic status make greater use than average of primary care services (which accords with their needs), but are no more likely than average to be prescribed medication. Moreover, they are less likely to be referred for elective outpatient treatment and have lower rates of elective surgery in relation to need. For example, one study found that the lowest socioeconomic groups are 20 per cent less likely to have a hip replacement.¹²

The Labour government has introduced a number of measures explicitly designed to reduce inequity. For example, it established the NHS Cancer Plan in September 2000 to try and equalise the quality of cancer care across the country. It also set up the National Institute for Clinical Excellence (NICE) in 1999 with the aim of ending the ‘postcode lottery’ of medical prescriptions.
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However, the success of such measures is in doubt. For example, the House of Commons select committee on public accounts reported in February 2006 that cancer mortality rates still varied widely across the country with the highest number of deaths in deprived areas (see page 27).

More recently, some critics have claimed that government reforms – especially the introduction of greater patient choice – will exacerbate inequity. The government has responded by insisting that its reforms are designed not only to improve the quality of care but to reduce inequity – by making health services more responsive to those most in need. However, the government also has sought to appease its critics by trialling a system of health advisors designed to help patients, especially in deprived areas, work through the system.

In common with other public services, the socially advantaged appear better able to navigate through the health system and secure the best care. The government needs to take further steps to ensure the least advantaged can also access the best specialist care. This is not simply a case of providing better information to disadvantaged groups or targeting services more closely according to need. Policymakers need to understand the decision-making process of doctors when they refer patients for treatment. There is strong evidence that doctors are affected by the social characteristics of their patients, and are less inclined to refer disadvantaged groups for further treatment. For example, Afro-Caribbean and Black African patients deemed by their GP to need mental healthcare receive far fewer referrals than white British patients.

The lack of access to health services for certain social groups remains a serious problem within the NHS. The government should do more to try and improve access. But inequity only forms a small part of the much broader problem of health inequalities. Even if all social classes had fair access to treatment, sharp inequalities would persist. It is the battle to address these inequalities which forms the core of this paper.
Health inequality policymaking

Governments can tackle health inequalities in three ways. First, they can concentrate on improving the health of the most disadvantaged, without any direct reference to inequality. Second, they can seek to close the gap between specific social or ethnic groups. Finally, they can attempt to reduce health inequalities throughout the whole population.

The first approach remains the most commonly employed (see box, page 21). Governments use a range of interventions – whether public health or social justice policies – to improve the health of the most disadvantaged. However, critics point out this approach may do little to reduce inequality as such – the health of the rich may continue to improve at an even faster pace. A focus on the disadvantaged also risks missing inequalities suffered by other groups.

The second approach is the one adopted by the British government (see below). The inclusion of relative targets makes it a far more challenging approach than one that simply seeks to improve the absolute health of the most disadvantaged.

No government is yet to embrace the comprehensive third approach. This would require policymakers to, as one academic puts it, “equalise health chances across socioeconomic groups”.

This means developing policies to tackle “systematic differences in life chances, living standards and lifestyles associated with people’s unequal positions in the socioeconomic hierarchy”. However, it is questionable whether governments would be willing or able to devote sufficient resources and/or curb individual freedoms in the pursuit of this goal.

The British approach

The Labour government arrived in office in 1997 with a manifesto commitment to tackling health inequalities. The government seemed determined to make good the perceived wrong of the
Conservative’s shelving of the Black Report. In 1997, the then health secretary Frank Dobson described the impact of health inequality as, “the worst inequality of all. There is no more serious inequality than knowing you’ll die sooner because you’re badly off”.

In line with other key policies, such as its commitment to reducing child poverty, the government has based its approach to health inequality on a series of targets. The government’s Cross-Cutting Review (see box, page 21) laid down the vague ambition to reduce “inequalities in health outcomes by 10 per cent by 2010 as measured by infant mortality and life expectancy at birth”. The government has subsequently spelt out its overall goals more clearly:

- Starting with children under one year, by 2010 to reduce by at least 10 per cent the gap in mortality between routine and manual groups and the population as a whole;
- Starting with local authorities, by 2010 to reduce by at least 10 per cent the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole.

These headline targets are supported by regular assessments of progress in 12 underlying measures of health inequality. These include: a reduction in major diseases, such as heart disease and cancer; the promotion of good health behaviour, such as curbing smoking and increasing fruit and vegetable consumption; and an improvement in socioeconomic indicators, for example education levels, which have a strong link with health inequalities.

The government has adopted a broad range of measures in pursuit of its health inequality goals, including the Sure Start Early Years Development scheme, targeted tax credits and the New Deal jobs packages. However, most of these policies are not specifically designed to address health inequalities. Rather they represent existing health or social justice policies which could deliver a reduction in health inequalities as a by-product. This approach raises two obvious problems. First, since many of the measures are not specifically designed to tackle health inequalities, their effectiveness must be in doubt. Furthermore, these policies could be altered or dropped depending on political circumstances that are unrelated to the battle against health inequalities. Second, it
is not clear how the government expects its actions will translate into meeting the health inequalities targets.

**Government action since 1997**

1998: An independent inquiry into health inequalities, led by Sir Donald Acheson, publishes a first report. It identifies three key actions: introducing a health inequality dimension to health policies; giving a high priority to the health of families with children; and taking steps to reduce income inequalities and improve the living standards of poor households. The report makes 39 recommendations ranging from tackling poverty, reform of the tax and benefits systems through to education and employment measures.

1999: The government publishes a new broad health strategy, ‘Saving lives: our healthier nation’ in addition to ‘Reducing health inequalities: an action report’. The latter sets out action across government to tackle health inequalities, including socioeconomic factors which were missed in the Acheson Report.

2000: Public health prevention measures and tackling inequalities become a key part of the health service’s remit.

2001: The government unveils a first set of health inequality targets.

2002: The Cross-Cutting Review on health inequalities assesses progress and identifies further priorities.

2003: The government publishes ‘Tackling health inequalities: a programme for action’, produced by the Department of Health (DoH) with the support of 11 other government departments. This sets out specific measures to reduce the life expectancy gap, such as a reduction in smoking in manual social groups; the prevention and management of poor diet and obesity; and an improvement in housing quality. Infant mortality measures include: improving the quality and accessibility of ante-natal care and early years support in disadvantaged areas; reducing smoking and improving nutrition in pregnancy and early years; cutting teenage pregnancy rates and supporting teenage parents.

2004: The Wanless Report: ‘Securing good health for the whole population’ is published. This paper focuses on prevention and wider determinants of health and seeks to provide an assessment of the cost-effectiveness of action to reduce health inequalities.

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The government’s record

It is too early to provide a definitive assessment of the government’s record on health inequality. The 2010 target remains some four years away. The most recent data for key measures such as longevity derives from 2004 – barely two years into the government’s programme. Many of the proposed measures will take several years to take full effect. However, most studies, including the government’s own status report, find that the (long-running) trend in inequalities is not yet diminishing:21

Life expectancy

The government’s life expectancy target relates to the gap between the fifth most deprived local authorities (the Spearhead group) and the national average. As the graph below shows, on these terms the gap in life expectancy has not improved: standing at 2 years in 2002-04, compared with 1.92 in 1995-97. To put this in context, the gap needs to decline to 1.8 years by 2010 to meet the target.

Table 6: Inequalities in male life expectancy by local authority

![Graph showing life expectancy gap]

Source: DoH
The government’s focus on the average also conceals the stark and rising life expectancy difference between top and bottom. The gap between the very top and very bottom local authorities has increased by 15 per cent since the government came to power to stand at 11.5 years, the largest difference since the Victorian era.\textsuperscript{21} Similarly, the gap between the ten best and ten worst local authorities has also widened from 7.58 to 8.13 years. These results are confirmed by other studies. For example, one analysis using narrow social cohorts (income tenths rather than quintiles) found that while life expectancy has improved for all groups, inequality continues to rise.\textsuperscript{22}

**Infant mortality**

The government wants to reduce infant mortality deaths by 10 per cent in routine and manual classes when compared with the national average. The graph below shows that the gap has actually widened slightly since 1997 – on average the routine and manual classes suffer an extra 0.3 deaths per 1000 live births. However, an examination of the difference between the ten best and worst performing local authorities shows a decline in inequalities from 11.74 extra deaths in 1997-99 to 10.8 in 2002-04. This improvement should be treated with some caution as the number of births in local authority areas is often small and volatile.

**Table 7: Infant mortality by social class**

<table>
<thead>
<tr>
<th>Year</th>
<th>Gap between top ten and bottom ten local authorities</th>
<th>Gap between 'routine and manual' group and national average</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997-99</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>1998-00</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>1999-01</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td>2000-02</td>
<td>11</td>
<td>3</td>
</tr>
<tr>
<td>2001-03</td>
<td>11</td>
<td>4</td>
</tr>
<tr>
<td>2002-04</td>
<td>11</td>
<td>5</td>
</tr>
</tbody>
</table>

*Source: DoH*

Overall, infant mortality has fallen in all classes since the mid-1990s. However, the decline has been most marked in the
skilled and professional classes. Infant mortality rates among the professional and managerial and technical classes have fallen by nearly 20 per cent between 1995-7 and 2000-02 to stand at 3.6 per 1000 births. A baby born to an unskilled family is 90 per cent more likely to die before his or her first birthday than one born to a professional family. The gap in infant mortality rates between the top and bottom classes has thus widened since Labour came to office, standing at 3.3 deaths per 100,000 in 2000-02 compared with 3.0 in 1995-7.

These figures understate the extent of infant mortality inequality as they exclude sole registered births – that is births where only the mother’s name is given as the parent. Sole registered births are far more common in the lower social classes (but the government does not issue formal figures as the classification system is reliant on the father’s occupation). Infant mortality among sole registered babes has declined only marginally during the last decade to stand at 7.3 deaths per 100,000 in 2000-02. Mortalities are more than twice as common among sole registered births than those babies born to managerial and professional classes.

Table 8: Infant mortality by selected social class

<table>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deaths per 1000 live births</td>
<td>4.0</td>
<td>3.5</td>
<td>3.1</td>
<td>2.8</td>
<td>2.6</td>
<td>2.4</td>
</tr>
<tr>
<td>Sole registration</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Semi-routine &amp; routine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Managerial &amp; professional</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: DoH
Secondary indicators

The government also monitors a series of secondary indicators as part of its health inequalities action plan. In particular, effective action to tackle high heart disease and cancer rates in disadvantaged social groups – which explain around two-thirds of the life expectancy gap – should translate into a reduction in overall inequalities. The government has had some success in reducing the impact of these ‘big killers’ – in terms of the absolute gap at least. However, there are some signs that the pace of progress, in areas such as reducing smoking, may be slowing.

Heart Disease

As Table 9 below shows, the total number of deaths from coronary heart disease is declining across all parts of the country. The absolute gap between the best and worst performing areas has also improved slightly. In 1997, an average of 17 people died prematurely of a heart attack per 100,000 of population in the top ten local authorities, compared with 73 in the bottom ten, a gap of 56. By 2004, this gap had declined to 38.2 – there was an average of 9 deaths from coronary heart disease in the top ten local authorities, compared with 47.2 in the bottom ten.

Table 9: Deaths from coronary heart disease, by local authority

![Graph showing trend in deaths from coronary heart disease](source: DoH)
Cancer

The absolute number of deaths from cancer has fallen in all classes since 1997. The gap between the worst and best performing local authorities also has declined slightly. In 2003 there were 75 more deaths per 100,000 of population in the bottom ten local authorities than the top ten compared with 86 in 1997.

Table 10: Gap in incidence of cancer in the under-75s between the top ten and bottom ten local authorities

![Bar chart showing the gap in incidence of cancer between the top and bottom ten local authorities from 1997 to 2003.]

Source: DoH

Smoking

The government is aiming to reduce smoking in routine and manual groups from 31 per cent in 2002 to 26 per cent or less by 2010. However, as the table below shows, smoking rates remain strongly linked to socio-economic class. In the most deprived groups, smoking rates reach over 70 per cent. The poorest tenth of the population spend around 15 per cent of weekly income on cigarettes, compared to a national average of 2 per cent. The Kings Fund warns that the government could struggle to meet their target. While overall smoking rates continue to drift downwards, “the steep falls of earlier years have not been seen since the 1990s”.23

23 The Kings Fund warns that the government could struggle to meet their target. While overall smoking rates continue to drift downwards, “the steep falls of earlier years have not been seen since the 1990s”.24
Table 11: Prevalence of smoking by socioeconomic status, 2004

<table>
<thead>
<tr>
<th>Socioeconomic Status</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managerial &amp; professional</td>
<td>10</td>
</tr>
<tr>
<td>Intermediate</td>
<td>20</td>
</tr>
<tr>
<td>Routine &amp; manual</td>
<td>30</td>
</tr>
<tr>
<td>Never worked &amp; long term unemployed</td>
<td>25</td>
</tr>
</tbody>
</table>

Source: DoH

Alcohol

Alcohol abuse, whether through binge drinking or high overall consumption, is not mentioned in the government’s ‘Tackling health inequalities’ strategy, or in subsequent reports. However, alcohol misuse is a growing health problem in the UK, both in terms of increasing numbers of patients, and in its cost implications for the NHS. Average alcohol consumption has increased from 9.8 litres of pure alcohol per person per year in 1997 to 11.6 litres in 2004. The total number of deaths from alcohol-related causes has doubled since 1979. The government’s strategy unit estimates that alcohol misuse costs around £20 billion a year through direct NHS spending but also through the costs of sickness, crime and anti-social behaviour etc.

As the table below shows, there is a strong health inequality dimension to alcohol abuse. The lowest social group has significantly higher mortality rates for both alcohol dependence and chronic liver disease. The King’s Fund found that “men aged 25-39 in class V (unskilled) are between ten and 20 times more likely to die from alcohol-related conditions than those in class I (professional). There is also significant geographical variation
in alcohol-related mortality – in 2001-03, there were 13 times more alcohol related deaths in the bottom local authority than compared with the top.\textsuperscript{25}

Table 12: Alcohol related mortality by social class, men aged 20-64, 1991-93

\begin{figure}
\centering
\includegraphics[width=\textwidth]{chart.png}
\caption{Alcohol related mortality by social class, men aged 20-64, 1991-93}
\end{figure}

Source: Marmot and Feeney, 1999.
The international approach to health inequalities

The UK is not alone in having experienced an increase in health inequality over recent decades. All developed countries have seen a widening in the gap between life expectancy of the wealthiest and poorest in society, albeit to differing degrees.

As a result, health inequality is gradually moving onto both the national and international policy agenda. Canada and the US were among the first to develop a distinctive approach to the problem. Canada arguably led the way with the publication of the Lalonde Report in 1974. In the US, the Surgeon General’s report set out ideas on tackling health inequalities in 1979. The US has the (nominal) target of eradicating all inequalities in health by 2010, although the Bush presidency has made no attempt to pursue this goal.26

Internationally, the World Health Organisation (WHO) has encouraged developed countries to take the problem seriously. The WHO’s European office issued a general declaration in 1998 which called for the gap in life expectancy between the best and worst off to be reduced by at least 25 per cent by 2020. It also called for progress in reducing other indicators of inequality, such as major killers like cancer and heart disease.

More recently, the European Union (EU) has begun to explore the issue. The UK made the battle against health inequalities one of the key themes of its EU presidency during the second half of 2005. New research has confirmed that health inequalities are present in all EU countries – the chance of a premature death is always higher in lower socioeconomic groups, although the lack of comparable data makes direct comparisons difficult.27 This risk is reflected in lower overall life expectancy for more disadvantaged groups: in most European countries, the poor live between four to six years less than the rich, although the report notes this gap is notably larger in Britain and Finland.

EU countries adopt a number of differing approaches to health inequality policy.28 A few countries, such as the Czech Republic and Latvia, have embraced the WHO targets. Some countries such as Hungary focus on reducing inequalities between their minorities and majority population: the Hungarian government is seeking to reduce the decade long gap in life expectancy between its Roma and ethnic Hungarian populations. A number of EU members attempt to address health inequality as part of their commitment to ensuring health equity. For example, Sweden has the aim of creating “societal conditions which ensure good health, on equal terms, for the entire population”.29 It has
established 11 broad public health objectives, including ensuring a healthier working life, securing participation and influence within society, and developing safe and favourable conditions during childhood and adolescence. Finland and the Netherlands have just one broad health inequality target – in the former the aim is to reduce the mortality differential by gender, education and occupation by 20 per cent by 2015. Scotland and Wales also have adopted a different tack to England seeking to improve the absolute position of the poor, rather than reducing the gap between the most deprived and the average (or richest). Scotland is aiming to increase the rate of improvement of the poorest in society across a range of targets by 15 per cent by 2008.

The growing exchange of ideas at EU level should prove useful in helping governments discover what works, given the paucity of evidence on effective health inequality policy. The fact that other European governments have decided to pursue very different targets from those adopted in England also should yield valuable insights into setting credible targets. However, there is no case for the EU stepping up its direct involvement on this issue. The main levers of health inequality policy remain rightly at the national or local government level.
A flawed approach?

As the previous chapter has shown, the government will struggle to meet its health inequalities targets by 2010. Critics point to a number of serious shortcomings in the current strategy. In particular, the government stands accused of providing only a short term response to a long term problem; setting ineffectual targets; building an insufficient evidence base for fruitful policy interventions; and not co-ordinating its policymaking effectively.

A short term response to a long term problem

By definition, health inequalities that begin in the womb and end in premature death only can be alleviated by long term policy interventions. Governments, which are tied to the electoral cycle, are not particularly good at making this kind of investment in time and effort.

This problem is compounded by the hyperactivity of the current government. Too often it has not allowed reforms to bed in before sweeping them away in another change of direction.

Health action zones (HAZs) are a case in point. The government set up 26 HAZs in 1997 granting them £450 million to spend on developing “partnerships, collaborative working and systematic planning processes” to tackle health inequalities. However, they were abolished in another sweeping round of reforms in 2003 and their responsibilities handed over to the primary care trusts.

Even during their brief institutional life, HAZs were hampered by what one study describes as “constant change... The changes in priorities for HAZs and uncertainty surrounding their future reduced local ownership and support for them”. Ultimately, the study concludes that: “HAZ resources were not sufficient to make significant changes in the lives of their populations... the
timescale of the HAZ initiative was too short to achieve changes in the long term causes of inequalities.” This conclusion is backed by a separate report by the government’s own NICE which stated that “the HAZs felt that their direct impact on health inequalities were minimal”.31

Ineffectual targets

There are a number of profound difficulties in setting targets for as complex a phenomenon as health inequality – not least because there is no obvious way of ensuring that government intervention achieves the desired results. The British government lacks clear evidence on the effectiveness of its various measures (see below). But the failure to meet headline targets risks bringing the whole policy into disrepute.

Some critics argue that since there is no means of guaranteeing success, ‘global targets’ for reducing inequalities in health should be regarded as ‘a policy dead end’.32 One alternative would be to scrap the headline targets and focus entirely on tightly defined secondary goals where there is more obvious chance of success. However, there is the danger that a narrow focus could create perverse incentives for action. This is already arguably the case for the headline goals as the target date of 2010 is too short term to affect fundamental change. It means that the focus of policy activity is on those most immediately at risk of a life-threatening disease rather than the underlying causes of health inequalities or new threats such as obesity (see ‘New Threats’, page 35).

The subject of the targets also has to be clearly measurable. Here again there are problems with the government’s approach. For example, the infant mortality target excludes the ‘sole registration’ of births – that is the 17 per cent of births outside marriage where only the mother’s name is on the birth certificate. As a result, a section of the population most at risk of health inequalities is excluded from the government’s target.

The life expectancy target also misses a significant section of the population which most needs help. The government’s target is based on area, rather than social class. This means that those disadvantaged not living in poorer areas could be ignored by government interventions.
For both the key headline targets, the government has chosen to compare relatively disadvantaged groups with the national average rather than with the highest performers. As the previous chapter demonstrated this means it is not focusing on the full extent of health inequalities. On the other hand, as one expert notes the infant mortality target is ‘deceptively challenging’, even though the point of comparison is the average not the wealthiest groups. This is because the government wants to move both routine and semi-routine social groups – accounting for close to half the population towards the national average – which in turn will rise as the bottom half improves.

A lack of evidence

One problem the government faces in its attempt to tackle health inequalities is the lack of evidence about what works. Academic Raymond Illsey has spelt out how good health inequalities policy-making depends on a strong evidence base. “Credible policy options demand that priorities be clearly identified”, he writes, “that the supposed benefits will indeed flow from the policy and the action, that there is some indication of the scope, scale and timing of actions and outcomes, that the outcomes are measurable and responsibilities clearly allocated and accepted.” As currently formulated, the government’s health inequalities action plan fails this test.

Even the government commissioned Wanless Report was critical of the shortage of evidence on the effectiveness of public health policies. For example, Wanless notes there was no assessment of how social justice policies, such as improving poor housing, could reduce health inequality. The problem is especially acute in terms of targeted public health interventions, such as anti-smoking or healthy eating campaigns. Wanless found that there was virtually no evidence about what works among disadvantaged groups and little consideration of how policy might impact social classes differently. This reflects a general lack of timely data and statistics. Wanless concludes that there is “very limited information on the local prevalence of some of these risk factors such as smoking and much of the national information is not timely. So where targets and objectives have been set, there has not always been an appropriate and consistent degree of challenge, nor evidence about how they can be achieved cost-effectively,
nor what incentives and strategies are needed for their practical delivery.”

Weak inter-governmental co-ordination

Health inequality requires a range of central and local tiers of government and the public sector to work together effectively. Despite the best efforts of the current government to develop ‘joined-up government’ even central ministries do not always co-ordinate effectively. As one academic states: “The machinery of government is ill-equipped to deal with cross-cutting issues like health inequalities. The Treasury’s Cross-Cutting reviews and joint units are positive developments, but questions of accountability and scrutiny are inevitably raised. ‘Joined-up government’ is hampered by departmentalism — the careers of ministers and civil servants are still closely tied to departments, for example. Taskforces are introducing external views in the policy-making process but they may be unfamiliar with or detached from policy-making processes.”

The government has introduced a range of initiatives to try and improve co-ordination of health inequalities policies. A health inequalities unit within the Department of Health seeks to monitor progress while a cabinet sub-committee seeks to co-ordinate efforts across government. Meanwhile, an inter-departmental programme board, chaired by the Chief Medical Officer reviews implementation. However, the government faces an uphill task in trying to overcome the long-standing centralising culture and inter-departmental rivalry that is rife in the British civil service.
New threats

Critics can point to one further substantial criticism of the government’s approach to health inequality policy. It has tended to focus its energies on reducing the impact of ‘big killers’, such as cancer and heart disease. But it has failed to channel sufficient resources towards rising public health threats, such as obesity and mental illness, which are becoming increasingly important drivers of health inequalities.

Obesity

Obesity has risen relentlessly over the last two decades (see Table 11). Over half the English adult population is now classified as overweight or obese. This trend looks set to continue with obesity also increasing rapidly among children. Between 1995 and 2003, the percentage of obese children aged two to ten increased from 9.9 per cent to 13.7 per cent.\textsuperscript{37}

Table 13: Obesity in British adults,
As Table 14 below shows, obesity is most common in deprived households – 17.1 per cent of children within semi-routine or routine households were classified as obese compared with 12.4 per cent of those from managerial and professional households. Also, obesity is more prevalent in certain ethnic groups – children from Asian families are four times more likely to be obese than average. Health workers report that they are now seeing the first case of Type 2 diabetes – normally associated with obese adults – in children.

**Table 14: Prevelence of obesity among children aged 2-10 by socioeconomic status of household reference person, 2001-02**

<table>
<thead>
<tr>
<th>Socioeconomic Status</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managerial and professional occupations</td>
<td>17</td>
</tr>
<tr>
<td>Intermediate</td>
<td>16</td>
</tr>
<tr>
<td>Small employers and own account workers</td>
<td>15</td>
</tr>
<tr>
<td>Lower supervisory &amp; technical occupations</td>
<td>15</td>
</tr>
<tr>
<td>Semi-routine and routine</td>
<td>20</td>
</tr>
</tbody>
</table>

*Source: DoH*

This sharp rise in obesity is storing up costly problems for the future. Obesity reduces life expectancy by nine years on average, greatly increasing the risk of a wide range of diseases, such as heart disease, but also depression, stress and even infertility. The National Audit Office (NAO) estimates that obesity already
directly costs the NHS around £1 billion a year, a figure that is set to more than triple to £3.6 billion by 2010. In short, the rise in obesity could undermine the limited progress made in tackling other causes of health inequalities.

This rise in obesity is not unique to UK but is a problem across the developed world. The European Commission recently estimated that the number of life years lost due to obesity and related nutritional problems is now higher than smoking, costing the EU economy up to £230 billion a year in direct and indirect costs. However, European countries still lag behind the US where in 2004 just under two-thirds of the population were overweight or obese (with nearly a quarter classified as obese). At the current rate of growth, 73 per cent of the US population will be overweight by 2008. Some experts are now predicting that the problem in the US is so severe that the century long increase in life expectancy will go into reverse. Worryingly as Table 15 shows, the UK is now recording the fastest rise in obesity rates.

Table 15: Obesity, percentage of adult population with a body mass index >30 kg/m²

<table>
<thead>
<tr>
<th></th>
<th>1980</th>
<th>1990</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finland</td>
<td>7.4</td>
<td>8.4</td>
<td>12.8</td>
</tr>
<tr>
<td>France</td>
<td>5.8</td>
<td>9.4</td>
<td></td>
</tr>
<tr>
<td>Japan</td>
<td>2</td>
<td>2.3</td>
<td>3.2</td>
</tr>
<tr>
<td>Sweden</td>
<td>5.5</td>
<td>9.7</td>
<td></td>
</tr>
<tr>
<td>UK</td>
<td>7</td>
<td>14</td>
<td>23</td>
</tr>
<tr>
<td>USA</td>
<td>15</td>
<td>23.3</td>
<td>30.6</td>
</tr>
</tbody>
</table>

Source: OECD ‘Health Data 2005’

What has caused this rapid increase in obesity is a matter of controversy. Fast food chains and food manufacturers are frequently scapegoated. They are currently coming under huge political pressure to improve the nutritional value of their products. But the reality is that a complex array of socioeconomic factors are at the root of the rise in obesity, of which the prevalence of unhealthy convenience food is just one. These include the decline of manual labour; an absence of exercise facilities in
poorer areas; poor infrastructure which discourages walking; the lack of affordable fruit and vegetables; as well as the availability of cheap and unhealthy alternatives.

To date government intervention to tackle the problem has largely been limited to public information campaigns to encourage people to eat healthily and exercise more. These have had only a limited impact: in the mid-1980s the British government introduced targets seeking to reduce obesity rates in men from 7 per cent in 1986-7 to 6 per cent in 2005 and for women from 12 to 8 per cent. But by 2004, 25.6 per cent of women and 24.5 per cent of men were classed as obese.

The failure of public information campaigns has led to a growing clamour to take a more interventionist approach. Governments could take action in a number of direct ways, such as banning fast food advertisements, regulating the content of food products more tightly, or imposing ‘sin taxes’ on products deemed bad for health. Such an approach would understandably provoke criticisms about the infringement of personal freedom. Why should government penalise the majority of the population who enjoy, say crisps or chocolate in sensible quantities?

An interventionist approach also raises some major practical difficulties. The first is definitional – it will prove difficult and highly controversial defining exactly which products should face an advertisement ban or be covered by a ‘sin tax’. New and complex red tape could raise food costs. Moreover, dietary science is still evolving at a fast pace and the advice offered on healthy eating habits changes regularly. Finally, ‘sin taxes’ will bear disproportionately on the poor who spend a higher share of their income on fast food. The Institute for Fiscal Studies (IFS) modelled a hypothetical food tax and found that “the poorest households lose around seven times more, as a proportion of income, than the richest households do, on the assumption that there is no behavioural change”. They concluded that: “The regressivity of a ‘fat tax’ is likely to hold no matter how the tax is implemented – whether on fat content, on calories or just attached at a particular rate to certain foods”.

The British government so far has shied away from taking direct action, although it is likely shortly to recommend some curbs on junk food advertising for children. But it is beginning to develop a more sophisticated approach to curbing the problem. It has
set a new target aimed at halting by 2010 the year on year increase in obesity among children under 11.\textsuperscript{43} The plan includes some 20 actions aimed at both the prevention and treatment of childhood obesity, including measures to improve school meals, encourage exercise and improve play areas. However, as the National Audit Office (NAO) has noted, there is still a shortage of evidence on what works for obesity.\textsuperscript{44} They found that: “There has been little comprehensive research on the effectiveness of prevention strategies in this area [tackling childhood obesity].” The government thus risks wasting resources. Moreover, many of the programmes the government lists in its action plan are not specifically directed at obesity. The danger is that obesity reduction will remain a worthwhile but coincidental benefit while other priorities attract greater resources.

The government should make curbing the rise in obesity a priority in its health inequality action plan. Its new approach should include a commitment to:

- Target its resources at disadvantaged children who are most at risk of obesity. It should make other public health education policies subservient to the needs of tackling obesity, not the other way round as it currently stands. It is obesity, not mild overweight or lack of fitness, which risks knocking years off life expectancy and heightening health inequalities.

- Place schools at the centre of the campaign. Campaigns such as Jamie Oliver’s battle to improve school dinners have already turned the spotlight on the role schools can play in improving children’s health. In many ways the school curriculum is already too prescriptive.\textsuperscript{45} But it is hard to argue that a strong grasp of the value of nutrition and exercise is not a vital basic skill. In particular, all schools should teach some basic cooking skills – the rise in convenience foods has contributed to a now second generation growing up unable to cook.

- Develop more effective ways of reaching parents. Even if adults are unwilling or unable to change their own diets and exercise regimes, it is vital that they are able to support their children in a healthier regime. This requires a targeted, sophisticated and positive public informa-
Mental health

There is a strong link between poor mental health (of all kinds) and reduced life expectancy. Consequently, a long term strategy for improving mental health is vital to tackling health inequality. But, as the government admits in the latest status report, mental health is not a fully integrated part of its health inequality strategy.

Britain’s mental health has deteriorated during the last few decades. According to the Government’s Strategy Unit, one in six adults and one in ten children now suffer from some form of mental illness. Around a third of all incapacity benefit claims are mental health related – in 1995, 600,000 people were receiving incapacity benefit or severe disablement allowance on the basis of mental or behavioural disorders; by 2004, this figure had increased to just over 1 million.

The increasing prevalence of mental illnesses in children is especially worrying. According to a recent report from the British Medical Association, around 20 per cent of children and adolescents have mental health problems at some point. Disadvantaged children are especially at risk. For example, around half of children with hyperkinetic disorder live in households with an income of less than £300 per week. Similarly 54 per cent of children with an emotional disorder live in low income households. Nearly 1 in 6 children from households with a weekly income of less than £200 suffered mental health problems compared with 1 in 20 for children in households with a weekly income of more than £600, as table 14 shows. Children in care are most at risk of mental ill health – an Office for National Statistics (ONS) report in 2003 found 45 per cent suffered some form of mental disorder compared with an average of 10 per cent in private households.
Experts are rightly critical of the government’s lack of focus on mental health problems. The government promised an extra £700 million for mental health treatments in the 1999 National Service Framework. However, the King’s Fund recently warned that progress had been slow in developing services. The report pointed to problems such as “the poor environment of acute wards; lack of adequate community care; an increasing number of people with dual diagnosis (mental health and substance abuse); difficulty in accessing services for black and ethnic minority communities; and underinvestment in mental health promotion”.

Richard Layard, the economist, has argued that because of a shortage of funding, most people with mental illnesses are offered no more than “a few minutes with the GP and some pills”.

The government needs to increase substantially total investment in mental health services. But its immediate focus should be on the provision of services in the deprived areas where they are most needed. In particular, it should target services at those people suffering mental illness who are claiming incapacity benefit. It should also follow the advice of its own medicines body, NICE, and make cognitive behaviour therapy more widely available.

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Table 16: Prevalence of mental disorders among children by household income, 1999

<table>
<thead>
<tr>
<th>Gross weekly household income</th>
<th>Percentage with a disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under £100</td>
<td>18%</td>
</tr>
<tr>
<td>£100-£199</td>
<td>15%</td>
</tr>
<tr>
<td>£200-£299</td>
<td>12%</td>
</tr>
<tr>
<td>£300-£399</td>
<td>9%</td>
</tr>
<tr>
<td>£400-£499</td>
<td>6%</td>
</tr>
<tr>
<td>£500-£599</td>
<td>3%</td>
</tr>
<tr>
<td>£600-£770</td>
<td>2%</td>
</tr>
<tr>
<td>Over £770</td>
<td>1%</td>
</tr>
</tbody>
</table>

Source: ONS / DoH, 2005
A new approach to tackling health inequalities

The British government deserves credit for developing the first substantial programme to reduce health inequalities. However, as the previous chapters have demonstrated, the current strategy suffers a number of major problems. There is an urgent need to foster a broader political debate on the best ways of redressing health inequality and to take steps to improve the evidence base. Also, the government should revise its headline targets and localise delivery. But above all, the focus of any health inequalities strategy should be targeted public health interventions.

Foster a greater political debate

No government can expect to resolve a problem as deep rooted as health inequalities. Even the most initially committed administration may lose interest due to short term political demands. As the sorry Black Report saga has shown, a change of government can lead to the issue disappearing entirely from the political agenda.

At present, the problem of health inequalities is too often the sole preserve of experts and practitioners. It is vital to encourage a meaningful political debate on health inequality. In the present political climate, this appears to be a realistic goal. The Liberal Democrats are committed to reducing health inequalities. While the Conservatives have not directly pronounced on the issue, David Cameron has stated that the true test of the party’s policies is their impact on the most socially disadvantaged. Furthermore, that party has recently embraced the government’s commitment to end child poverty. It would only be a small step also to sign up to the fight against health inequality. But a consensus on the importance of the problem does not mean endorsing the same solutions. With so much uncertainty about what policies work best, political competition between the major parties on this issue should be welcomed.
Expand the evidence base

As the NAO and other expert institutions have repeatedly pointed out, there is still only very limited evidence on what policies work to reduce health inequalities. For example, an NHS review of obesity policies concluded that: “There is a complete lack of evidence regarding the effectiveness of interventions targeting specific socioeconomic, ethnic or vulnerable groups. This reflects the general dearth of evidence in relation to public health interventions that address health inequality issues.” Yet, as the British Medical Journal (BMJ) recently put it: “Improving public health is about changing behaviour. We need an in-depth understanding of the personal values, beliefs, preferences, and aspirations that drive behaviours in different social groups. Only then can we begin to design interventions to modify deep seated cultural norms and to challenge ingrained ambivalence.”

The government is thus left with a dilemma – the lack of evidence means it risks wasting scant resources on unproductive programmes. On the other hand, if it does not pursue some policies, it will be unable to build the evidence base. The constant changes of policy direction do not help either – many programmes cannot be effectively evaluated due to their short duration. The government’s exercise referral schemes are a case in point. Some GPs have been prescribing exercise since the 1980s, but the government extended the scheme in 2001, as a cheap way to improve health. The national standards set in 2001 were announced as “part of the Government’s commitment to tackle health inequalities”. However, as NICE pointed out, the government did not provide any resources for the evaluation of the programme. Consequently, NICE recommended scrapping the scheme – only for the government to unveil a new (untested) system of ‘health trainers’, which closely resembles the exercise referral programmes.

The government needs to devote far greater resources to expanding the evidence base on health inequality policy. All programmes should include a means of evaluation as part of their budget line. Given the entrenched nature of health inequalities, the government also needs to provide more support to research projects which examine outcomes over the long term.
There is also much to be learnt from local level experimentation (see below). Information from local programmes should be centrally collected and shared throughout the country. The government also should support and expand on the WHO and EU initiatives for collecting and sharing information.

Improve the links between social and health policy

Health inequality is a manifestation of wider social problems. However, there is not always a strong enough link between the government’s approach to health inequalities and social justice. Too often social justice policies, such as the New Deal employment package, are simply retrospectively defined as part of the health inequality strategy. There appears little debate about whether these are the most effective measures for reducing health inequality, or even whether they could be amended to take greater account of health issues. In future, the government should conduct a health inequalities impact assessment on all relevant social justice policies. Policies that increase employment, tackle poor housing, raise education levels and heighten social mobility will over the long term reduce health inequalities. In the short to medium term, the primary focus must be on policies that directly tackle the problem, especially targeted public health interventions.

Revise the targets

It is very difficult to set health inequalities targets with any confidence of success. The government has faced strong and justified criticisms over the precise formulation of its key targets (see ‘A flawed approach’, page 31). Some critics question whether the targets have any value at all. At the very least, the government’s existing headline targets appear arbitrary.

Despite these weaknesses, health inequality targets still have an important purpose: they provide a focal point for debate and ensure that the government can be held to account for its policies. Thus, the headline targets should not be abolished, but reformulated to better take account of the huge uncertainties surrounding policymaking in this area:
At the moment, health inequality goals cannot be reliably numerically expressed, given the limitations of the evidence base. Rather than applying an arbitrary numerical value, the long term target should make ‘substantial’ progress in reducing inequalities. In the future, the better performing developed countries should provide a valuable point of reference – although first there needs to be more thorough comparative research to establish suitable benchmarks. Experts can then assess whether the government is on track to fulfil its goals.

The target dates, especially for life expectancy, should be pushed back from the medium to long term – 2010 should be kept as an interim target for assessment purposes. The regular status reports provide an opportunity to monitor progress in the meantime.

The focus of the headline targets for life expectancy and infant mortality should be the absolute gap between the bottom and top (see box below). This is a more challenging goal than the government’s existing focus on the average, but the gap between rich and poor is the only true measure of the extent of health inequalities in society.

Central government should not set prescriptive targets beyond the two headline goals. Local authorities and primary care trusts should be left to produce secondary targets which provide a focus for action at grass roots level.

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## Absolute and relative targets

In the academic literature there is an often arcane discussion about the relative merits of absolute and relative targets. Absolute targets (in relation to health inequalities) measure the overall gap between two social groups. Relative targets, which are usually expressed as a ratio, provide a useful measure of the heightened frequency of a particular disease or some form of socioeconomic disadvantage in the relevant social group. However, as the disease becomes relatively less common, they often present a misleading picture of the extent of inequalities. The UK figures for heart disease are a case in point. The numbers of deaths per
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100,000 in the worst performing local authorities has fallen from 73 in 1997 to 49.2 in 2004 – substantially reducing the gap with the top authorities from 56 deaths to 38.2. However, on a relative measure, inequality has actually increased – you are now 5.2 times more likely to die of a heart attack if you live in the worst performing local authorities than in the best, compared with 4.3 times in 1997. This is because as the prevalence of a disease decreases, very small absolute changes translate into large percentage movements. To put it another way, the ratio would have remained constant if the top local authorities had suffered on average just two more deaths. These small fluctuations, which are amplified by the relative measure, are volatile and likely to be beyond the reach of government intervention. Thus, the focus of any target should be on reducing the absolute gap between the top and the bottom.

Localise delivery

The various tiers of government need to co-operate effectively in the battle against health inequalities. While central government will continue to provide much of the funding, effective targeted programmes can be delivered only at the local level. As the Wanless report concludes: “This cycle [of obesity] can be difficult to break. It is likely to need action on a local basis. Where national programmes exist, they need to be carefully considered and implemented on the ground by those who know the local issues.”

The government has begun to pay at least some heed to the calls for greater autonomy in the delivery of some health inequality related policies – not least by making the highly centralised NHS more responsive to local needs.

In the latest round of public services agreements (contracts between central and other tiers of government), the government has given some limited freedom of manoeuvre to both local authorities and primary care trusts (PCTs) to pursue their own health inequality priorities. Top (3 star) rated councils are being encouraged to devise health inequalities targets. PCTs are also permitted to “set local targets in response to local needs and priorities”.

But local authorities, healthcare trusts and social services need to be given real freedom to pursue their own strategies. They should seek to translate the headline health inequality targets
into concrete action on the ground. Central government should limit its role to monitoring performance and sharing best practice, rather than prescribing action. This devolution of responsibility is necessary not simply to achieve greater efficiency. It is also vital to allow innovation and experimentation in a policy area that, as this paper has demonstrated, is still in its infancy. Above all, those most affected by health inequalities need to be brought much more closely into the policymaking process. Central government is far too remote to engage effectively with the people it is supposedly trying to help.

Focus on targeted public health measures

One study estimates that tackling key risk factors through public health and related measures is three times more effective in preventing deaths than trying to treat existing diseases.\textsuperscript{56} Hence, over the medium term it would be more economical to switch resources into public health measures which curb the growth in new health risks, such as obesity and mental health. In the context of the battle against health inequalities, these resources need to be targeted at those most in need – which implies a substantial redistribution of resources into public health measures in deprived areas.

However, while a series of governments have paid lip service to the need to create a ‘national health’ rather than ‘national sickness’ service, spending remains overall concentrated on traditional NHS priorities. The government’s White Paper, ‘Choosing health: making healthier choices easier’, published in 2004, hinted it wanted to place a greater emphasis on public health measures. Prevention may be better than cure. But in politics, helping the ‘sick’ still trumps investing in the ‘healthy’. The incentives built into the system are also towards health care delivery rather than preventing illness or reducing inequalities. The current furore surrounding service cuts in hospital trusts as a result of overspending shows just how difficult it will be to shift resources to public health measures.
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Notes

17. Health Inequalities PSA Target, DoH website, www.dh.gov.uk
22. The top performing local authority in 2002-04 was Kensington and Chelsea.

J Mackenbach, ‘Health inequalities: Europe in profile’.


I Crombie et al, ‘Policies to reduce health inequalities in 13 developed countries’.


M Marmot, ‘Tackling health inequalities since the Acheson inquiry’.


S Williams, Hansard, 16 February 2006.


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