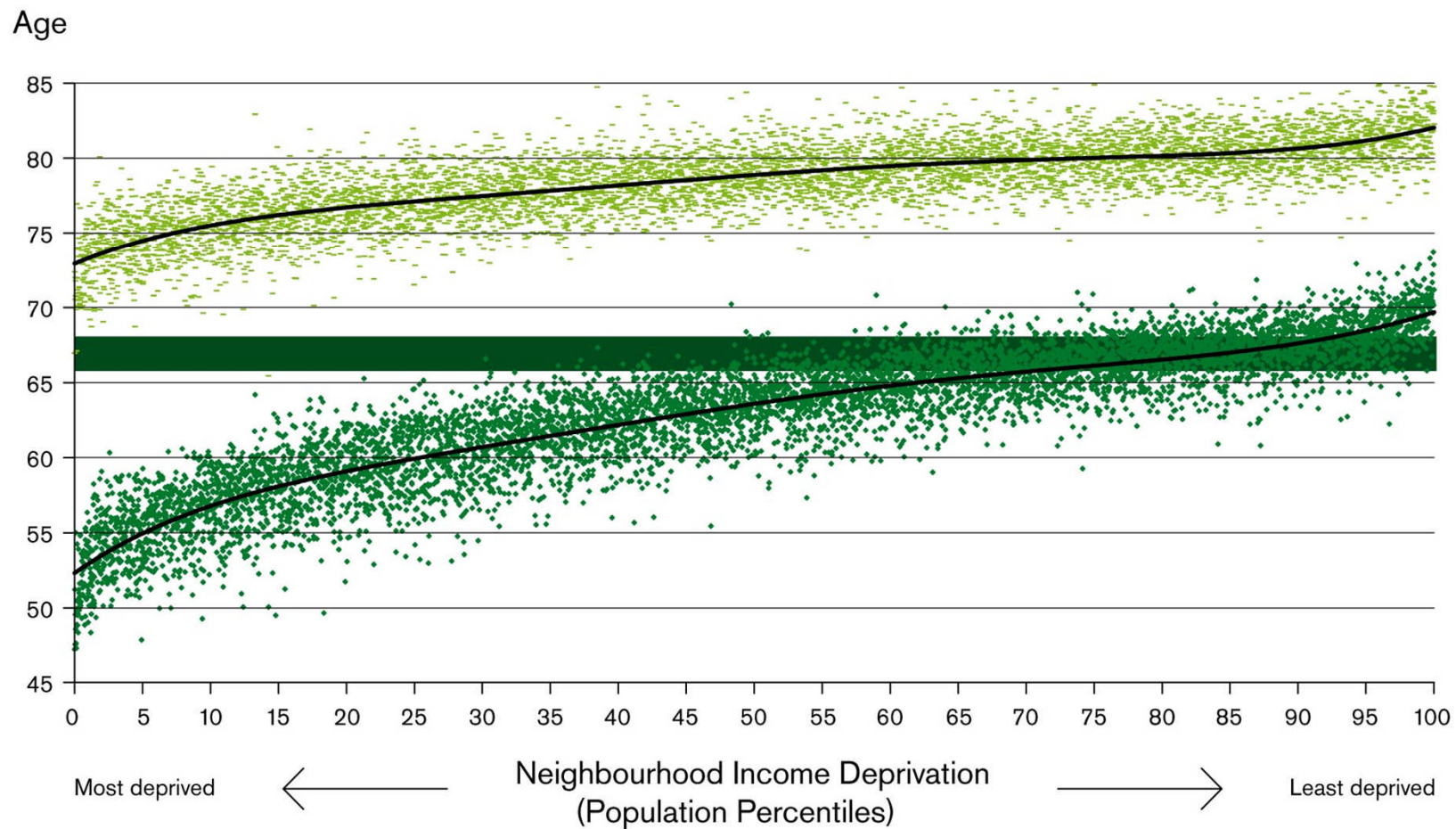# Strategic Review of Health Inequalities in England post-2010

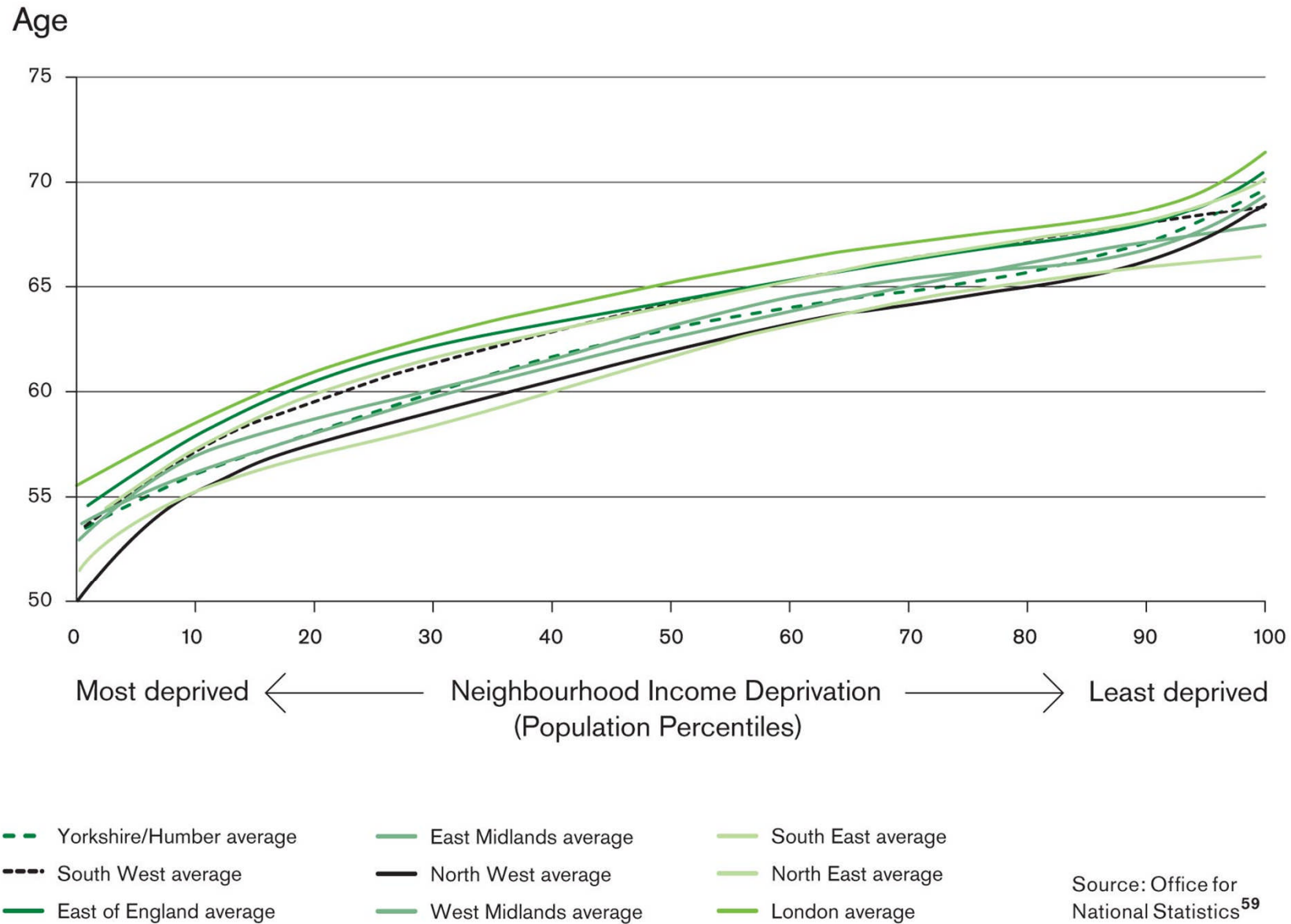**Figure 1** Life expectancy and disability-free life expectancy (DFLE) at birth, persons by neighbourhood income level, England, 1999–2003

Age

Neighbourhood Income Deprivation
(Population Percentiles)

Most deprived ← → Least deprived

Life expectancy
DFLE
Pension age increase 2026–2046

Figure 2.9 Disability-free life expectancy at birth, persons: regional averages at each neighbourhood income level, England, 1999–2003

Age

Most deprived ← Neighbourhood Income Deprivation → Least deprived
(Population Percentiles)

- - - Yorkshire/Humber average
-•-•- South West average
——— East of England average

——— East Midlands average
——— North West average
——— West Midlands average

——— South East average
——— North East average
——— London average

Key themes

Reducing health inequalities is a matter of fairness and social justice

Action is needed to tackle the social gradient in health – Proportionate universalism

Action on health inequalities requires action across all the social determinants of health

Reducing health inequalities is vital for the economy – cost of inaction

Beyond economic growth to well-being

Strategic Review of Health Inequalities in England post-2010

Cost of Inaction

- In England, dying prematurely each year as a result of health inequalities, between 1.3 and 2.5 million extra years of life.

- **Cost of doing nothing**

- Action taken to reduce health inequalities will benefit society in many ways. It will have economic benefits in reducing losses from illness associated with health inequalities. Each year in England these account for:
  - productivity losses of £31-33B
  - reduced tax revenue and higher welfare payments of £20-32B and
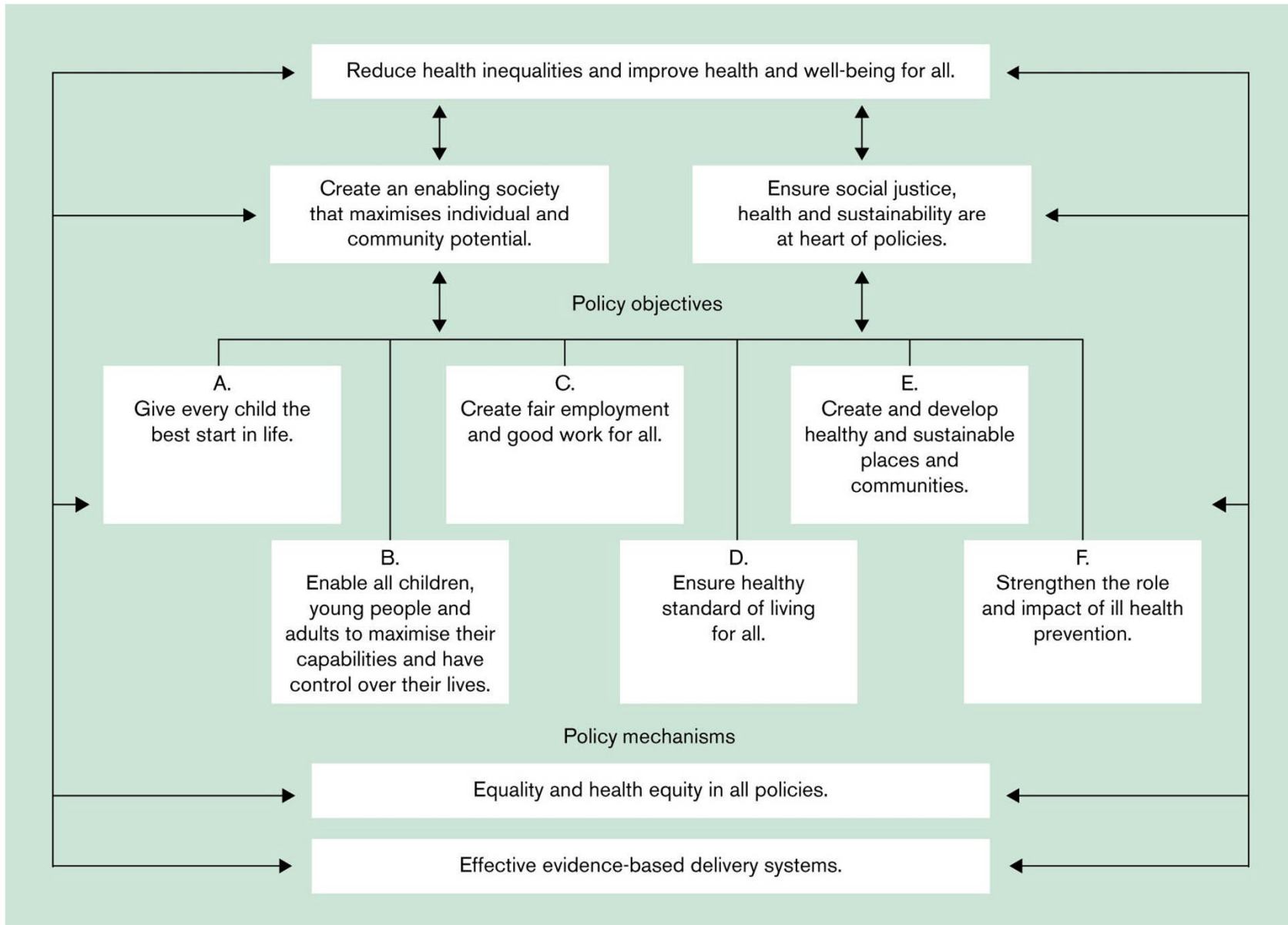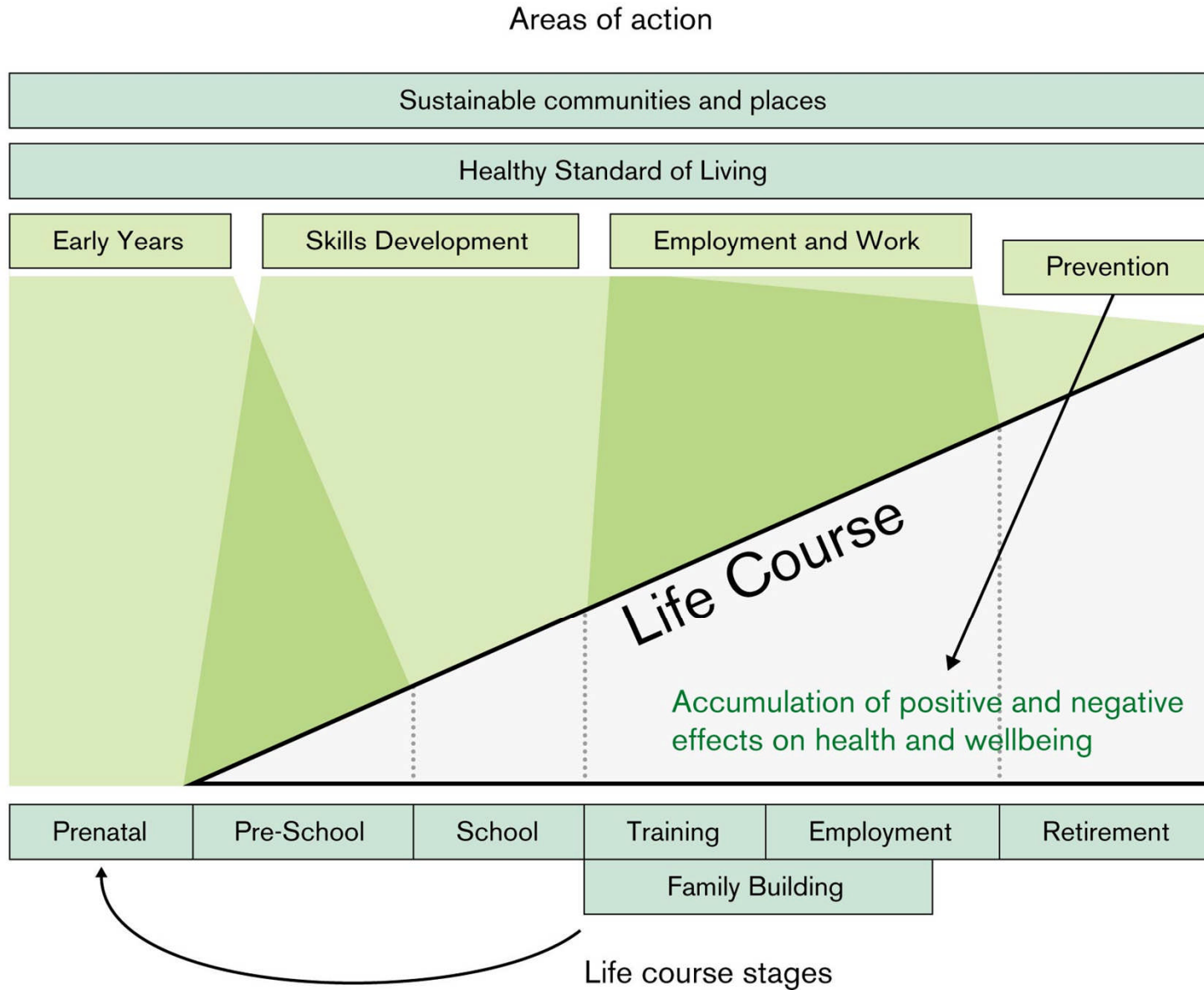 - increased treatment costs well in excess of £5B.

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Figure 4 The Conceptual framework

Reduce health inequalities and improve health and well-being for all.

Create an enabling society that maximises individual and community potential.

Ensure social justice, health and sustainability are at heart of policies.

Policy objectives

A. Give every child the best start in life.

C. Create fair employment and good work for all.

E. Create and develop healthy and sustainable places and communities.

B. Enable all children, young people and adults to maximise their capabilities and have control over their lives.

D. Ensure healthy standard of living for all.

F. Strengthen the role and impact of ill health prevention.

Policy mechanisms

Equality and health equity in all policies.

Effective evidence-based delivery systems.

Figure 5 Action across the life course

Areas of action

| Sustainable communities and places |
| Healthy Standard of Living |

| Early Years | Skills Development | Employment and Work |

Prevention

Life Course

Accumulation of positive and negative effects on health and wellbeing

| Prenatal | Pre-School | School | Training | Employment | Retirement |

Family Building

Life course stages

POLICY OBJECTIVE A

Give Every Child the Best Start in Life

Figure 2.20 Links between socioeconomic status and factors affecting child development, 2003–4

Birth weight

Kg

Socioeconomic status

Mother suffered post-natal depression

Percent

Socioeconomic status

Read to every day at age 3

Percent

Socioeconomic status

Regular bed times at age 3

Percent

Socioeconomic status
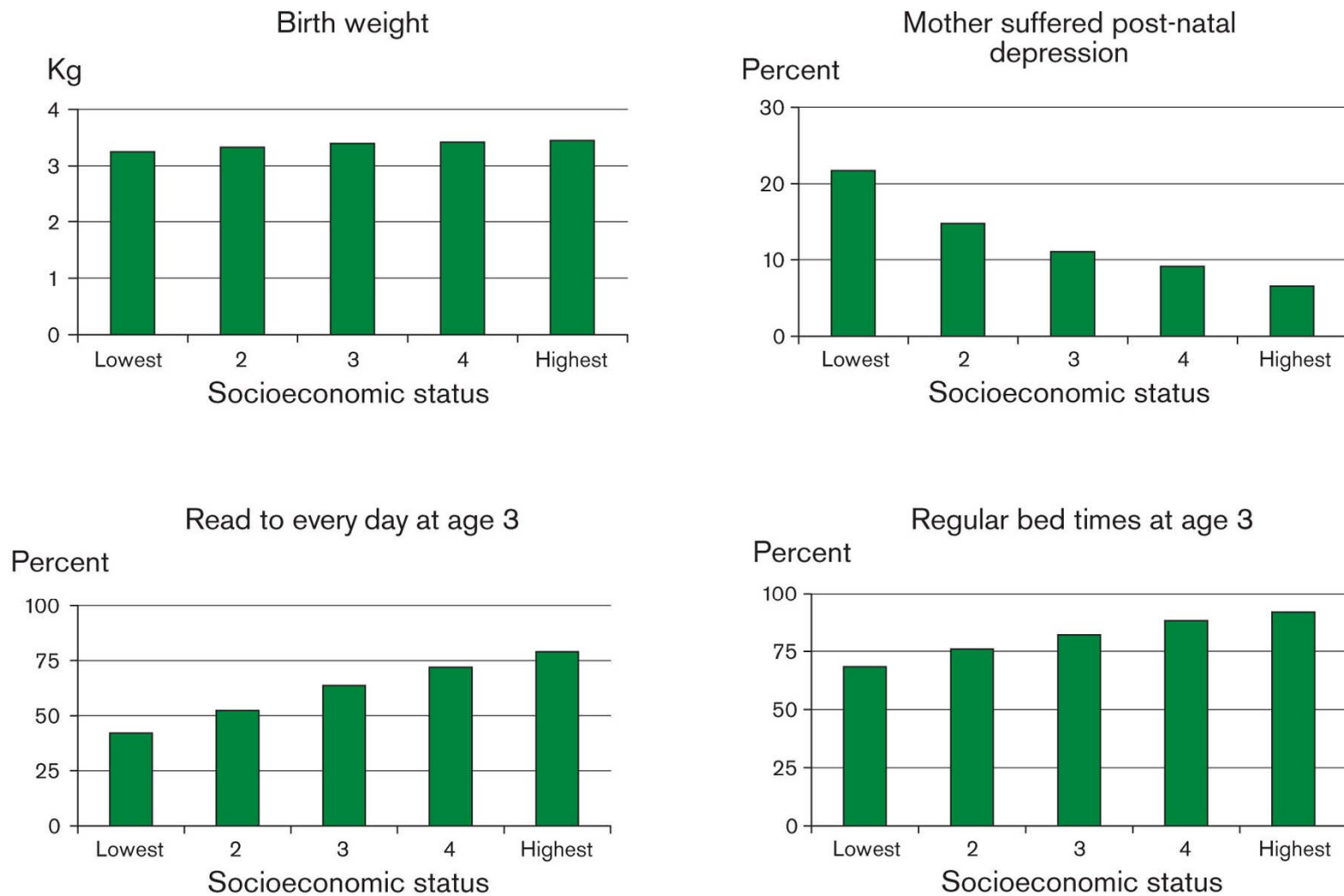
Source: Department for Children, Schools and Families[93]

Figure 6 Inequality in early cognitive development of children in the 1970 British Cohort Study, at ages 22 months to 10 years

Average position in distribution

High Q at 22m

Low Q at 22m

Months

High socioeconomic status

Low socioeconomic status

Note: Q = cognitive score
Source: 1970 British Cohort Study[17]
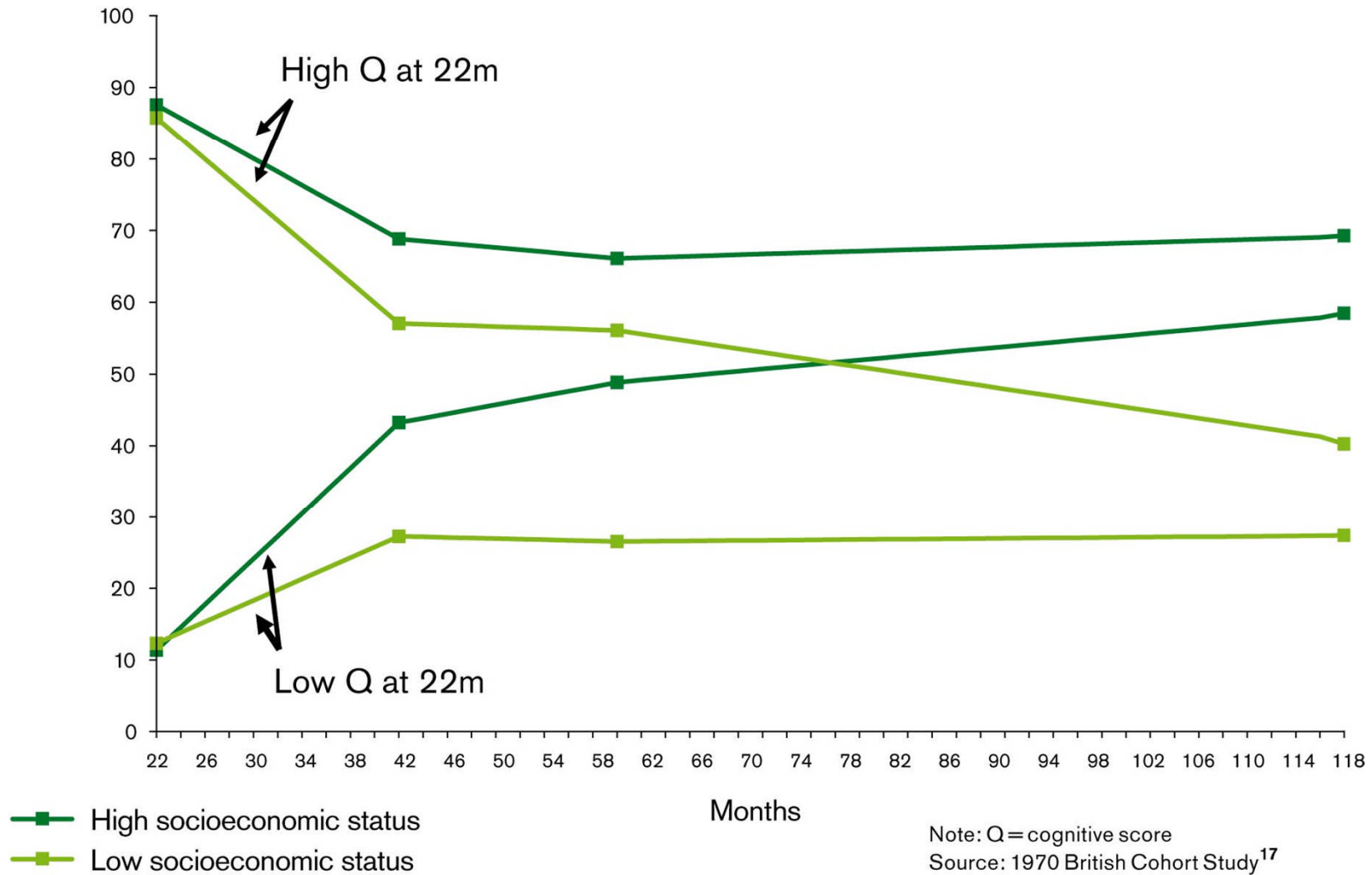
Figure 2.22 Indicators of school readiness by parental income group, 2008

Average percentile
score

Test Score
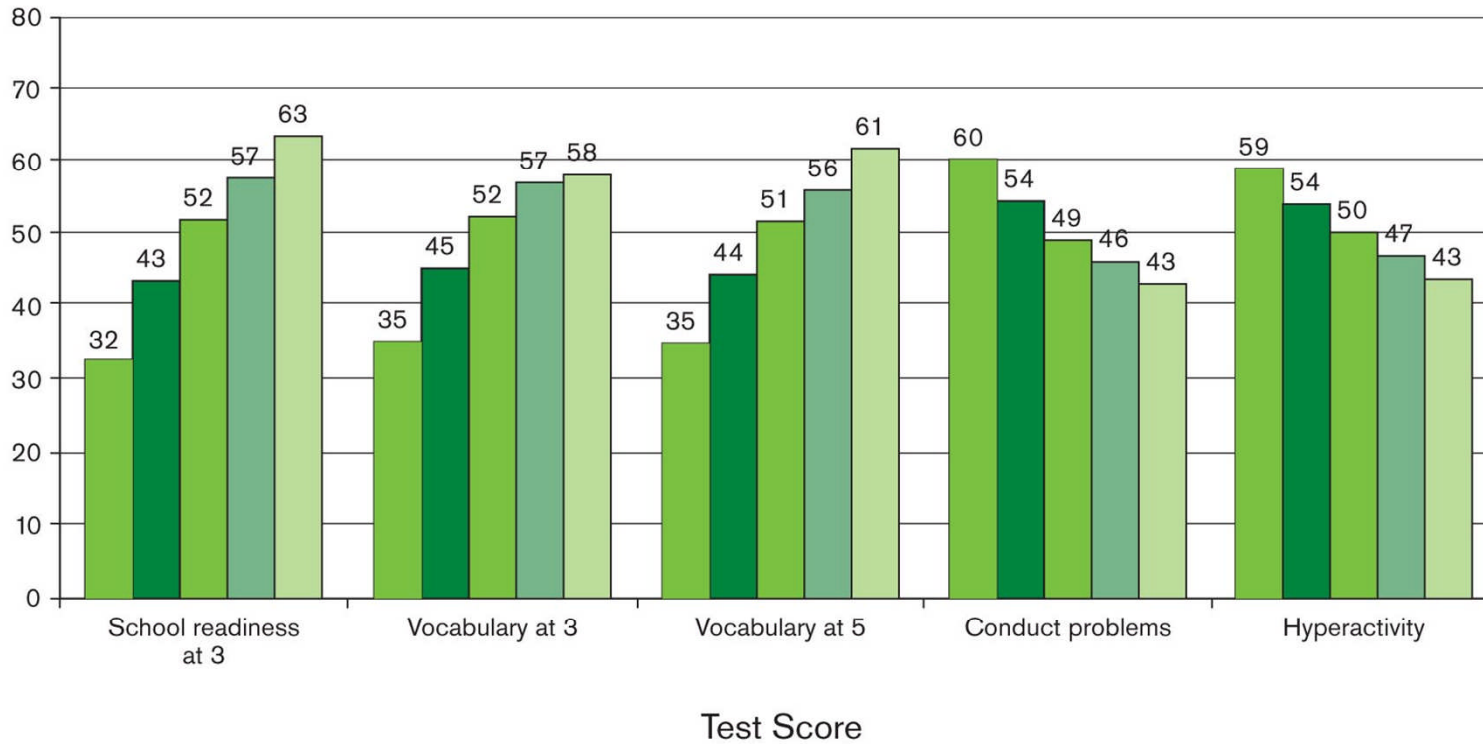
Income Q1
Income Q2
Income Q3
Income Q4
Income Q5

Source: Washbrook and Waldfogel[106]

Figure 4.2 Reading at age 11 by social class and pre-school experience, findings from the Effective Provision of Pre-School Eduction Project (EPPE), 2008
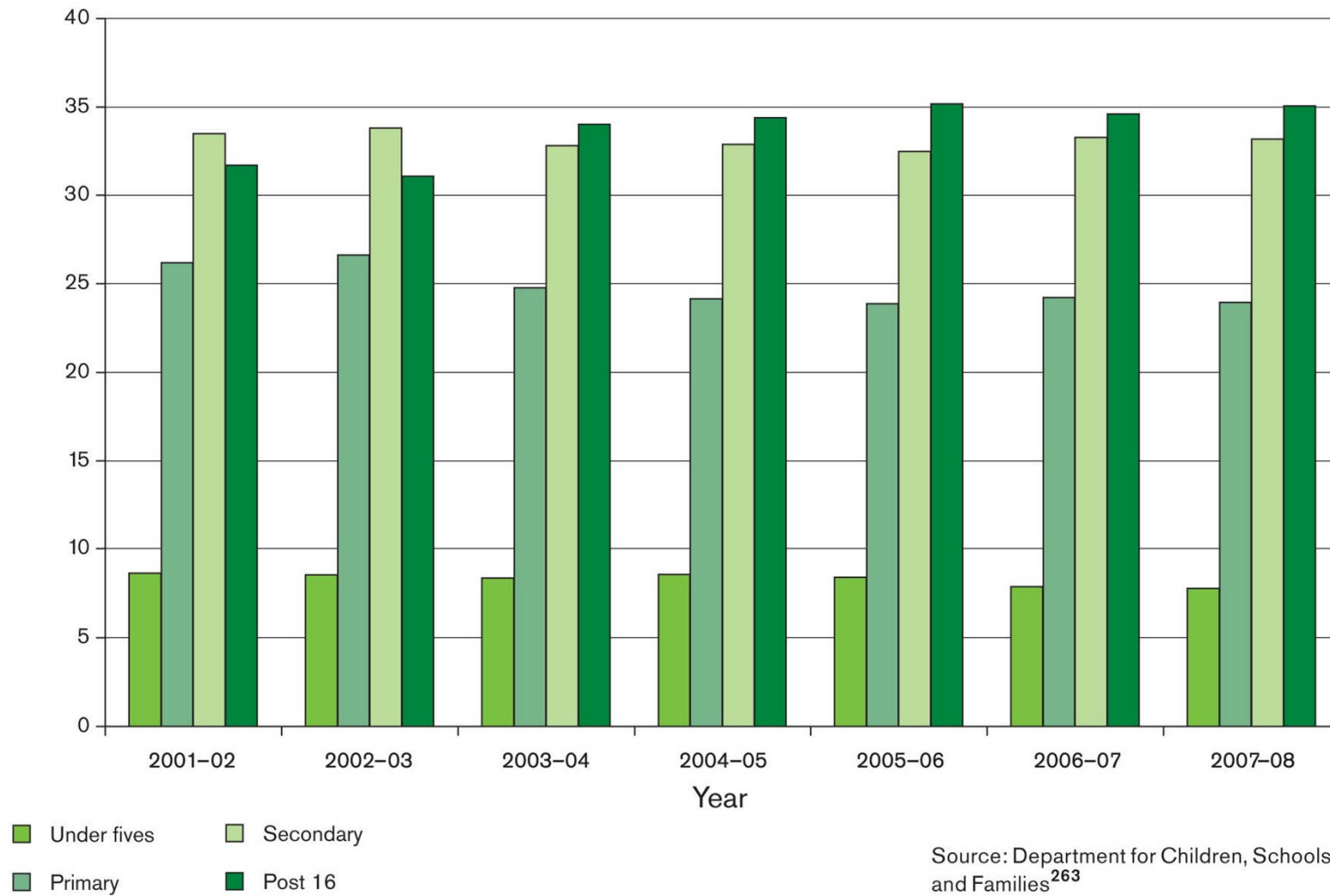
Mean Year 6
reading level

Social Class
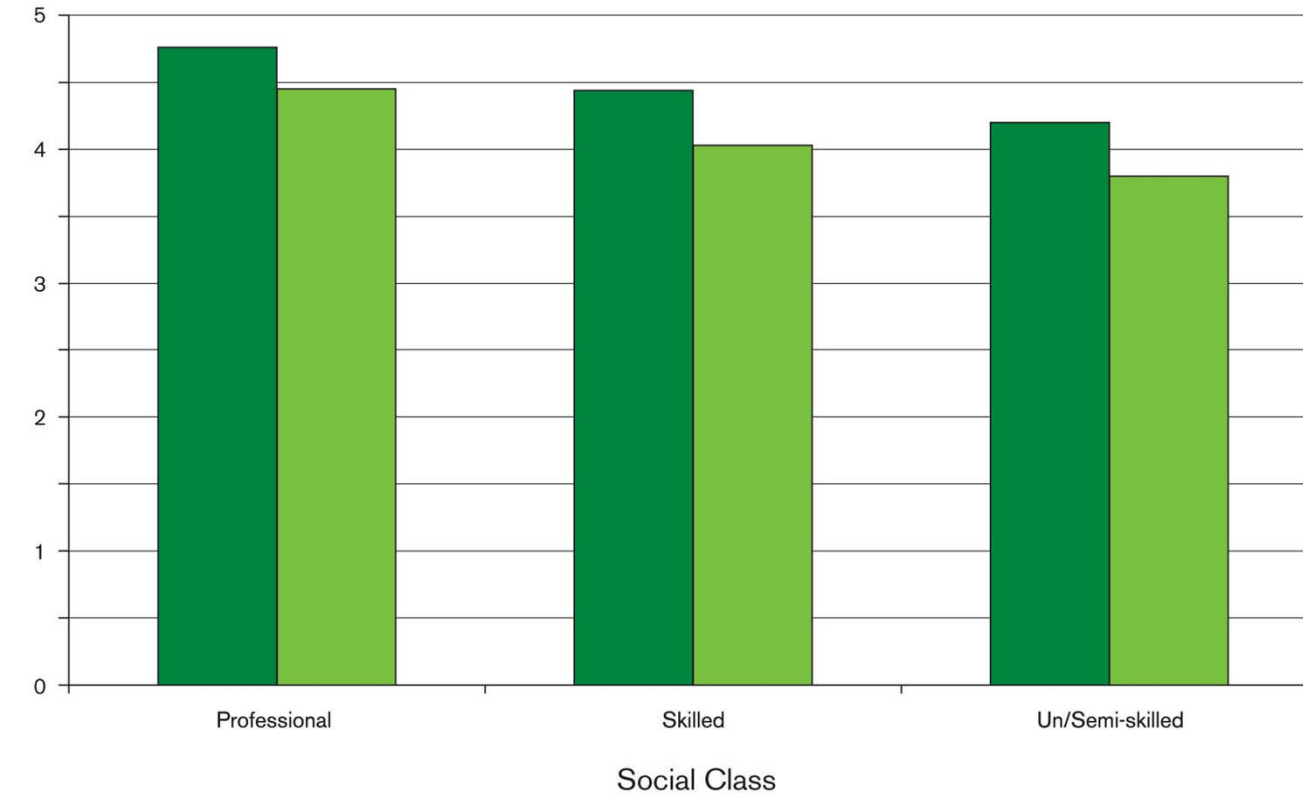
■ Preschool
■ No Preschool

Figure 4.1 Education expenditure by age group, 2001–8

Percent

Source: Department for Children, Schools and Families[263]

Policy Objective A

Recommendations

- Increase proportion of expenditure allocated to early years

- Support families (pre and post natal, parenting, parental leave, transition points)
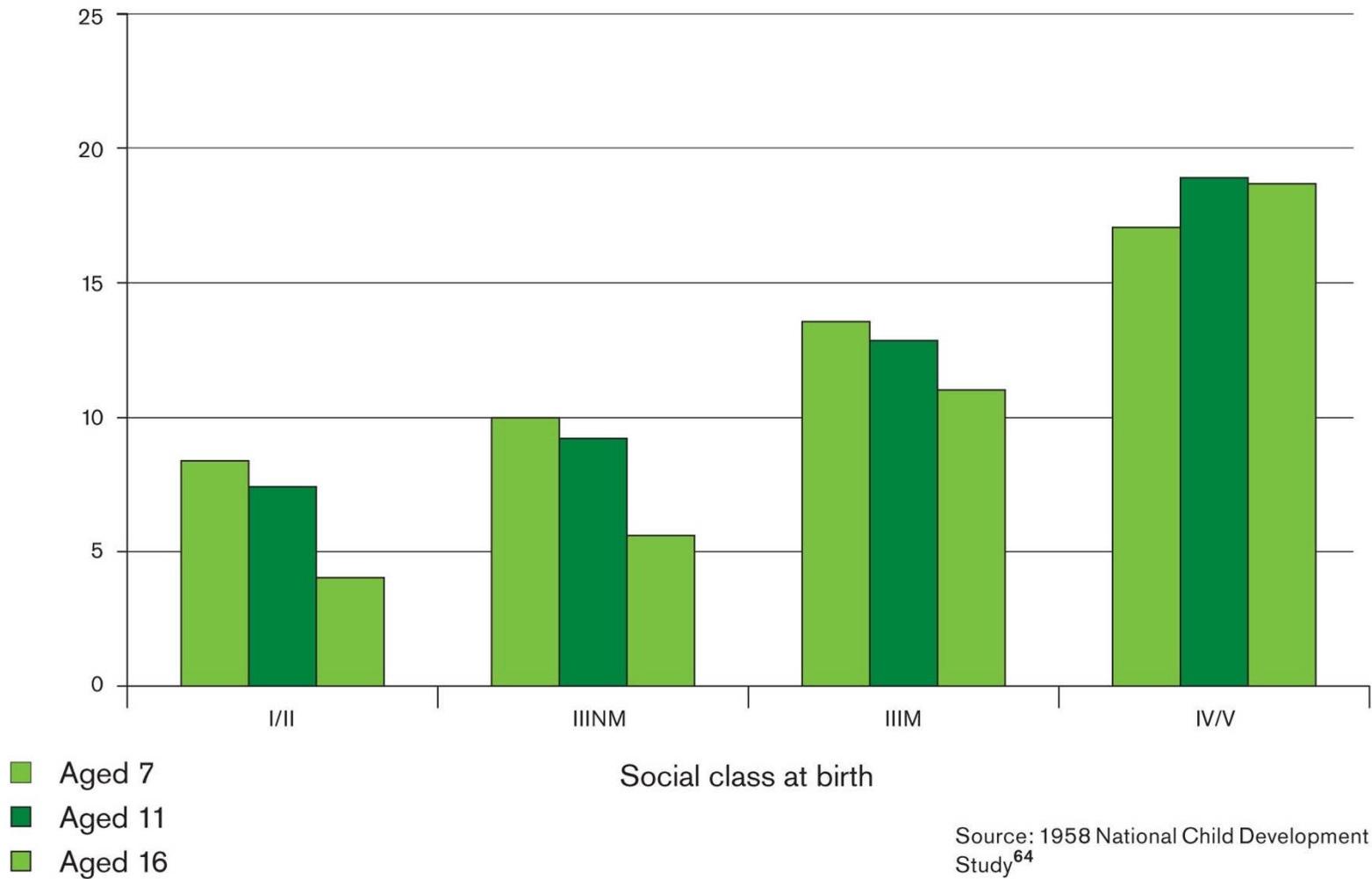
- Quality early years and outreach

POLICY OBJECTIVE B

Enable all young people, children and adults to maximise their capabilities and take control over their own lives

Strategic Review of Health Inequalities in England post-2010

Figure 2.12 Rates of poor social/emotional adjustment at ages 7, 11 and 16, by father's social class at birth, 1958 National Child Development Study
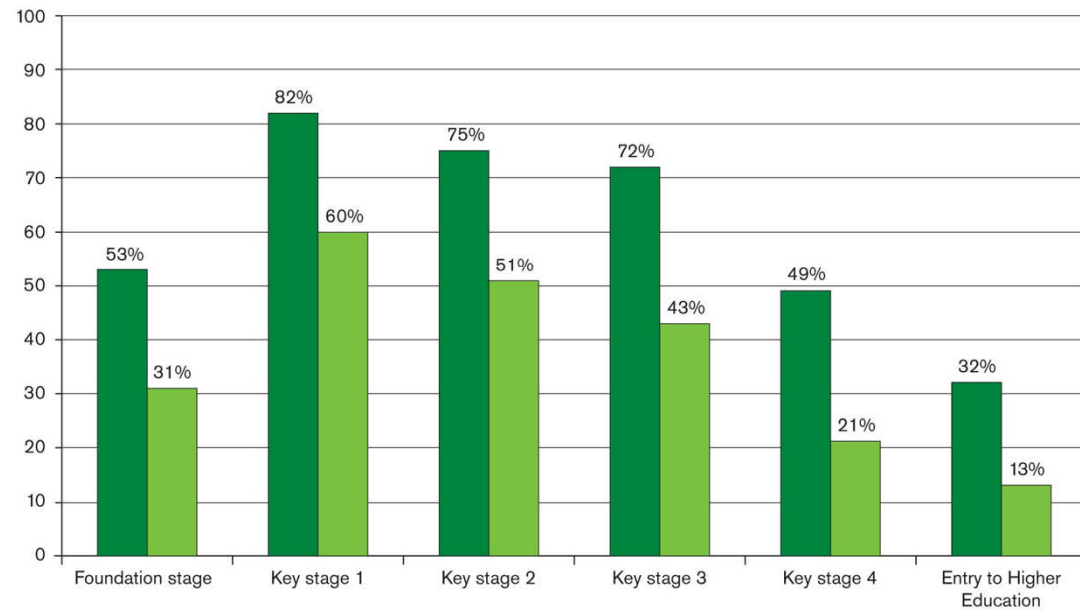
Percent poor adjustment

Social class at birth

- Aged 7
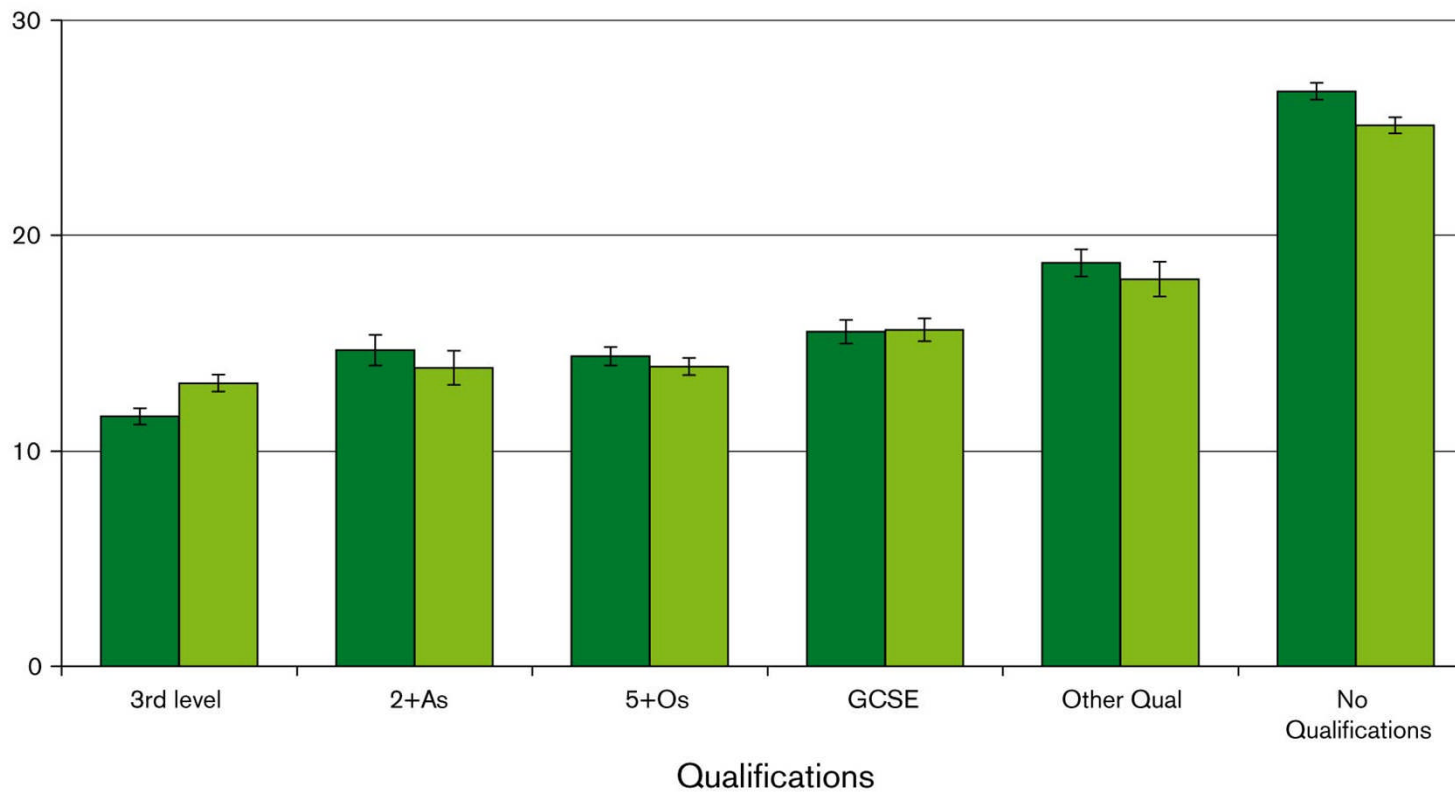- Aged 11
- Aged 16

Percentage reaching
expected level

- Not eligible for free school meals
- Eligible for free school meals

Source: Department for Children,
Schools and Families and Higher
Education Statistics Agency[107]

Figure 7 Standardised limiting illness rates in 2001 at ages 16–74, by education level recorded in 2001

Percent ill

Qualifications

■ Males
■ Females

Policy Objective B

Recommendations

- Continued priority to reducing inequalities in education outcomes

- Prioritise inequalities in life skills (whole child approach, full service schools, workforce)

- Increase access and use of quality lifelong learning (16-25 yr old support, work based learning, non-vocational courses)

POLICY OBJECTIVE C

Create Fair Employment and Good Work for All

Figure 8 Mortality of men in England and Wales in 1981–92, by social class and employment status at the 1981 Census

Standardised Mortality Rate

Employed in 1981

Unemployed in 1981

Social Class
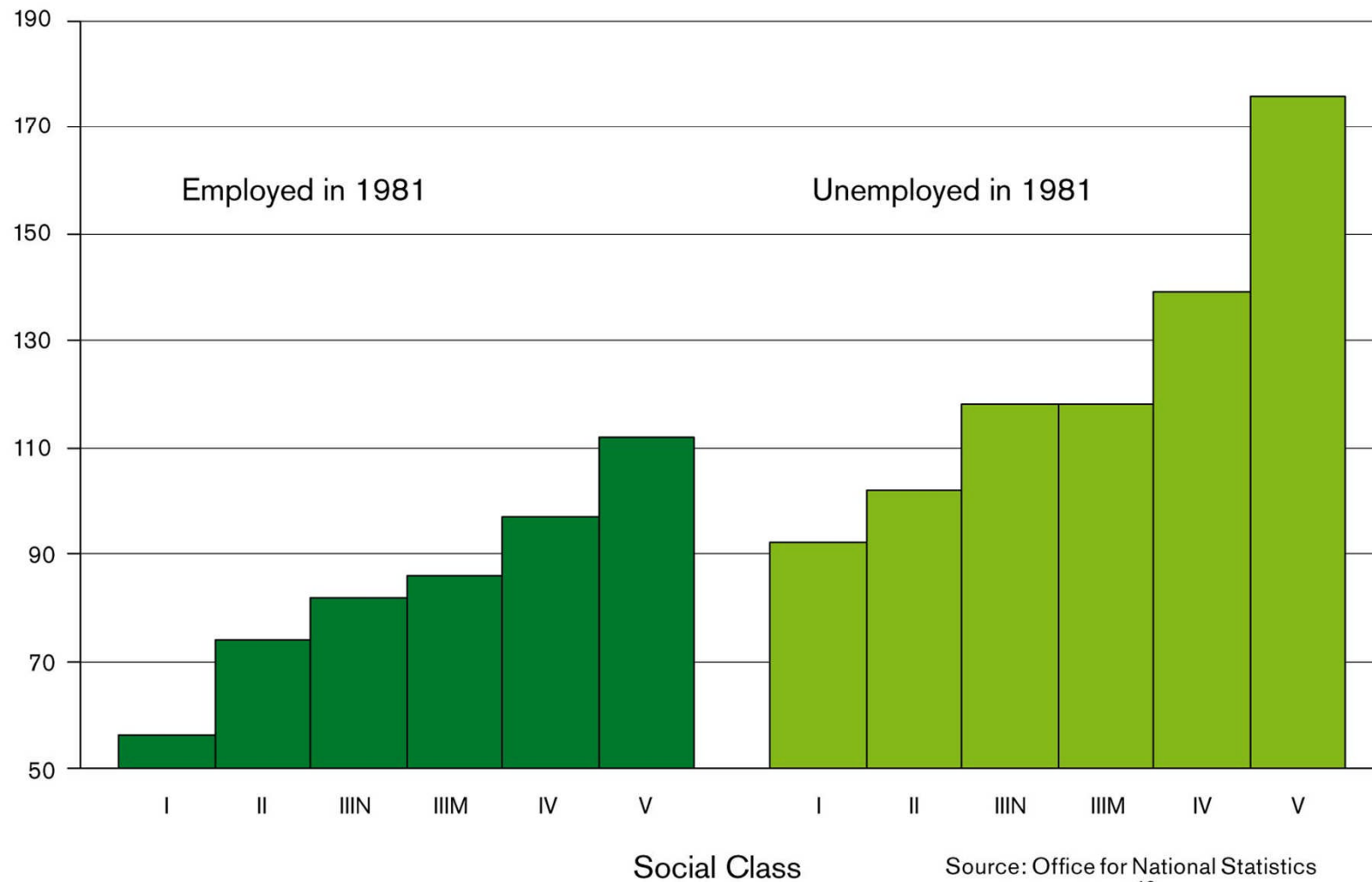
Source: Office for National Statistics Longitudinal Study[19]

Figure 2.33 The association of civil service grade with job control, Whitehall II study, 1985–88
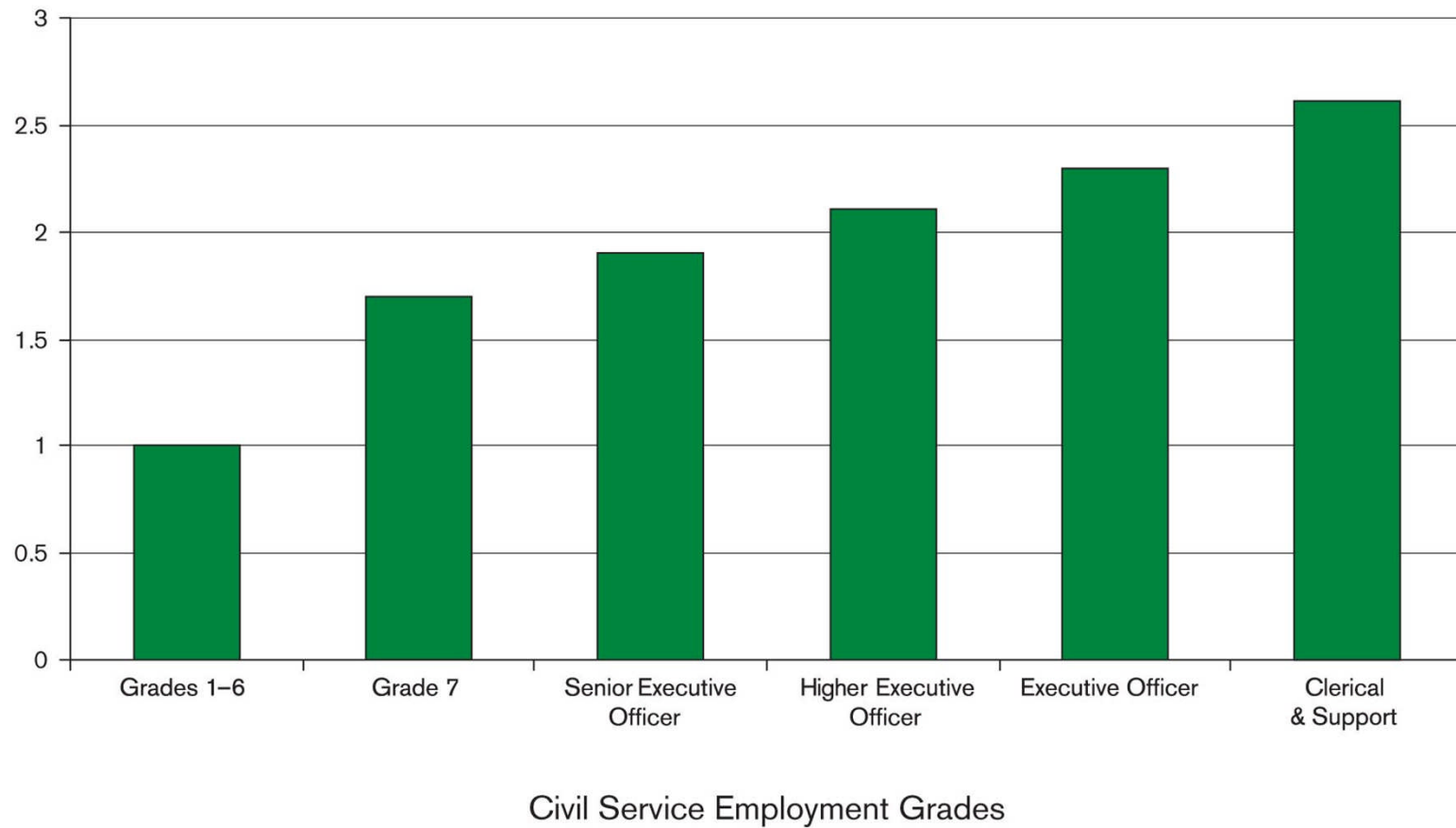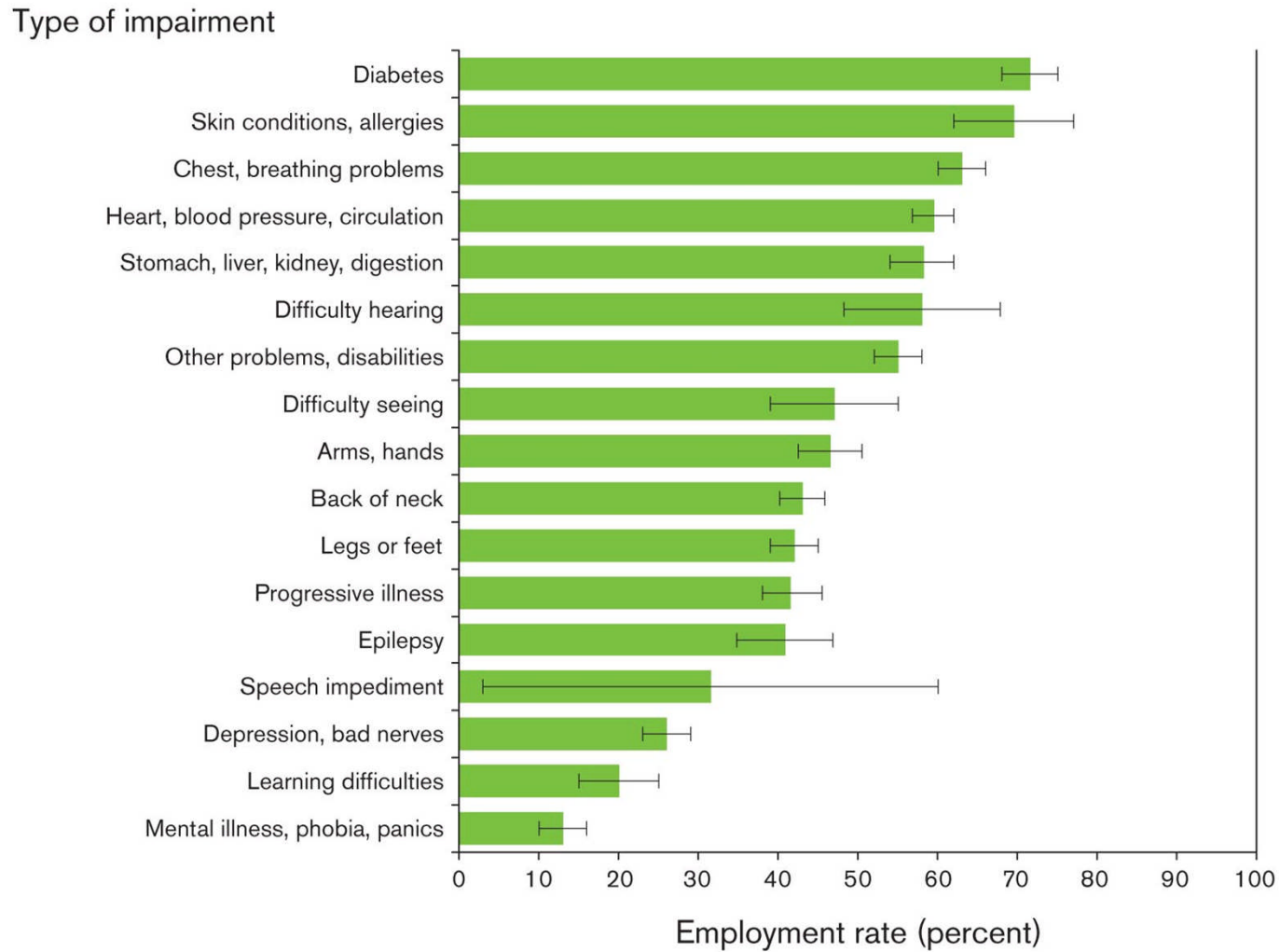
Score

Civil Service Employment Grades
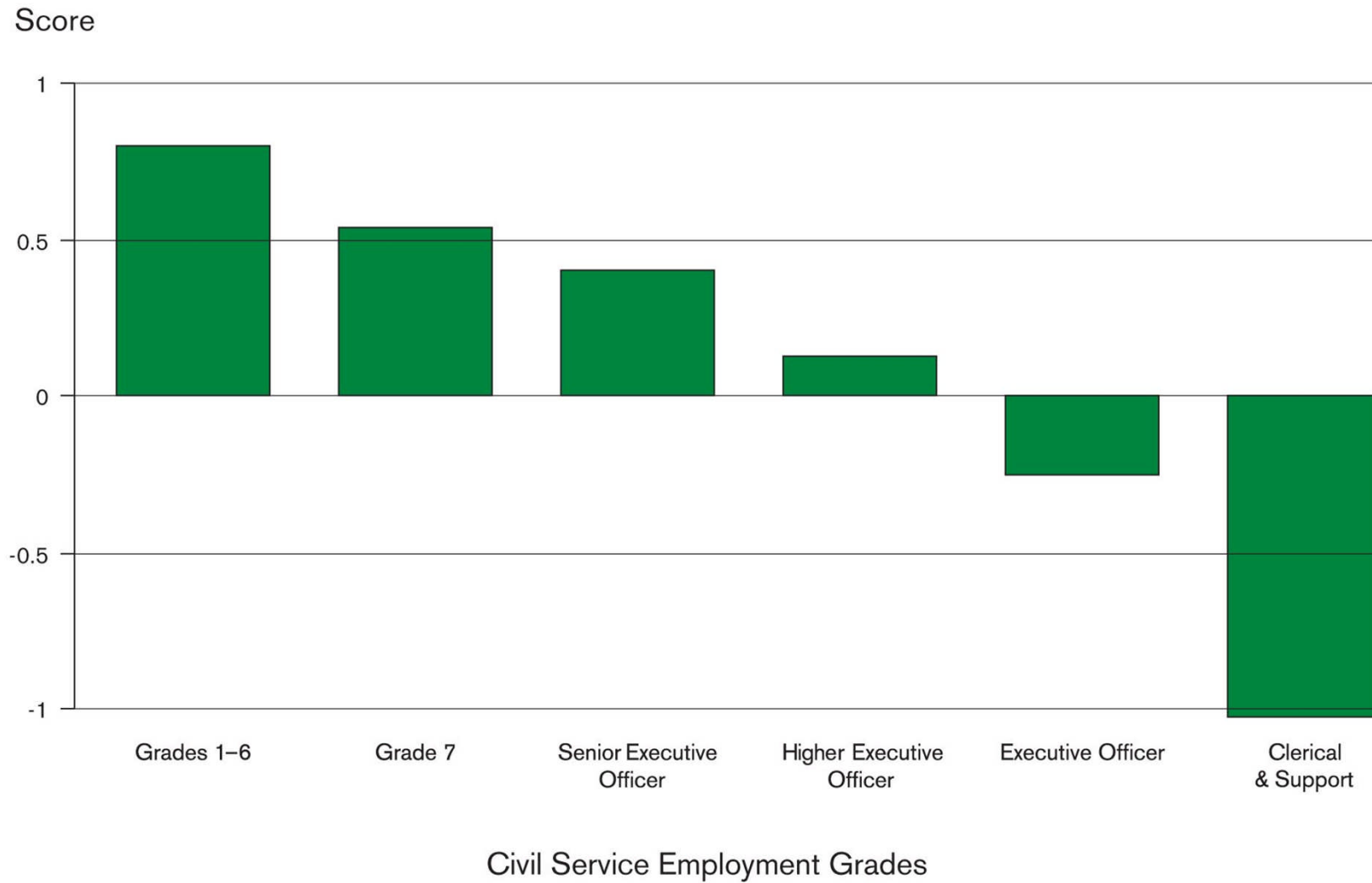
Figure 2.34 The social gradient in the metabolic syndrome, Whitehall II study, 1991–1993

Odds Ratios

Civil Service Employment Grades

Figure 2.30 Employment rates among working age adults by type of disability, 2008

Type of impairment

Type of impairment	
Diabetes	
Skin conditions, allergies	
Chest, breathing problems	
Heart, blood pressure, circulation	
Stomach, liver, kidney, digestion	
Difficulty hearing	
Other problems, disabilities	
Difficulty seeing	
Arms, hands	
Back of neck	
Legs or feet	
Progressive illness	
Epilepsy	
Speech impediment	
Depression, bad nerves	
Learning difficulties	
Mental illness, phobia, panics	

Employment rate (percent)

Note: For each disability, the percentage employed are indicated by the solid horizontal bar. Horizontal lines (—) indicate the width of the 95 per cent confidence interval.

Source: Office of Disability Issues, based on Labour Force Survey[132]

Policy Objective C

Recommendations

- Prioritise active labour market programmes

- Quality of jobs improved (equality legislation, well being, stress and mental health at work)

- Security and flexibility of employment (retirement and people with poor health and caring responsibilities)
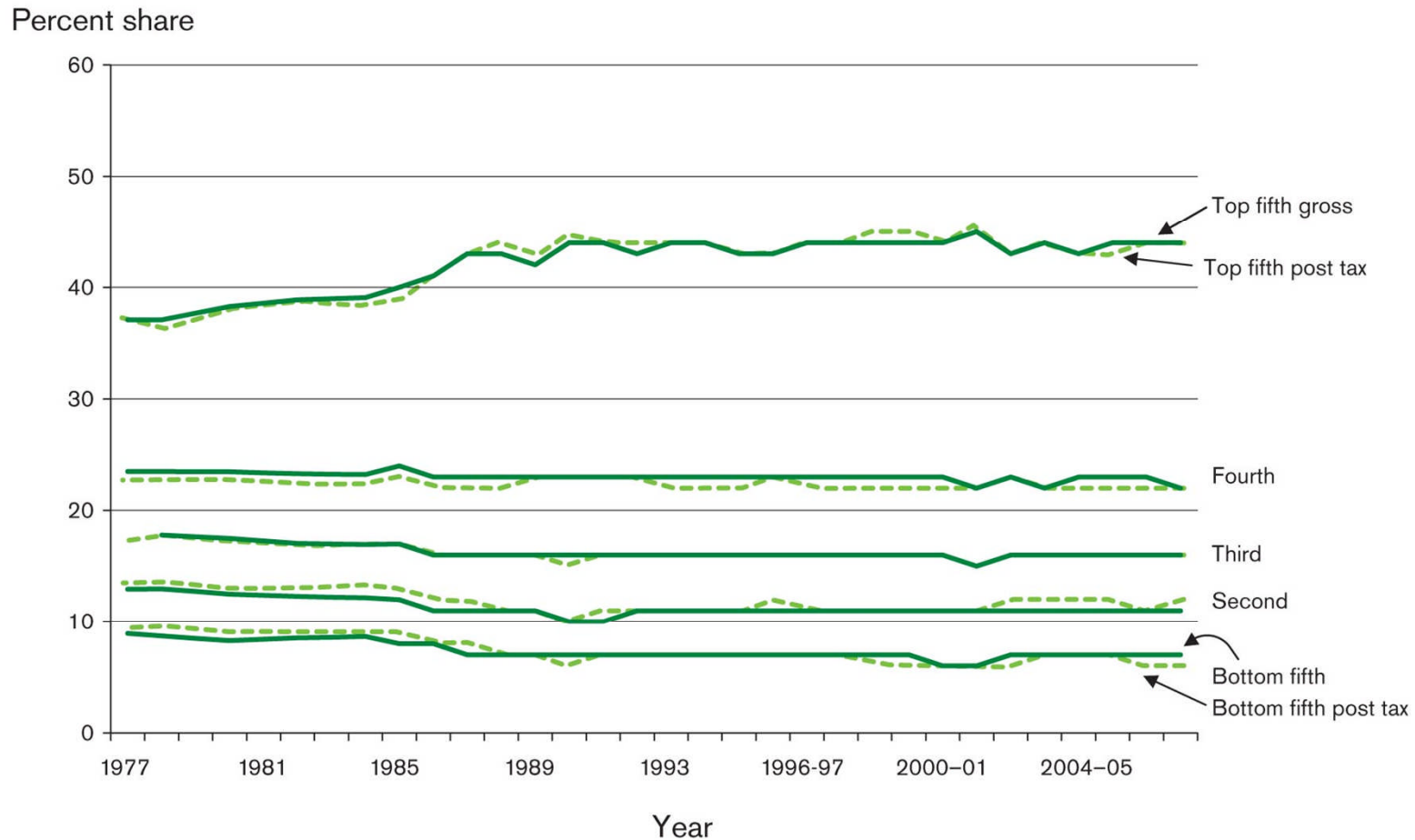
Strategic Review of Health Inequalities in England post-2010

POLICY OBJECTIVE D

Ensure Healthy Standard of Living for All

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Figure 2.37 Percentage shares of equivalised total gross and post-tax income, by quintile groups for all households, 1978–2007/8

Percent share

Note: Gross income comprises original income and direct cash benefits (e.g. pensions, child benefit, housing benefit and income support). Post-tax income comprises gross income after direct and indirect taxes (e.g. VAT).

Source: Office for National Statistics[148]

Figure 9 Taxes as a percentage of gross income, by quintile, 2007/8

Percent

Quintile of household equivalised disposable income
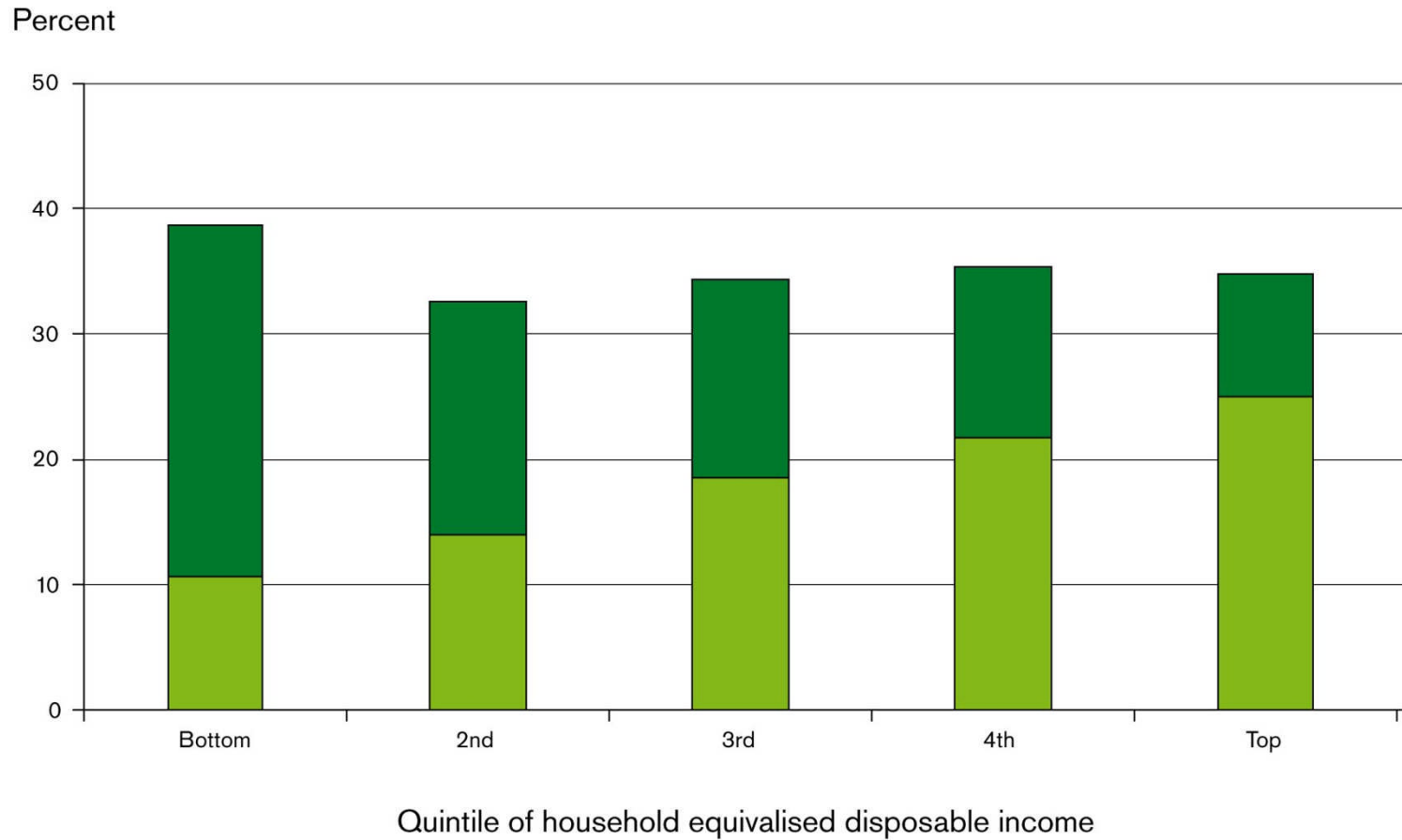
■ All indirect taxes
■ All direct taxes

Policy Objective D

Recommendations

- Minimum Income for healthy living
- Remove cliff edges
- Review taxation and welfare system

POLICY OBJECTIVE E

Create and develop healthy and sustainable places and communities

Figure 10 Populations living in areas with, in relative terms, the least favourable environmental conditions, 2001–6

Percentage of
the population

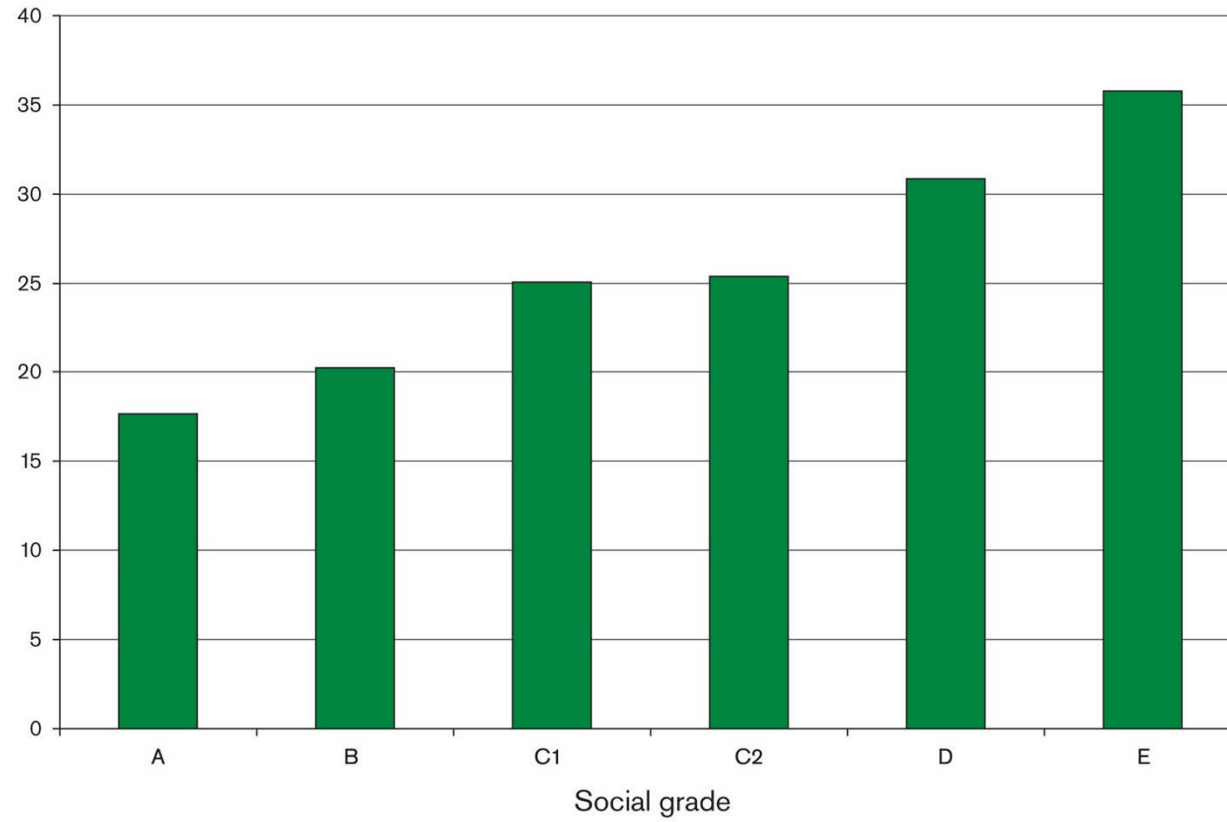Least deprived areas ⟵ **Level of deprivation** ⟶ Most deprived areas
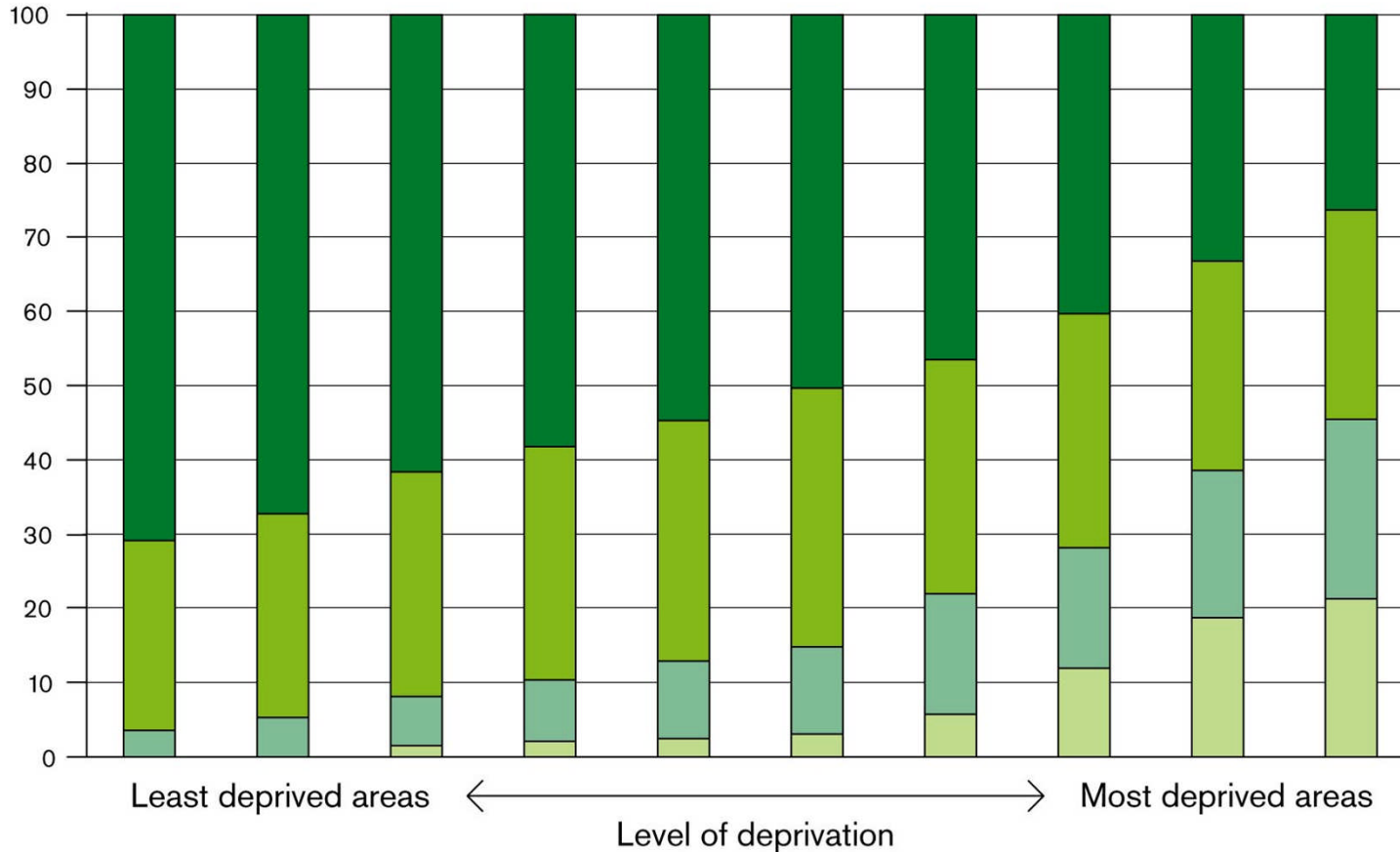
■ No conditions ■ 1 condition ■ 2 conditions ■ 3 or more conditions

Environmental conditions: river water quality, air quality, green space, habitat favourable to bio-diversity, flood risk, litter, detritus, housing conditions, road accidents, regulate sites (e.g. landfill)

Source: Department for Environment, Food and Rural Affairs[23]

Figure 4.7 Percentage of population by social grade who visit a green space infrequently in a year, 2009

Percent of population

Figure 4.10 Percentage of those lacking social support, by deprivation of residential area, 2005

Least deprived: Some lack 23%, Severe lack 12%
Second quintile: Some lack 25%, Severe lack 13%
Third quintile: Some lack 24%, Severe lack 13%
Fourth quintile: Some lack 25%, Severe lack 16%
Most deprived: Some lack 26%, Severe lack 19%

Legend:
■ Some lack
■ Severe lack
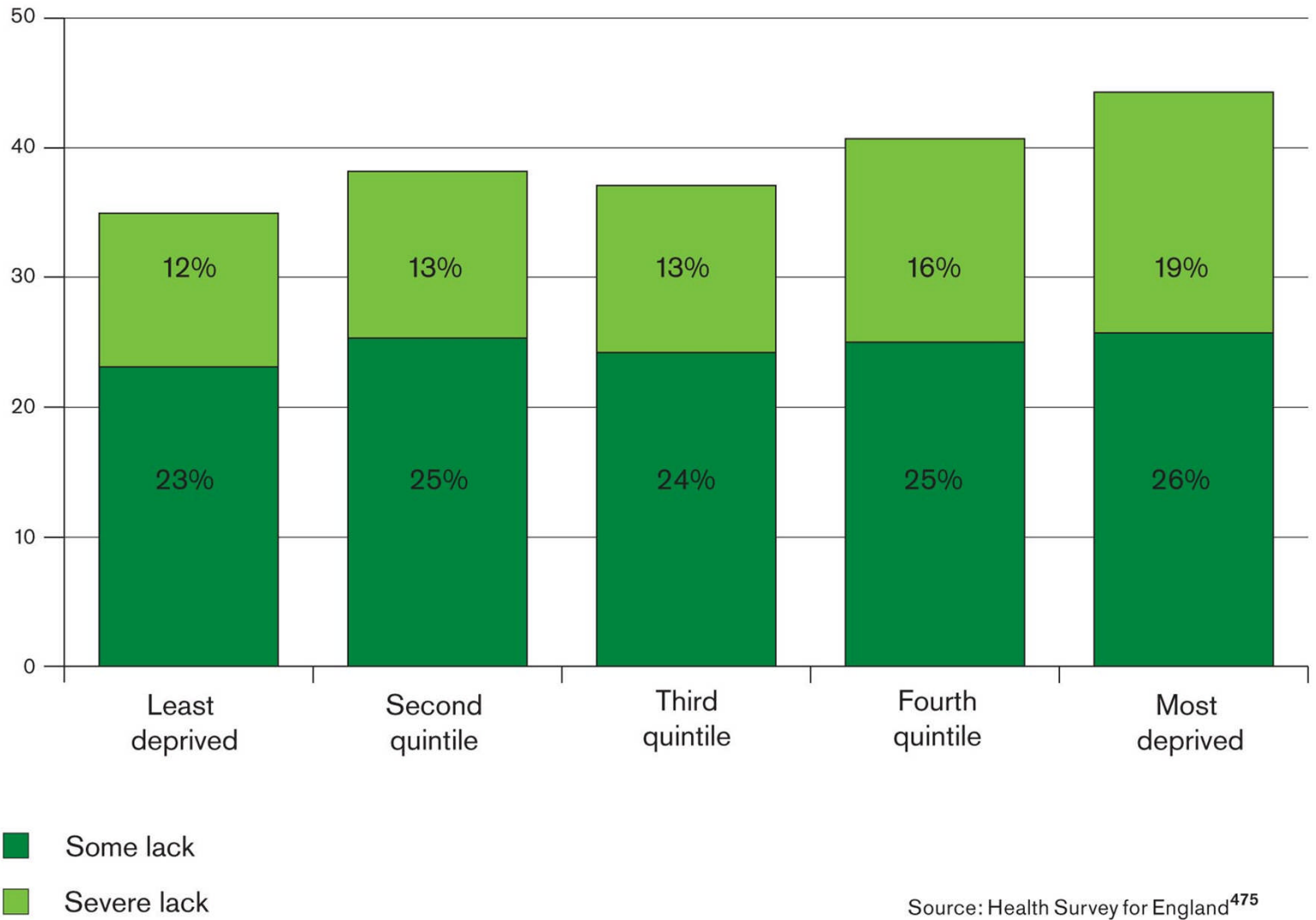
Figure 2.41 Distance travelled per person per year in Great Britain, by household income quintile and mode, 2008

Distance travelled
(miles)

12,000

10,000

8,000

6,000

4,000

2,000

0

Lowest   Second   Third   Fourth   Highest

Income quintile

Legend:
- Other public transport
- Taxi and minicab
- Rail
- Bus and coach
- Other private transport
- Car passenger
- Car driver
- Cycle
- Walk
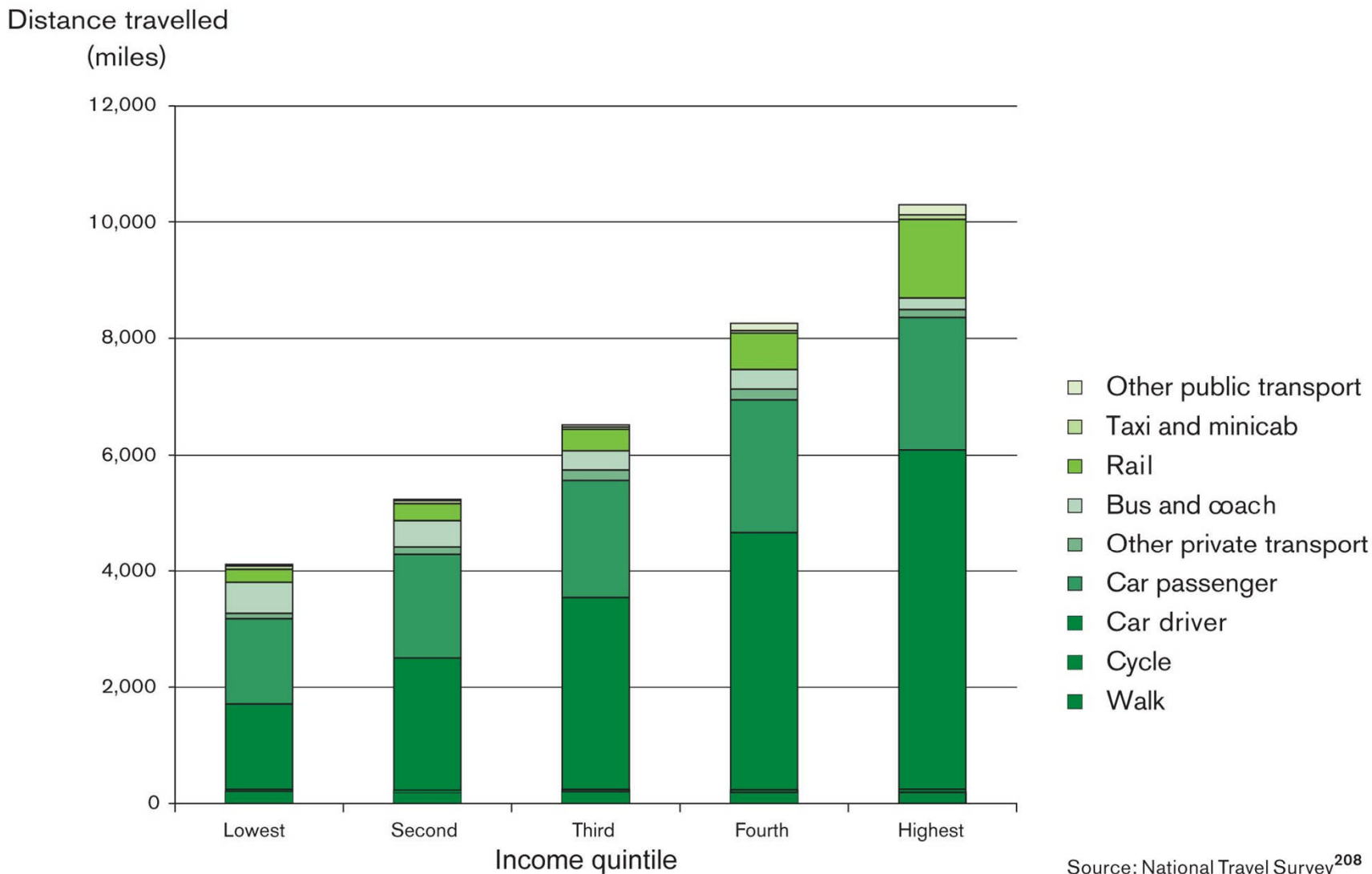
Policy Objective E

Recommendations

- Combining policies to mitigate climate change and health (active travel, green space, food environment, energy efficiency)

- Integrate planning, transport, housing environmental and health systems

- Regeneration based on reducing social isolation and remove barriers to action

POLICY OBJECTIVE F

Strengthen the Role and Impact of Ill Health Prevention

Figure 2.13 Percentage of (a) males and (b) females smoking, by socioeconomic class (NS-SEC), 2001–7

(a) Males

Percent

Year

Managerial and professional

Intermediate

Routine and manual

Note: NS-SEC=National Statistics Socioeconomic Classification
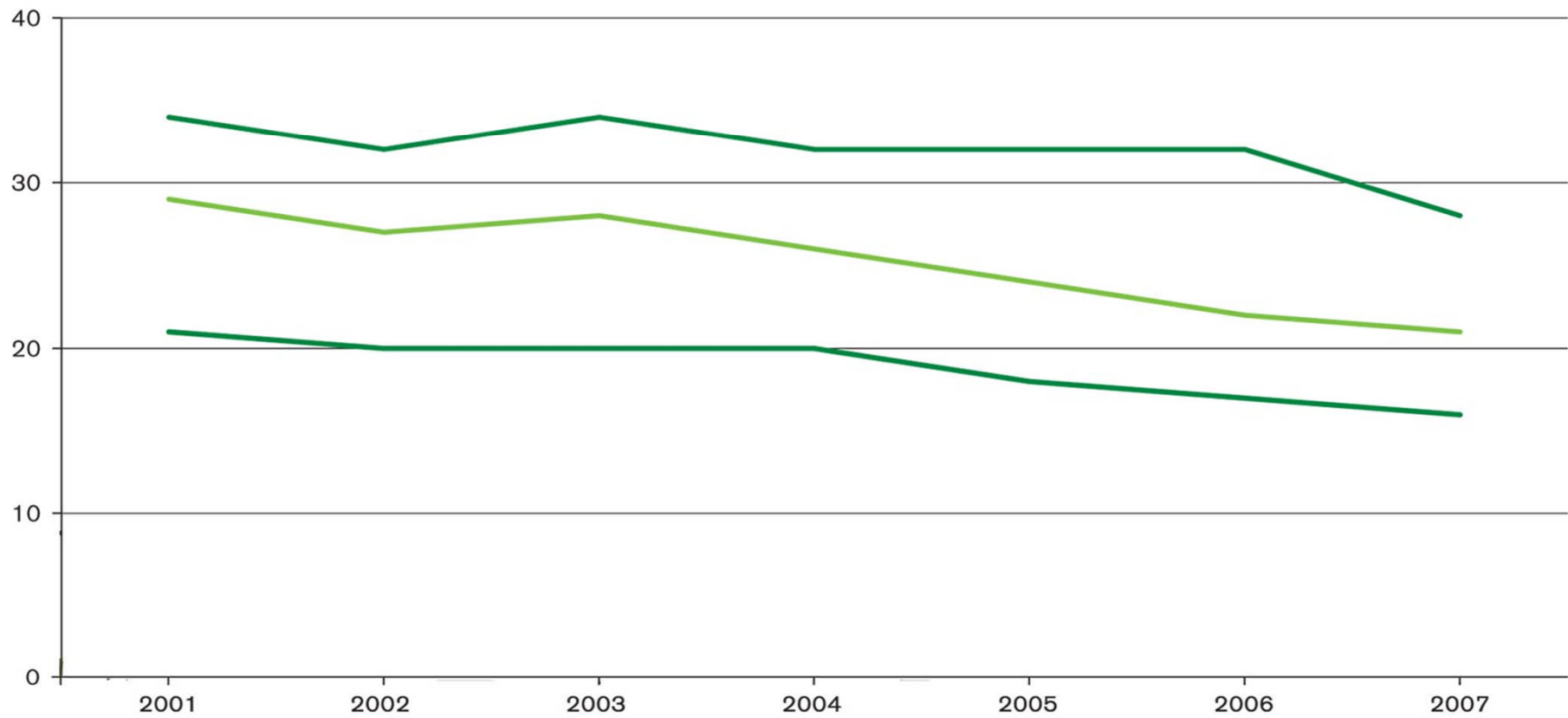Source: Office for National Statistics General Household Survey[65]

Figure 2.13 Percentage of (a) males and (b) females smoking, by socioeconomic class (NS-SEC), 2001–7
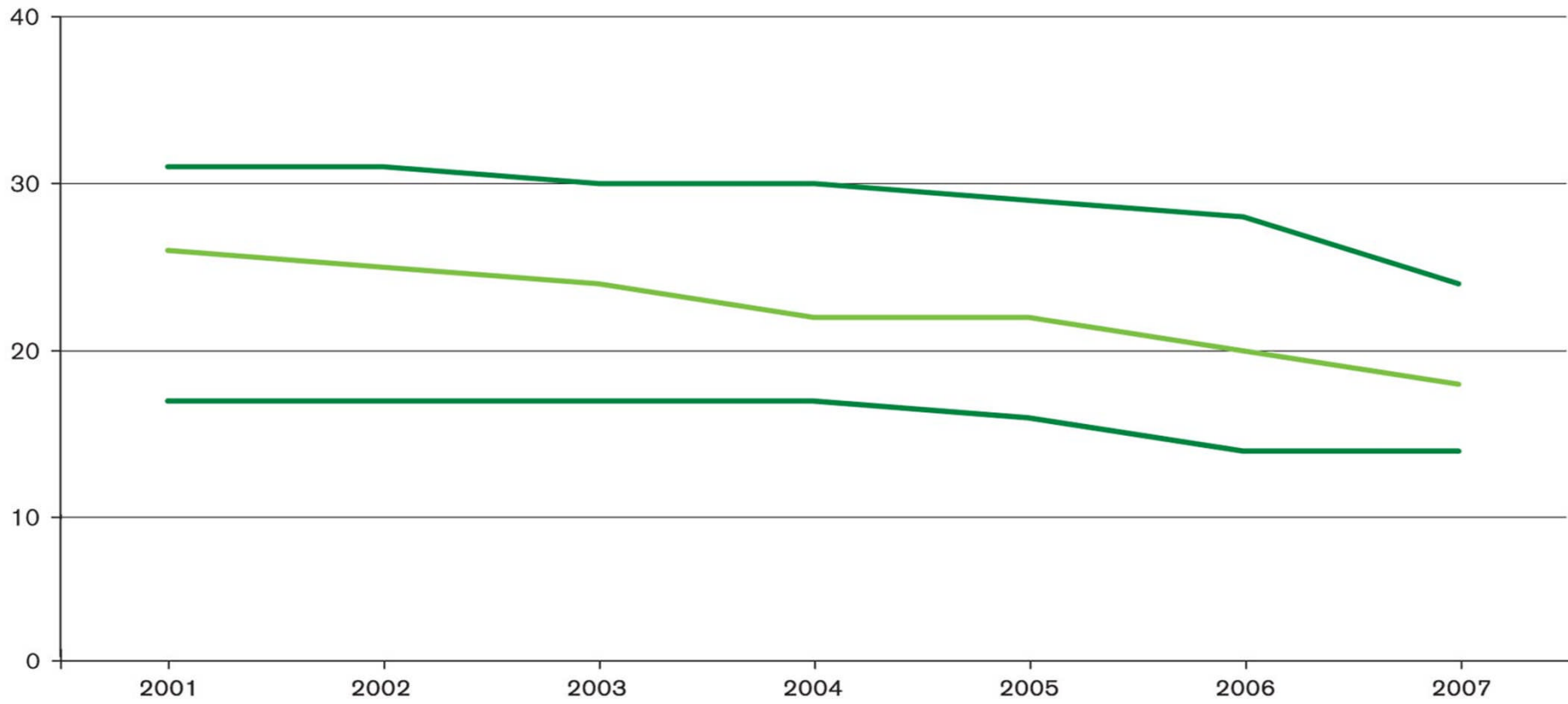
(b) Females

Percent

Year

Managerial and professional

Intermediate

Routine and manual

Note: NS-SEC=National Statistics
Socioeconomic Classification
Source: Office for National Statistics
General Household Survey[65]

Figure 11 Prevalence of obesity (>95th centile), by region and deprivation quintile, children aged 10–11 years, 2007/8

Prevalence of obesity

Region of residence

- ◆ Quintile 1 (least deprived)
- ■ Quintile 2
- ▲ Quintile 3
- × Quintile 4
- ✳ Quintile 5 (most deprived)

Source: National Obesity Observatory, based on National Child Measurement Programme[24]
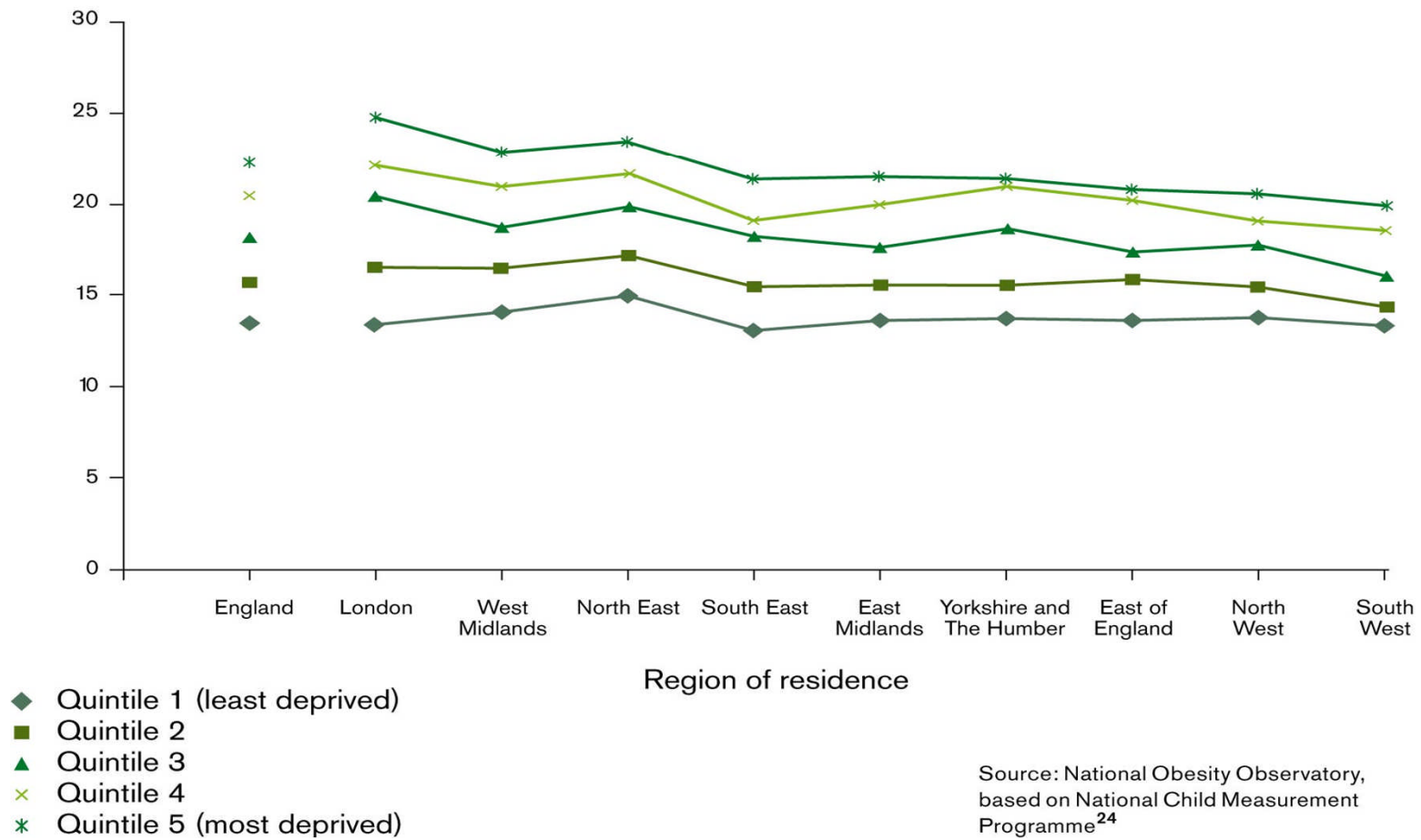
Figure 2.17 Prevalence of problematic drug users aged 15−64 years by local authority of residence and Index of Multiple Deprivation, 2006/7

Rate per 1,000

IMD Score 2007
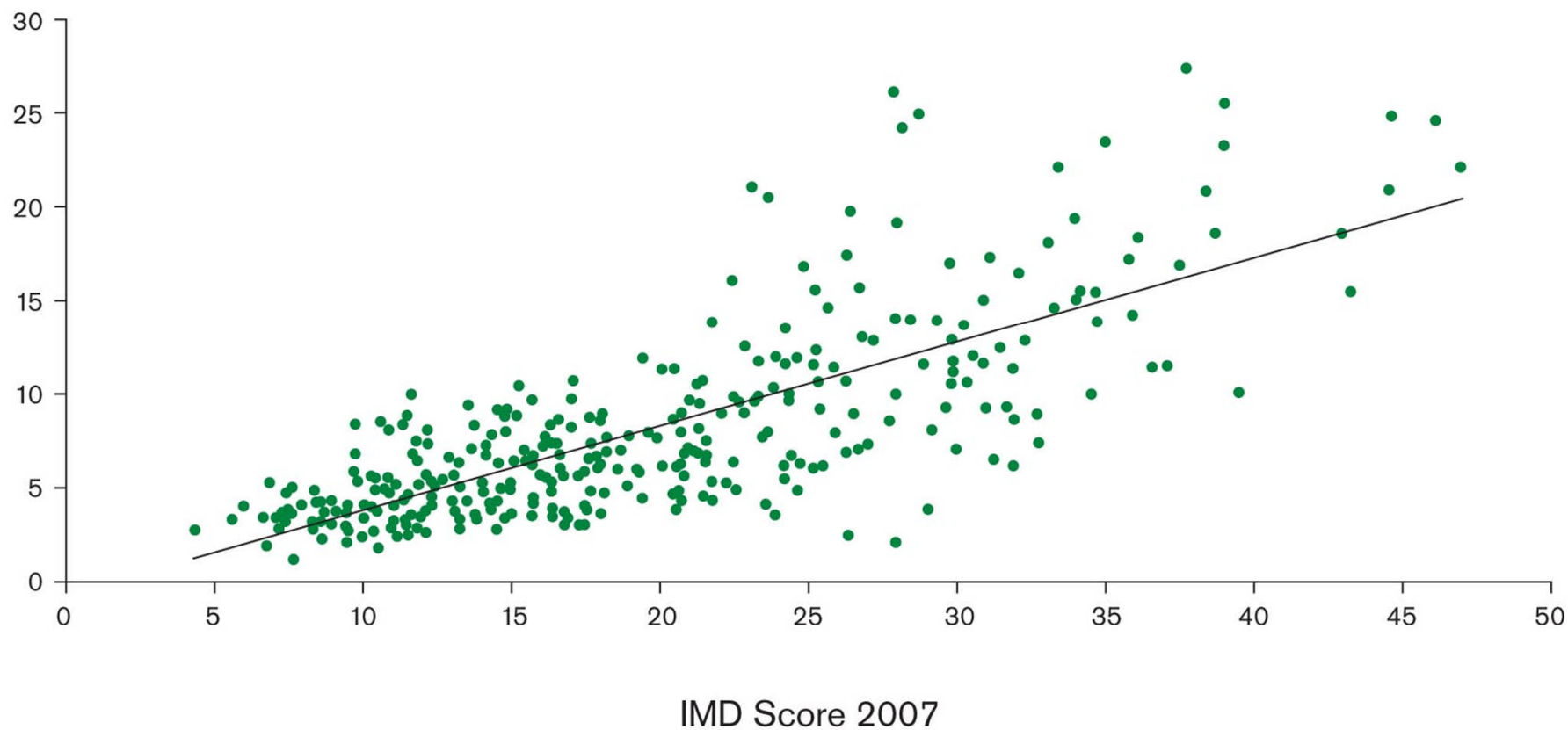
IMD = Index of Multiple Deprivation
Source: North West Public Health
Observatory[80]

Figure 2.14 Alcohol-attributable hospital admissions by small area deprivation quintile in England, 2006–2007

Age standardised persons per 100,000

Deprivation quintile (IMD 2007)
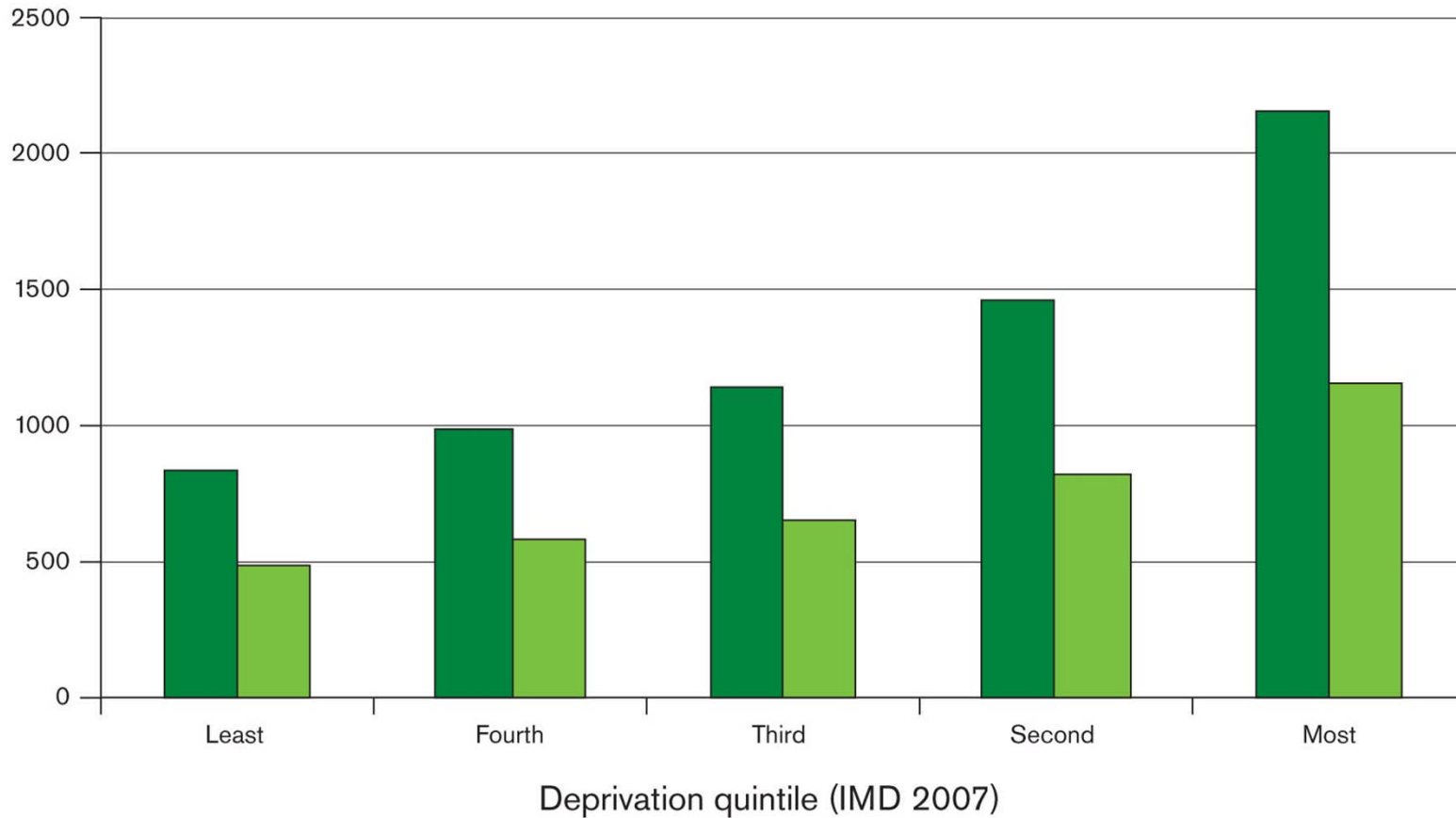
■ Males (Gradient = 2.6)

■ Females (Gradient = 2.4)

Note: IMD = Index of Multiple Deprivation for Lower Level Super Output Areas
Source: NHS Information Centre Hospital Episode Statistics[69]

Policy Objective F

Recommendations

- Prioritise investment – up from 4% of NHS budget

- Medicalise drug treatment

- Gradient in smoking, obesity and alcohol

- Public Health - social determinants

Strategic Review of Health Inequalities
in England post-2010

Delivery and Measurement

- Annex 2: Indicators of progress and targets
- Delivery systems – partnerships, local empowerment, LSPs
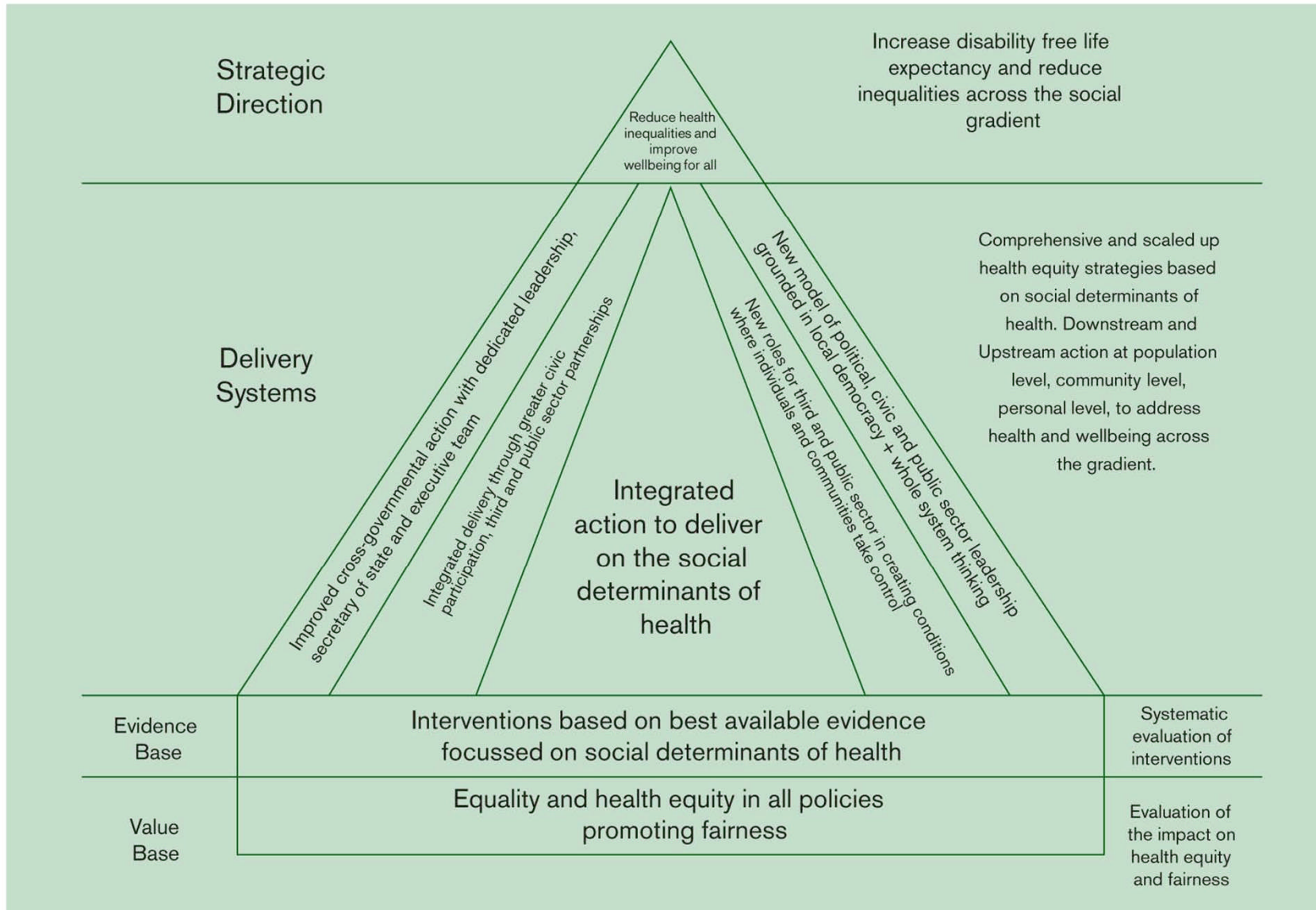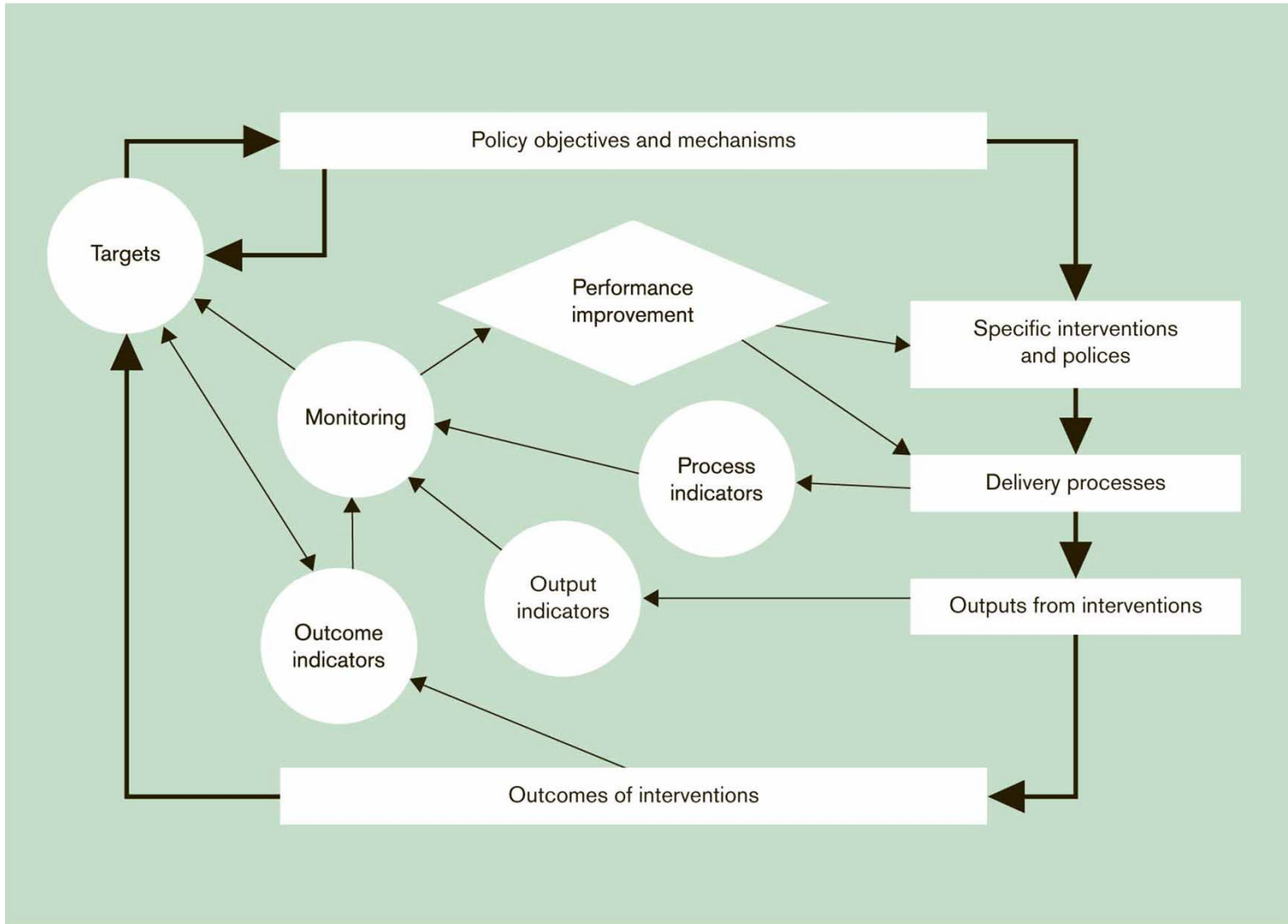
Figure 5.1 Future delivery scenario

Strategic Direction

Reduce health inequalities and improve wellbeing for all

Increase disability free life expectancy and reduce inequalities across the social gradient

Delivery Systems

Improved cross-governmental action with dedicated leadership, secretary of state and executive team

Integrated delivery through greater civic participation, third and public sector partnerships

Integrated action to deliver on the social determinants of health

New roles for third and public sector in creating conditions where individuals and communities take control

New model of political, civic and public sector leadership grounded in local democracy + whole system thinking

Comprehensive and scaled up health equity strategies based on social determinants of health. Downstream and Upstream action at population level, community level, personal level, to address health and wellbeing across the gradient.

Evidence Base

Interventions based on best available evidence focussed on social determinants of health

Systematic evaluation of interventions

Value Base

Equality and health equity in all policies promoting fairness

Evaluation of the impact on health equity and fairness

Figure 5.2 Framework for indicators and targets

WEBSITE

www.marmotreview.org

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