



HM TREASURY



Tackling Health Inequalities

**Summary of the
2002 Cross-Cutting Review**



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Note: the statistics presented in this report are those which were available at the time of the Review, which took place between Summer 2001 and Summer 2002.

Foreword

It is a pleasure to present this summary report of the 2002 Cross-Cutting Review on health inequalities. I would like to thank everyone involved with the Review, and in particular Yvette Cooper, who led it.

Tackling health inequalities is a top priority for this Government.

Despite increased national prosperity, wider opportunity and improving health over the last twenty years, there remain striking inequalities in health between groups and areas. In some areas of the country, life expectancy is the same now as the national average in the 1950s.

For us, it is unacceptable that the opportunity for a long and healthy life today is still linked to social circumstances, childhood poverty, where you live, what job you do, how much your parents earned, your race and your gender. Our vision is of a country in which everyone has the same chance of good health, regardless of where they live or their social circumstances. To achieve it, we must tackle health inequalities where they occur now, and break the inter-generational cycle to prevent inequalities in future.

One of the first things we did on coming into office was to commission Sir Donald Acheson's *Independent Inquiry into Inequalities in Health*. That report has given us the firm foundation of evidence we need about the nature and scale of health inequalities. We have since made health inequalities a national priority. *The NHS Plan* prioritised inequalities in the context of massive extra investment for a modernised NHS. Following that commitment, we have set two national targets for life expectancy and infant mortality, and we have made clear our belief that to achieve real, sustained improvement every part of society must play its part – the public, private, and voluntary sectors, and people themselves.

We have already seen substantial progress on many fronts. There have been improvements in life expectancy, reductions in teenage pregnancies and reductions in smoking among low-income groups. We are improving access to health services for the most disadvantaged, and targeting extra resources at the areas of greatest need. Across Government, the Chancellor's child poverty strategy and measures to increase employment opportunities, the National Minimum Wage, welfare and benefit reforms, transport and housing improvements, educational changes, Sure Start and the Neighbourhood Renewal Strategy will all have a major impact on reducing health inequalities. In addition, there has been a great deal going on at local level, especially by front-line staff, to tackle inequalities locally.

This Cross-Cutting Review was set up to assess our progress so far and to agree the priorities for future action. It sets out our long-term strategy to reduce health inequalities. This will form the basis of our cross-Government delivery plan for tackling health inequalities, which we will publish shortly. Our strategy gets at the root causes of the problem. It puts responsibility for tackling health inequalities at the heart of every key public service, harnessing the power of billions of pounds of extra Government funding. It has recognised that to achieve real, sustained improvement there needs to be concerted action across Government and with other sectors. And it empowers local communities to address the health inequalities in their areas, working in partnership with all agencies with a role to play locally.

Ministers right across Government have worked with the Department of Health and the Treasury in preparing this report. I would like to thank them for their help and support throughout the Review. I look forward to continuing our work together to deliver our strategy, creating a society where the opportunity for good health is enjoyed equally by all.

A handwritten signature in black ink, reading "Hazel Blears". The signature is written in a cursive style with a long horizontal line underneath.

Hazel Blears MP
Parliamentary Under-Secretary of State for Public Health

Summary of the Cross-Cutting Review on Health Inequalities

The problem

1. This country has seen increased prosperity and reductions in mortality over the last 20 years. However, inequalities in health outcomes persist, for example between socially disadvantaged and affluent sections of the population, males and females, and people from different ethnic groups. Many of these gaps are large and in some cases the gaps are wider now than 20 years ago. Health inequalities affect people at all stages of life and across different parts of the country. There are wide geographical variations in health status, reflecting the multiple problems of material disadvantage facing some communities. These differences begin at conception and continue throughout life. Babies born to poorer families are more likely to be born prematurely, are at greater risk of infant mortality and have a greater likelihood of poverty, impaired development and chronic disease in later life. This sets up an inter-generational cycle of health inequalities.
2. Observational data suggest that an individual's risk of developing ill-health and dying are related in part to the circumstances of the previous generation. If so, then intervening before and during pregnancy and early in life should improve health. Data from actual intervention studies bear this out. An increasing amount of evidence, from the US and elsewhere, shows overwhelmingly that early intervention makes a difference. The earlier, the more intensive and the greater the quality of intervention the greater likelihood there is of long term, sustainable success. Early investment programmes can produce significant long and short term benefits for children in terms of improved health, improved social and emotional development and improved educational attainment.

Figure 1

Key facts: The problem of health inequalities and its inter-generational cycle

- In Manchester, boys can expect to live almost eight years fewer, and girls almost seven years fewer than their contemporaries in Kensington, Chelsea and Westminster.
- Life expectancy for males in social class V is over 7 years less than for professional social classes: 71.1 years compared with 78.5 years. For women the gap is over 5.5 years.
- Some populations in this country have the same levels of early death as the national average occurring in the 1950s.
- Babies with fathers in social classes IV and V have a birthweight that is on average 130 grams lower than that of babies with fathers in classes I and II. Low birthweight is closely associated with death in infancy, as well as being associated with coronary heart disease (CHD), diabetes and hypertension in later life.
- Research shows that lower birthweight and father's social class can both increase your chance of dying of CHD over and above the impact of your own income and social class.
- An analysis of over 100 local education authority areas found educational attainment at age 15–16 to be significantly associated with both CHD and infant mortality.

3. Health inequalities follow a social gradient, with the health gap increasing steadily with poorer social class. Because of this gradient, and the distribution of the population in the different social groups, analysis in the Review shows that interventions must reach more than the most deprived areas and the most disadvantaged, socially excluded populations to meet the national targets and make progress on health inequalities more generally. It will be necessary to achieve change in all the manual social groups and to tackle pockets of deprivation in all parts of the country.

The review

4. The Cross-Cutting Review on Health Inequalities ('the Review') was established to address this challenge. The Review has, for the first time, brought together Ministers and officials from across Government departments and from local government, along with academic experts, to consider how better to match existing resources to health need and to develop a long-term strategy to narrow the health gap. The high level summary of this strategy is set out in **Annex A**. The Review established an Inter-Departmental Group (IDG) at official level, and the Departments involved are shown at **Annex B**. The terms of reference of the Review are set out in full in **Annex C**.
5. The work of the Review also highlighted the importance of local community involvement in action to tackle health inequalities, if interventions are to have a long-term and sustainable impact. The approach of the Review has been that it should set the strategic direction and then make recommendations for structures which will enable and empower local communities to tackle health inequalities effectively. The need for partnership, across Government, with local government and the NHS, between Government and local communities, and within local communities, has been a strong theme of the Review and is essential for such a complex and cross-cutting issue.

The evidence base

6. The causes, risk factors and impact of differences in health status are inherently complex. Health inequalities range across a number of dimensions: by socio-economic class and by geographical area; by ethnicity, age and gender. These risks of early death and ill health have a different impact at different stages of the life course and appear to be clustered in some geographical areas and around individuals in identifiable groups. Furthermore, health inequalities cross the generations, significantly affecting the life chances and quality of life not only of individuals, but of their children and grandchildren.
7. The Review considered the evidence base for health inequalities and effective interventions to narrow the health gap. A summary of the evidence of the gaps in health status is set out in **Annex D**. A full discussion of the approach and analysis of the Review are set out in a longer version of this summary available at www.doh.gov.uk/healthinequalities/ccsrsummaryreport
8. In addition, analysis of the evidence identified the following characteristics of successful approaches to improving health, particularly among the most disadvantaged. The Review considered these alongside a range of other evidence, as well as advice from the DH consultation process and practical experience derived from Sure Start, Health Action Zones and other relevant programmes. These findings should underpin all the interventions identified by the Review.

Figure 2
Key Findings on Successful Interventions

- Local assessment of needs, especially involving local people in the research process itself.
- Mechanisms that enable organisations to work together – ensuring dialogue, contact and commitment.
- Representation of local people within planning and management arrangements – the greater the level of involvement, the larger the impact.
- Design of specific initiatives with target groups to ensure that they are acceptable (i.e. culturally and educationally appropriate), and that they work through settings that are accessible and appropriate.
- Training and support for volunteers, peer educators and local networks, thus ensuring maximum benefit from community-based initiatives.
- Visibility of political support and commitment.
- Re-orientation of resource allocation to enable systematic investment in community-based programmes.
- Policy development and implementation that brings about wider changes in organisational priorities and policies, driven by community-based approaches.
- Increased flexibility of organisations, so supporting increased delegation and a more responsive approach.

A long-term strategy for tackling health inequalities

9. The Review has developed a long-term strategy to tackle health inequalities, setting out what needs to be achieved through concerted effort from a wide range of individuals and organisations including a range of Government departments, the NHS, local government, the community, voluntary and business sectors. The approach is one of mainstreaming work on health inequalities so that it is at the heart of Government policies rather than a marginal “add on”. The theme is one of partnership, across Government and between Government and local communities. This approach should ensure long-term sustainable change, making tackling inequalities an integral part of policy development and implementation across the board. Following the conclusion of the Review, a cross-Government Delivery Plan is being developed which will be taken forward by proposed new Ministerial and official structures. This plan will focus on the immediate spending review period to March 2006, but action will be necessary beyond this period if it is to have an impact on this complex and deep rooted problem.
10. Assessing the impact of reductions in inequalities on health service use is complex. Many aspects of health inequality show adverse (widening) trends, which the Government is committed to reversing. Within the health service, activity will lead to improved access and better quality services for disadvantaged groups – particularly in relation to preventive services.

Top priorities for meeting the national health inequalities targets

11. In addition to tackling health inequalities across the board, the Review had a particular focus on meeting the two national health inequalities targets, announced by the Secretary of State for Health in 2001, to narrow the gap in life expectancy by area and to reduce the difference in infant mortality across social classes by 2010. This is a relatively short period in which to expect change in such persistent and long-term trends. Analysis of available evidence on the problem, and on effective and promising interventions which will impact in this timeframe, showed the most significant interventions which will support the delivery of these targets by 2010 are as follows.

12. Interventions likely to make the major impact on achievement of the life expectancy target are:
 - **Reducing smoking** in manual social groups through extended smoking cessation services, complementary tobacco education campaigns and other supporting interventions.
 - **Prevention and effective management of other risk factors in primary care** (e.g. through early identification and intervention on poor diet, physical inactivity, obesity and hypertension through lifestyle and therapeutic interventions, including use of statins and anti-hypertensives according to need).
 - **Environmental improvements** to improve housing quality to tackle cold and dampness and increase safety at home (e.g. smoke alarms, hand rails), and to prevent road accidents among old and young road users.
 - **Targeting over-50s** where the greatest short-term impact on life expectancy will be made.
13. Interventions likely to make the major impact on the infant mortality target and on early years development are:
 - **Building on Sure Start** to improve early years support in disadvantaged areas.
 - Reducing **smoking in pregnancy**.
 - Preventing **teenage pregnancy**, and tackling its causes and effects.
 - **Improvements in housing conditions** for children in disadvantaged areas.
 - Other forms of **early intervention for the NHS**, for example to increase immunisation rates and breastfeeding, improve diet, family support and education about infant sleeping position.
14. Health inequalities cannot be effectively tackled by NHS interventions alone. The Review has drawn up a cross-Government strategy for reducing health inequalities that identifies the key interventions needed. It is clear that a cross-Government and cross-sector approach at local as well as national level is essential.

Key themes of the review

15. The work of the Review highlighted the cross-cutting nature of the determinants of health inequalities. It identified the following themes from the analysis of the evidence. These informed the development of the long-term strategy.

Breaking the Cycle of Inequalities

16. There is a strong correlation between health inequalities and poverty and deprivation that begins at birth and continues throughout life. A child's health is significantly influenced by their parents' socio-economic status. The Government's policies for tackling poverty and deprivation have a key role to play in narrowing the health gap. Education and employment have been identified as fundamental determinants of health inequalities, and the Review has highlighted the importance of reducing the differences in the early years' development of children in order to ensure that children from low-income families are able to take full advantage of opportunities at school and subsequently at work. Teenage pregnancy is strongly associated with deprivation, and there are associated risks for the health of the baby.

Figure 3

Key information – Breaking the cycle of health inequalities

- **education** plays a key role in this cycle. A significant association has been demonstrated between educational attainment at age 15–16 and CHD. Finishing full-time education at an early age is associated with higher subsequent mortality rates. Educational qualifications are a major determinant of labour market position, and influence income, housing and other material resources;
- parental **employment** affects their children's future health: father's social class and birthweight can both increase their chance of dying of CHD over and above the impact of their own income and social class;
- if **smoking in pregnancy** fell by 10% (from 18% to 16.2%), it is estimated that the average infant birthweight would rise by just over 3.5 grams. Low birthweight is associated with increased mortality and morbidity in the first year of life, and throughout childhood;
- if no mothers smoked, the average birthweight would rise by an estimated 36 grams;
- smoking in pregnancy is four times more prevalent among women in households in social class V than those in social class I. Teenage mothers are the most likely of all age groups to smoke in pregnancy – nearly two thirds of under 20s smoke before pregnancy and almost a half during it;
- the effect of halving the number of **teenage births** would by itself achieve an estimated 10% of the target reduction in infant mortality rates (the infant mortality rate for teenage mothers is 60% higher than for older mothers);
- the risk of becoming a teenage mother is almost ten times higher for a girl whose family is in social class V than those in social class I;
- the **infant mortality** rate among children in social class V in 1998–2000 was double that for social class I, with rates rising from 4 deaths per 1000 live births in social class I to 5.4 in social class III (manual), 6.2 in social class IV and 8.1 in social class V. For lone parents the rate was 7.6 deaths per 1,000 live births.

Tackling the major killers

17. The Review has identified strong social gradients in the incidence of the major killers and risk of injury, together with significant differences between ethnic groups. Differences in cancer and circulatory diseases account for the greatest part of the potential improvement in overall life expectancy if they could be eliminated: of the gap between the fifth of geographical areas with the lowest life expectancy and the national average, an estimated 20 per cent is due to cancer and 40 per cent is due to circulatory diseases. Smoking is the single most significant causal factor for the socio-economic differences in the incidence of cancer and heart disease. However, also important are physical activity and nutrition, with a continued epidemic of heart disease forecast as a result of current trends in inactivity and unhealthy diet. There are also inequalities in health for people in black and minority ethnic groups in relation to cardiovascular disease, diabetes and cancer. Policies that give people the skills, information and support to make and sustain healthy lifestyle choices are therefore important. In addition, there is evidence of significant inequalities in the incidence of accidents and injuries, especially among children from low-income families.

Figure 4

Key information – Tackling the major killers

- **smoking** is responsible for the major part of mortality differentials by social class in middle age. Amongst males aged 35–69, it has been estimated that, if smoking rates among social class V were the same as those in social class I, this would remove around half of the inequality;
- the death rate from **CHD** is three times higher among unskilled manual men of working age than among professional men. The death rate in men under 65 years is 1.6 times higher in the North West Region than in the South East. In Manchester, the death rate for people under 65 years is over three times higher than in Kingston & Richmond: 69.3 and 20.6 per 100,000 respectively in 1998–2000. Emerging evidence suggests that a cause of CHD may be **work-related stress**, particularly where there is high demand and low control at work. CHD in civil servants has been found by the Whitehall II studies to be more prevalent in the lower socio-economic groups;
- **obesity** is more prevalent in lower social classes – 28% of women in social class V are obese, compared to 14% in social class I (England, 1998);
- **lung cancer** incidence is higher in the north than the south of England, and higher in urban than in rural areas;
- manual workers make up 42% of the workforce, but account for 72% of **reportable work-related injuries**;
- children in social class V are five times as likely to suffer **accidental death** than their peers in social class I, 83 and 16 per 100,000 respectively;
- residential **fire deaths for children** are 15 times greater for children in social class V compared to those in social class I;
- an unskilled working man was, at the time of the last Census, almost four times more likely to commit **suicide** than his professional counterpart. Rates in partly skilled and manual skilled workers were twice as high as the professional group;
- the death rate from CHD is up to five times higher for people with **diabetes**. One in twenty people over 65 have diabetes.

Improving Access to Public Services and Facilities

18. There is evidence that those in greatest need of public services often have the lowest levels of use and the poorest access to these services. This is greatly compounded by poor access to public transport and few alternative transport options. Access and use of the NHS, local authority services, employment services, housing and other social services and community facilities can affect health inequalities. For example, for black and minority ethnic groups, service providers' insensitivity to cultural, religious and language issues and lack of cultural competence can have an impact on the take up of services and facilities. The same applies for insensitivity to gender differences and people with physical and learning disabilities in the take up of services and service preferences. Some vulnerable groups have difficulty accessing mainstream services too, and need targeted programmes, as set out below.

Figure 5

Key information – Improving Access

- **fewer GPs** tend to serve the most disadvantaged communities: for example, in October 2000, whole time equivalent general practitioners (including registrars) numbered around 45 per 100,000 weighted population in Sunderland, but 69 per 100,000 in North Yorkshire.
- **rates of hospital admission** for coronary artery bypass grafts and coronary angioplasty are not generally higher in areas with the greatest need (i.e. those in areas with the highest CHD mortality).
- analysis of the fourth National Survey of Morbidity in General Practice showed that the **rates of consultation** for preventive care were 37% lower in men aged 16–24 years from social classes IV/V than for those in social classes I/II. For men aged 25–39 years, preventive care consultation rates were 31% lower.
- women of Bangladeshi origin are less than half as likely as those in the general population to take up invitations to **cervical cancer screening**.
- of those without access to a car, 27% face difficulties travelling to hospital, 13% find accessing primary care difficult, and 16% find access to supermarkets hard.
- 40% of job seekers say that their job search was limited because of the costs involved. For the majority this was to do with **transport**.
- 47% of 16 to 18 year old students said they found their transport costs hard to meet. On average, annual transport costs were £370 a year.
- **older people**, particularly very old people, do not get fair access to health and social care services. The Acheson Report found that lack of access to transport is experienced disproportionately by older people, limiting their access to goods, services, opportunities and social contacts.

Strengthening Disadvantaged Communities

19. Many areas across the country suffer from multiple deprivation, and the links between area-based deprivation and health inequalities are strong. The Government's Neighbourhood Renewal Strategy is vital for tackling the area based influences of ill-health, and there is an urgent need for improvements in the 88 deprived areas receiving the Neighbourhood Renewal Fund. However, there are pockets of deprivation right across the country and health inequalities will need to be tackled in all these areas if the national targets are to be met. The Review made links to a parallel review by the Cabinet Office on Area Based Initiatives, through which it was agreed that Health Action Zones had done a great deal of innovative work in deprived areas, and that this should be mainstreamed to other parts of the NHS.
20. Area based differences in health status are not simply a reflection of differences in health relating to social class. Rates of death among unskilled working men vary greatly between areas in the north and the south. A poor physical environment itself has a negative impact on health. Physical as well as mental health are influenced by the stress associated with living in neighbourhoods where the environment is seen as threatening, where the quality of the housing is poor and transport facilities are lacking. In addition it can be difficult for businesses to set themselves up in areas where crime is likely to be high, or for public services to attract staff. This is particularly true of the NHS where access to, and the quality of, primary health care in deprived areas is often significantly below that available elsewhere.
21. Evidence of effective interventions to improve health, particularly among the most disadvantaged, shows the importance of building partnerships and developing community-based approaches. The social support networks, relationships, and levels of participation and trust in a community are important influences on the health of individuals in that community and on local capacity to address health problems. Interventions to improve health work best with pro-active local participation in their design and implementation.

Figure 6

Key information – Strengthening Disadvantaged Communities

- over a third of all **ethnic minority householders** in England live in the 10% most deprived wards;
- 46% of households in the 10% most deprived areas contain no one in **paid work**, compared with 33% of households elsewhere;
- deprived areas contain a higher proportion of **lone parent households** (12%) than other areas (5%);
- the **infant mortality rate** in the lowest income areas is around 70% higher than in the most affluent areas;
- **teenage conception rates** are over four times higher in the most deprived areas of England and Wales than in the least deprived;
- between 1992 and 1997, 48% of teenage conceptions occurred in the 20% most deprived wards as measured by the Index of Multiple Deprivation;
- those in the professional class have similar health status regardless of location, whilst **rates of death** for unskilled working men vary greatly between north and south;
- some wards have current death rates equivalent to the national average in the 1950s;
- a woman in an affluent area is more likely to live for at least five years after a diagnosis of breast cancer than a woman in a deprived area (71% surviving for five years as compared with 63%).

Supporting Targeted Interventions for Specific Groups

22. The Review used a life-course approach in its initial analysis of interventions needed to reduce health inequalities. This identified the early years of childhood and older age as life stages where action to tackle health inequalities is particularly important and likely to have a significant impact. In addition, the Review identified a number of groups which are particularly at risk of health inequalities and who have complex needs, including vulnerable older people, vulnerable members of black and minority ethnic communities, people who are unable to heat their homes adequately (“the fuel poor”), rough sleepers, prisoners and their families, refugees and asylum seekers, looked after children, people with physical or learning disabilities, long-term medical conditions or mental health problems. While the long-term aim must be to meet the complex needs of these groups through mainstream services, the Review recognised that there may be a need to make targeted interventions in the short-term to address the specific needs of those with particularly poor health outcomes.

Figure 7
Key information – Specific Groups

- 57% of the ‘fuel poor’ are aged 60 and over;
- unmodernised homes have high heating costs and contribute to fuel poverty. Cold housing increases the likelihood of ill health (illnesses such as influenza, heart disease and strokes are all exacerbated by the cold) and may contribute to the excess of winter deaths seen in older people and also to fuel poverty. Properties in poor condition are disproportionately occupied by single older people;
- in the five years from 1994/5, the lowest 30% income households have spent over twice as much of their income proportionally on fuel than the average for all households and over three times that of the highest 30% income households;
- poor housing design contributes to serious accidents, particularly in older people, and seemingly minor accidents which may have grave consequences;
- of the 4,000 accidental deaths in the home in 1999, older people accounted for 47% (although only 16% of the population). Falls caused the largest number of fatal injuries in older people (62%), and are a major cause of disability;
- the Acheson Report highlighted the fact that, compared to the national average, the mortality rates in people aged 60 to 74 who had been living in local authority rented accommodation showed a 16% excess;
- the average life expectancy of rough sleepers is around 42 years of age;
- the proportion of adults assessed as having a neurotic disorder was 80% higher in social class V than in social class I in 1993;
- among adult prisoners of working age, 90% have a history of mental ill-health and/or substance misuse;
- morbidity resulting from diabetes complications is three and a half times higher in social class V than social class I. Certain ethnic groups are more likely to develop diabetes and people in the most deprived fifth of the population are more likely to suffer diabetes.

Delivering the health inequalities strategy

23. Tackling the causes of health inequalities requires action at both national and local level, involving Government Departments, NHS organisations and local authorities. To date, health inequalities have been seen as primarily an issue for the NHS. However, addressing the underlying causes requires co-ordinated action, bringing together health services with a range of other interventions and programmes. The aim of the Review has been to set the strategic direction for action across Government, in local government and for local communities and services. To be effective, interventions to tackle health inequalities need to have leadership at the local level and be accountable to local communities. The intention is to put in place delivery mechanisms and structures to empower those at local level to design and carry out the interventions most effective and appropriate for their communities to deliver the strategy.
24. The Review was particularly concerned to:
- Ensure that health inequalities remained a Public Service Agreement (PSA) target for the Department of Health, and that DH should take the lead on the issue across Government
 - Ensure that health inequalities remained part of the national PSA for local government, from which local PSA targets are derived
 - Ensure that a cross-Government Delivery Plan should be drawn up, with DH responsible for co-ordinating action across Government to implement it, and with a role for Treasury and the Prime Minister’s Delivery Unit in monitoring progress

- Ensure strong cross-Government Ministerial drive and co-ordination by bringing oversight of the cross-Government Delivery Plan on health inequalities within the remit of the Cabinet's Domestic Affairs Sub-Committee on Social Exclusion and Regeneration (DA(SER)).
- Ensure effective joint working between primary care trusts (PCTs) and local authorities, along with other local partners and the community. This should include determining a single set of local priorities for health inequalities and working together in a coherent and co-ordinated way to tackle the different causes, with a clear focus on outcomes. The Review felt that existing or developing structures should be suitable for this purpose, particularly Local Strategic Partnerships.
- Ensure the PSA targets for health inequalities are made a clear priority for the NHS and local government and are integrated into their mainstream planning, performance management and funding structures. These performance systems and structures include:
 - the Priorities and Planning Framework for the NHS, and the performance management by Strategic Health Authorities of achievement against these priorities;
 - the NHS performance indicators for PCTs and acute trusts, which support the performance ratings;
 - Local PSA targets for councils, based on the national PSA for local government, with particular encouragement for councils in the areas of lowest life expectancy or in receipt of Neighbourhood Renewal Funding to adopt health inequalities targets;
 - Best Value Performance Indicators and comprehensive performance assessment framework.
- PCTs and local authorities to be encouraged to make joint appointments of Directors of Public Health

25. The Government is putting together a cross-Government Delivery Plan for tackling health inequalities, building on the work of the Review. This will set out the priorities for action across Government, including local government and in the NHS, in partnership with the community, voluntary and business sectors, and will be based on a mainstreaming approach to tackle the wider determinants of health. The cross-Government Delivery Plan will be published shortly.

Annex A

A Strategy for Health Inequalities: High Level Summary

The Aim of the Government's Strategy on Health Inequalities

To narrow the gap in health outcomes across geographical areas, across socio-economic groups, between men and women, across different Black and minority ethnic groups, age groups, and between the majority of the population and vulnerable groups and those with special needs. The Government will do this by:

- Taking concerted action, through joined up policy making and implementation across Departmental boundaries
- Working in partnership with other stakeholders including front-line staff, voluntary, community and business sectors and with service users.

Key Government Targets to Deliver the Strategy

Action to address health inequalities is cross-Government and must be sustained long-term. A key focus will be to deliver the national health inequalities targets which were announced in February 2001. As part of the Spending Review 2002 the PSA target for health inequalities was revised to include a single target on health inequalities, combining both elements of the targets previously announced:

- *By 2010 reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth.*

The single target is supported by the following two targets:

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

These targets have been developed from those announced in 2001, updating them to reflect changes in social classifications and NHS structures. These targets are also complemented by a PSA target on teenage pregnancy:

- *Improve life chances for children, including by reducing the under-18 conception rate by 50% by 2010.*

A range of other targets, linked to major Government programmes, also support the delivery of the strategy, particularly those on smoking in manual groups, fuel poverty, neighbourhood renewal.

The Context of Government Action on Health Inequalities

A strategy for delivering reductions in health inequalities fits well with other major Government priorities, especially those addressing poverty and disadvantage. Key programmes are:

- The Child Poverty Strategy
- The Local Government White Paper, *Strong Local Leadership – Quality Public Services*
- *The NHS Plan* and *Saving Lives – Our Healthier Nation* White Paper
- *Schools Achieving Success* White Paper
- *The National Strategy for Neighbourhood Renewal: Action Plan*
- The national housing strategy
- The UK Fuel Poverty Strategy
- The Wanless report *Securing Our Future Health: Taking a Long-Term View*
- The National Service Frameworks for Mental Health, CHD, Older People, Diabetes, and the Cancer Plan; also the forthcoming NSF for Renal Services, Children Services and Long Term Conditions
- The Teenage Pregnancy Strategy

Mainstreaming action to tackle Health Inequalities

- Tackling health inequalities should be mainstreamed within priority programmes. This should be reflected within the formulation and implementation of policy in respect of national and local government which has an impact on health inequalities. Assessing the impact and skewing the benefit of policies to take account of all the dimensions of health inequalities, including the social gradient, giving disproportionate benefit to those suffering material disadvantage or who have traditionally been poorly served.
- The national health inequalities targets need to be embedded in and delivered through mainstream programmes across Government.
- Formulae used by Departments for allocating national resources to sub-national units should reflect the geographical distribution of need
- Where appropriate, challenging floor targets should be set to level up service quality and outcomes.
- Where they do not already exist, mechanisms should be developed to disseminate learning from successful local initiatives including Sure Start and Health Action Zones.
- Progress towards the targets needs to be monitored and tracked using the cross-Government basket of indicators (currently being developed) and actively managed through appropriate performance assessment frameworks, notably that for the NHS, using local delivery targets and milestones

Breaking the cycle of health inequalities

- Reducing poverty, and especially child poverty, through measures in the tax and benefit systems [HM Treasury, DWP]
- Narrowing the gap in the educational attainment of disadvantaged children compared to the population as a whole. [DFES, LEAs]
- Rehabilitating people in receipt of incapacity benefits into employment. [DWP]
- Reducing smoking among pregnant women, including cessation support in maternity services. [DH]
- Reducing the number of teenage pregnancies. [DH (Teenage Pregnancy Unit), DFES]
- Providing high quality antenatal and maternal and child health services and screening programmes, including greater focus on women from low income backgrounds and the needs of black and minority ethnic groups. [DH]
- Improving the educational, social and emotional development of children from disadvantaged backgrounds during their early years to help them take full advantage of opportunities – eg through education and mainstreaming the lessons from Sure Start – for later life. [DH, NHS, DFES (Early years, Childcare and Sure Start)]
- Improving rates of breastfeeding and maternal and infant nutrition. [DH, NHS, FSA]
- Providing supported housing for teenage parents who would otherwise live alone, and supporting teenage parents to return to study or work. [DH (Teenage Pregnancy Unit), DFES, DWP, ODPM]
- Promoting Healthy Schools programmes, especially in disadvantaged areas, as a key means of reducing risk-taking behaviour and encouraging healthy active lifestyles. [DFES, LEAs, DH, FSA, DfT].

Tackling the major killers

- Promoting smoking cessation and tobacco education, in particular among people from manual socio-economic groups and those groups with the highest incidence of smoking rates (including lone parents and those black and minority ethnic groups which show high prevalence), and countering illegal drug use. [DH, NHS, Customs and Excise, HO, Police]

- Levelling up access to prevention, screening, diagnostic and treatment services for CHD and cancer, countering the inverse care law by developing service provision, access and quality in areas and among populations that are least well served in relation to need (eg through improved primary care, prevention and early intervention). [DH]
- Improving diet and nutrition of children (to establish healthy eating patterns early in life) and among disadvantaged groups, especially through increased consumption of fruit and vegetables. [DH, NHS, DEFRA, FSA]
- Promoting greater physical activity, especially among children and disadvantaged groups. [DCMS, DH, NHS, DfES]
- Improving access to sport and leisure facilities (eg swimming pools) in deprived areas and promoting their use – and also increasing uptake of walking and cycling among groups with low participation. [DCMS, LAs, DfT]
- Reducing illness and deaths caused by accidental injury (including through fires), and especially among children in low-income families. [DfT, ODPM, LAs, Fire Service, HO, Police, DH, NHS]
- Ensuring high quality mental health prevention and treatment services, addressing inequalities in access and treatment, and ensuring services are culturally sensitive. [DH]
- Reducing work-related ill-health and injury [HSE, NHS]

Improving access to public services and facilities

- Ensuring services are made accessible to all, including groups that face particular cultural or linguistic barriers. [All].
- Improving access to primary care services (including mental health services), especially in areas (inner city, some rural) which are currently under-served. [DH, NHS]
- Improving the quality of preventive and treatment services for CHD, stroke, diabetes and cancer through NSF implementation, and levelling up access for groups and areas which have been under-served. [DH, NHS]
- Where appropriate, improving service use by taking services to people (eg through NHS outreach). [DH, NHS, others].
- Improving the quality of primary care facilities and premises in disadvantaged areas. [DH]
- Improving access to healthy affordable food. [DH, FSA, LAs, DEFRA, DfT, ODPM, DTI]
- Improving accessibility of disadvantaged groups to core facilities (public services, retail outlets), through improved mainstream and targeted public transport links and through better land use planning. [DfT, ODPM, LAs, DH]
- Make services more joined up so they make sense on the ground and are more convenient for users. [All]

Strengthening disadvantaged communities

- Neighbourhood renewal of deprived areas, including action on work and enterprise, crime, education and skills, health, housing and the physical environment. [Neighbourhood Renewal Unit leading a wide range of other Government Departments and LAs]
- Tackling crime and promoting environments in which people feel safe to go out and which promotes community networks and activity. [HO, LAs, DfT]
- Assisting with the regeneration of disadvantaged areas through the location of public service facilities there, the promotion of local employment policies and local purchasing of goods and services. [LAs, NHS and other areas as possible]
- Improving housing conditions so that everyone can live in a decent home. [ODPM, LAs]

Supporting targeted interventions for specific groups

Including vulnerable members of black and minority ethnic communities, vulnerable older people, people who are unable to heat their homes adequately, rough sleepers, homeless people, travellers, prisoners and their families, refugees and asylum seekers, looked after children and care leavers, vulnerable people with physical or learning disabilities, (long-) term medical conditions or mental health problems.

- Designing services which can meet the complex needs of groups with particularly poor health outcomes, taking a holistic approach and joining up services at the point of delivery. [All]
- Promoting longer life expectancy, improved health and well being among older people and, in particular, reducing excess winter deaths. [DH, LAs and others]
- Improving the quality and availability of housing, especially high quality supported housing, with adaptations if needed, for those who need it – above all for teenage parents, families with young children and for older people on low incomes. [ODPM, LAs]
- Ending fuel poverty. [DEFRA]

Being responsive

- Linking up related services at local level, particularly for families and older people, to provide single points of access which reflect the needs of users not providers. [All]
- Empowering front line staff to be responsive and flexible, eg through devolved budgets and local identification of priorities.

Using information to support action

- Making information available where it is needed to support action, across the range of health inequalities dimensions including ethnic group, gender, age, disability etc. [ONS and all departments]
- Developing the evidence base, particularly on the effectiveness of interventions to address health inequalities. [DH, Health Development Agency, ONS]
- Developing health inequalities impact assessment [DH]

Note: lead Department, authority or service is shown in parentheses. The table focuses on the central and local Government activity, and other partners including the community, voluntary and business sectors are not shown but would need to be involved across the board. Where no lead is shown, a wide range of partners would need to contribute.

Key

| | |
|-------|--|
| DH | Department of Health |
| HMT | Treasury |
| ODPM | Office of the Deputy Prime Minister |
| DfT | Department for Transport |
| DWP | Department of Work and Pensions |
| DfES | Department for Education and Skills |
| LEA | Local Education Authority |
| FSA | Food Standards Agency |
| HO | Home Office |
| Defra | Department for the Environment, Food and Rural Affairs |
| DCMS | Department for Culture, Media and Sport |
| LA | Local Authority |
| HSE | Health and Safety Executive |
| DTI | Department for Trade and Industry |
| ONS | Office for National Statistics |

Annex B

Membership of the Inter-Departmental Group (IDG)

The IDG was chaired by HM Treasury.

The IDG consisted of representatives from the following:

- Audit Commission
- Cabinet Office
- Department for Culture, Media and Sport
- Department for Education and Skills
- Department of the Environment, Food and Rural Affairs
- Department of Health
- Office of the Deputy Prime Minister
- Department for Transport
- Department of Work and Pensions
- HM Treasury
- Home Office
- Local Government Association
- Neighbourhood Renewal Unit
- No 10 Policy Unit
- Social Exclusion Unit
- Sure Start Unit
- Teenage Pregnancy Unit
- Women and Equality Unit

The Review was also supported by prominent academics in the health inequalities field.

Annex C

Terms of reference of the Cross-Cutting Review

Terms of Reference

In support of the Government's objective of narrowing the health gap in childhood and throughout life between socio-economic groups and between the most deprived areas and the rest of the country; and in particular to help ensure that the Government delivers its national health inequalities PSA targets for life expectancy and mortality of children under one year:

1) Developing the evidence base

- building on consultation currently being undertaken by DH, to collate and evaluate the available evidence about the contribution that high quality public services across central and local government can make to tackling the causes of health inequalities;
- to establish a map of available resources and public services that will help tackle the causes of health inequalities;
- to identify the main obstacles arising from existing patterns of resourcing and service provision to delivery of the PSA health inequalities targets;

2) A strategy for delivery

- in the light of the evidence base, to develop a cross-governmental strategy for tackling the causes of health inequalities, that will help ensure delivery of the PSA targets;
- to make recommendations as necessary for better matching existing resources, and any proposed changes in departmental baselines in relevant areas, to health need in the NHS and across government;
- to establish a basket of indicators for monitoring progress against the PSA targets.

Organisation of the review

The lead minister for the review will be the Minister for Public Health. She will co-ordinate work with colleagues from across government and with other stakeholders.

Annex D:

Summary of the Gaps in Health Status

This country has seen increased prosperity and reductions in mortality over the past 20 years, yet differences in health status have persisted between different groups in the population. Many of these gaps are large and in some cases the gaps are wider now than twenty years ago. Figure 8 summarises the extent and nature of this health gap, referring to different types of health inequality and different health indicators. A full discussion of the approach and analysis of the Review are set out in a longer version of this summary at www.doh.gov.uk/healthinequalities

Figure 8

A gap in health status exists:

between social groups

- The difference in **life expectancy** at birth between men in social classes I and V widened from 5.5 years in 1972–6 to 7.4 years in 1997–9; average life expectancy in 1997–9 being 78.5 years in social class I and 71.1 years in social class V. For women this gap increased slightly from 5.3 years to 5.7 years over the same period. Both gaps have narrowed slightly over the 1990s.

between different areas in the country

- Male residents in Manchester can expect to live nearly 8 years fewer than those of Kensington, Chelsea and Westminster, and its female residents can expect to live nearly 7 years fewer (7.7 and 6.6 years respectively).

between the population as a whole and different Black and minority ethnic groups

- In 2000, **infant mortality** among babies of mothers born in Pakistan was 12.2 per 1000 live births, more than double the infant mortality rate for all babies.

between men and women

- Men live, on average, about five years fewer than women (75.4 and 80.2 years respectively).

throughout the lifespan, starting at birth

- The infant mortality rate among children in social class V in 1998–2000 was double that for social class I, with rates rising from 4 deaths per 1000 live births in social class I to 5.4 in social class III (manual), 6.2 in social class IV and 8.1 in social class V. For lone parents the rate was 7.6 deaths per 1000 live births.
- Children in social class V are five times as likely to suffer **accidental death** than their peers in social class I, 83 and 16 per 100,000 respectively. Children in social class V are five times more likely to be killed as pedestrians in road accidents than children in social class I.
- Residential fire deaths for children are 15 times greater for children in social class V compared to those in social class I.

and in different causes of death and ill-health

- The death rate from **coronary heart disease** is 3 times higher among unskilled manual men of working age than among professional men. The death rate in men under 65 years is 1.6 times higher in the North West Region than in the South East. In Manchester, the death rate for people under 65 years is over three times higher than in Kingston & Richmond: 69.3 and 20.6 per 100,000 respectively in 1998–2000.
- A woman in an affluent area is more likely to live for at least five years after a diagnosis of **breast cancer** than a woman in a deprived area (71% surviving for five years as compared with 63%).
- An unskilled working man was, at the time of the 1991 Census, almost four times more likely to commit **suicide** than his professional counterpart. Rates in partly skilled and manual skilled workers were twice as high as the professional group.

Some differences in health status are unavoidable, the consequence of genetic and biological differences

in individuals. But many others are avoidable, the consequence of significant differences in opportunity, access to services and material resources, as well as in personal lifestyle choices. The causes, risk factors and impact of these differences in health status are inherently complex. However, it is clear from figure 8 that health inequalities range across a number of dimensions: for example, by socio-economic class and by geographical area; by ethnicity, age and gender. These risks of early death and ill health have a different impact at different stages of the life course, and appear to be clustered in some geographical areas and around individuals in identifiable groups. Furthermore, health inequalities cross the generations, significantly affecting the life chances and quality of life not only of individuals, but of their children and grandchildren. Such inequalities in health are both avoidable and unjust.



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