Public Health England

Protecting and improving the nation's health

PHE Board Paper

Title of meeting	PHE Board
Date	Wednesday 25 May 2016
Sponsor	Kevin Fenton
Presenter	Ann Marie Connolly
Title of paper	**PHE support for action to reduce health inequalities in England**

1. Purpose of the paper

1.1 The purpose of the paper is to describe the national position in relation to health inequalities in England and present PHE's current approach to supporting action to reduce health inequalities. It is intended to inform discussion at the PHE Board meeting on 25 May 2016 about the strategic position that PHE should adopt in supporting reductions in health inequalities.

2. Recommendation

2.1 The Board is asked to:

a) **NOTE** the approach that PHE is taking in supporting action on health inequalities across public services and with wider partners
b) **COMMENT** on the issues that PHE might prioritise in its work on health inequalities

3. Background

3.1 Health inequalities are systematic, avoidable and unfair differences in health status between groups of people or communities. Since the 1970s a series of reports have described health inequalities in this country, setting out the evidence for their causes and, increasingly, proposing solutions to address these causes. The Black report in 1980[1] was the first report of this kind, presenting evidence that there was a gradient in health outcomes. Subsequently Sir Donald Acheson published his eponymous report in 1998, setting out a series of recommendations to the then Labour government.[2] It informed the policy and strategic thinking of the government of that time, including the creation of new national health inequality targets on infant mortality and life expectancy to narrow the gap between the quintile with the poorest outcomes and the national average.

3.2 A further key source of evidence for action on health inequalities is the Marmot strategic review of health inequalities in England (2010), which has provided a

[1] Black, Douglas (Chair) Dept of Health and Social Security. (*Inequalities in Health: report of a research working group chaired by Sir Douglas Black.* Department of Health adn Social Security, 1980.
[2] Acheson, Donald Sir. Independent Inquiry into Inequalities in Health. Report. Stationery Office; London,1998.

framework for national action since then.[3] The Review set out a compelling case that the fundamental causes of health inequalities are the conditions in which people are born, grow, live, work and age. These social determinants of health – for example, jobs, homes and social relations – in turn shape people's health behaviours, like smoking and physical activity, and access to health services. The review set out six key policy domains for action to reduce health inequalities incorporating multiple dimensions of the 'causes of the causes' and highlighting, through a lifecourse approach, how these causes of inequalities accumulate right across life, starting before birth.

4. Measures of inequalities in life expectancy

4.1 The slope indices of inequality (SII) in life expectancy and healthy life expectancy are system indicators for monitoring progress on reducing health inequalities, and are overarching indicators for the Public Health Outcomes Framework. These indicators use information on deaths in small areas classified by deprivation level as well as information on self-reported health.

4.2 Life expectancy at birth rose steadily for both males and females between 2002-04 and 2012-14 (Figure 1). In 2002-04 life expectancy at birth for males was 76.5 years rising to 79.5 years by 2012-14. The equivalent figures were females were 80.9 years and 83.2 years.

4.3 Despite general improvements in longevity, inequalities in life expectancy were stable over the period 2002-04 to 2012-14 – there was no statistically significant change. By 2012-14, the difference in life expectancy between the most and least deprived males was 9.2 years, and for females 7.0 years (Figure 2).

Figure 1: Trend in life expectancy at birth, England, 2002-04 to 2012-14

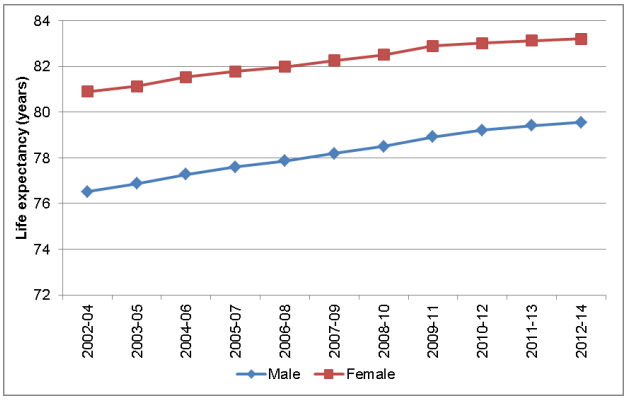
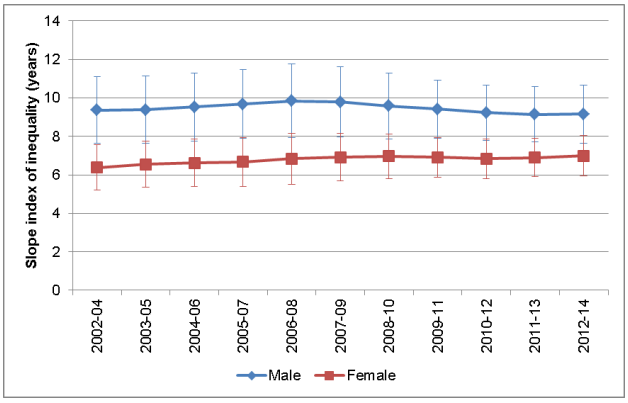


Figure 2: Trend in slope index of inequality in life expectancy at birth, England, 2002-04 to 2012-14



4.4 However, ONS data on trends in life expectancy by individual socio-economic group (rather than area-level deprivation) suggest widening inequalities over the 30-year period from 1982-1986 to 2007-2011. The Slope Index of Inequality (SII) in life expectancy at birth by socio-economic group widened for males overall from 5.6 years to 6.7 years; but since 1997-2001, when the gap was 7.5 years, it has narrowed. For females the SII widened from 3.8 years to 5.3 years and was widest in 2007-2011.[4]

[3] Marmot Review Team. *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post-2010,* 2010.

[4] ONS. Trend in life expectancy at birth and at age 65 by socio-economic position based on the National Statistics Socio-economic Classification, England and Wales: 1982-1986 to 2007-2011. Statistical bulletin, October 2015. Available at: http://www.ons.gov.uk/

4.5 The Public Health Outcomes Framework also includes information on inequalities in healthy life expectancy. Healthy life expectancy is a measure of lifetime spent in good health (using a self-reported health measure and information on life expectancy). For men the gap between those in the most and least deprived decile is 19.0 years (2012-14) while, for women, the equivalent difference between the most and least deprived groups is 20.2 years (2012-14). Trend data show no significant changes in the gap in healthy life expectancy over time.

4.6 Inequalities in health outcomes between areas can also be seen clearly using maps. Appendix 1 shows the area variation in premature mortality due to cardiovascular disease. There is a clear regional difference, or North-South divide, with worse outcomes more widespread in the North of England. However pockets of particularly high rates of preventable cardiovascular diseases are also evident across the South of England and the Midlands.

5. PHE's role on reducing health inequalities

5.1 The Health and Social Care Act 2012 introduced specific legal duties on health inequalities for the Secretary of State for Health, NHS England and clinical commissioning groups. PHE has a legal duty to have due regard to reducing health inequalities between the people of England on behalf of the Secretary of State for Health. These legal duties are underpinned by planning, assessment and reporting requirements.

5.2 The legal duty on health inequalities is complemented by the public sector equality duty (Equality Act 2010), which applies to all public bodies. The equality duty requires due regard to eliminating unlawful discrimination, promoting equality of opportunity, and fostering good relations between all of the communities we serve. PHE's approach has been to integrate our work to fulfil these two duties wherever possible as they are related but distinct.

Key actions to support reductions in health inequalities

5.3 Levers to reduce health inequalities exist at multiple levels from local to national and between different stakeholders of public, private, and community and voluntary sector organisations. PHE's work programme on health inequalities is therefore wide-ranging and involves setting appropriate strategies within the organisation, and more widely, influencing local and national systems to reduce health inequalities.

5.4 Since the inception of PHE we have focussed the programme of work on i) providing practical advice on translating the Marmot review into actions that local areas can take in partnership with the UCL Institute of Health Equity (IHE) ii) developing capacity of other teams across PHE to take a health equity lens to their programmes of work iii) promoting a Health (and health equity) in All Policies (HIAP) approach and iv) continuing to develop our intelligence and data tools to inform understanding of local and national on progress on health inequalities.

5.5. We have developed a Framework for PHE action on health inequalities to structure our approach on this agenda. The Framework includes annual commitments by specific teams on how they will address health inequalities as well as identifying areas for longer-term, collective, strategic action by the organisation – for example on promoting equity and fairness through devolution.

6 Opportunities and challenges

6.1 Many of the health inequalities we are seeing are persistent and seemingly entrenched. There are some very marked and contrasting pictures with a general North/South divide visible in the maps of health inequalities. However poor outcomes are also evident within the most affluent regions and local authorities when differences are examined at a small spatial scale. For example, when examining outcomes for London overall, or at a local authority level, the greater overall affluence of the city, and associated good health outcomes can mask the presence of poor health outcomes in specific neighbourhoods. Overall, while many areas across England have made some improvements, longstanding geographical differences in health persist.

6.2 A range of emerging trends and developments in the social, economic and public service landscapes may have implications for action on health inequalities. These include:

a) public spending constraints which are likely to persist in medium term. Spending constraints will have implications for local government service provision, creating both opportunities to do things differently and challenges, for example around the ability to invest in a broad spectrum of voluntary sector bodies that normally complement public sector provision
b) the drive to devolution, localism and decentralisation of services, may present new opportunities to shape the wider determinants of health in particular, but also creates some uncertainties about the future service environment
c) technological changes: new technologies in the digital age may present a range of opportunities if we can reach a wider range of people with, for example, apps to promote health or manage health conditions. Analysis of 'big data' may provide insights to inform design of interventions**.**

6.3 General government policy developments related to the key wider determinants of health – for example, income or welfare, employment and housing – may also have implications for public health and health inequalities. Risks and opportunities for reducing health inequalities will vary across different policy domains and precise measures, and will also be dependent on understanding actual implementation effects rather than policy intent.

7 Conclusion

7.1 Health inequalities are a wicked issue across industrialised nations. Our challenge is to drive measureable reductions in inequalities in life expectancy and health life expectancy – focusing on actions to prevent a range of contributory risk factors and diseases, and improve the underpinning social determinants of health. On the one hand, the data and intelligence available in England to support action on health inequalities is a tremendous asset. There is a wealth of existing evidence and experience on what actions will help to reduce health inequalities. On the other hand, our knowledge is still incomplete. In particular, our current task is to identify the best measures and tangible actions in a time of spending constraint, when the public service context is shifting rapidly.

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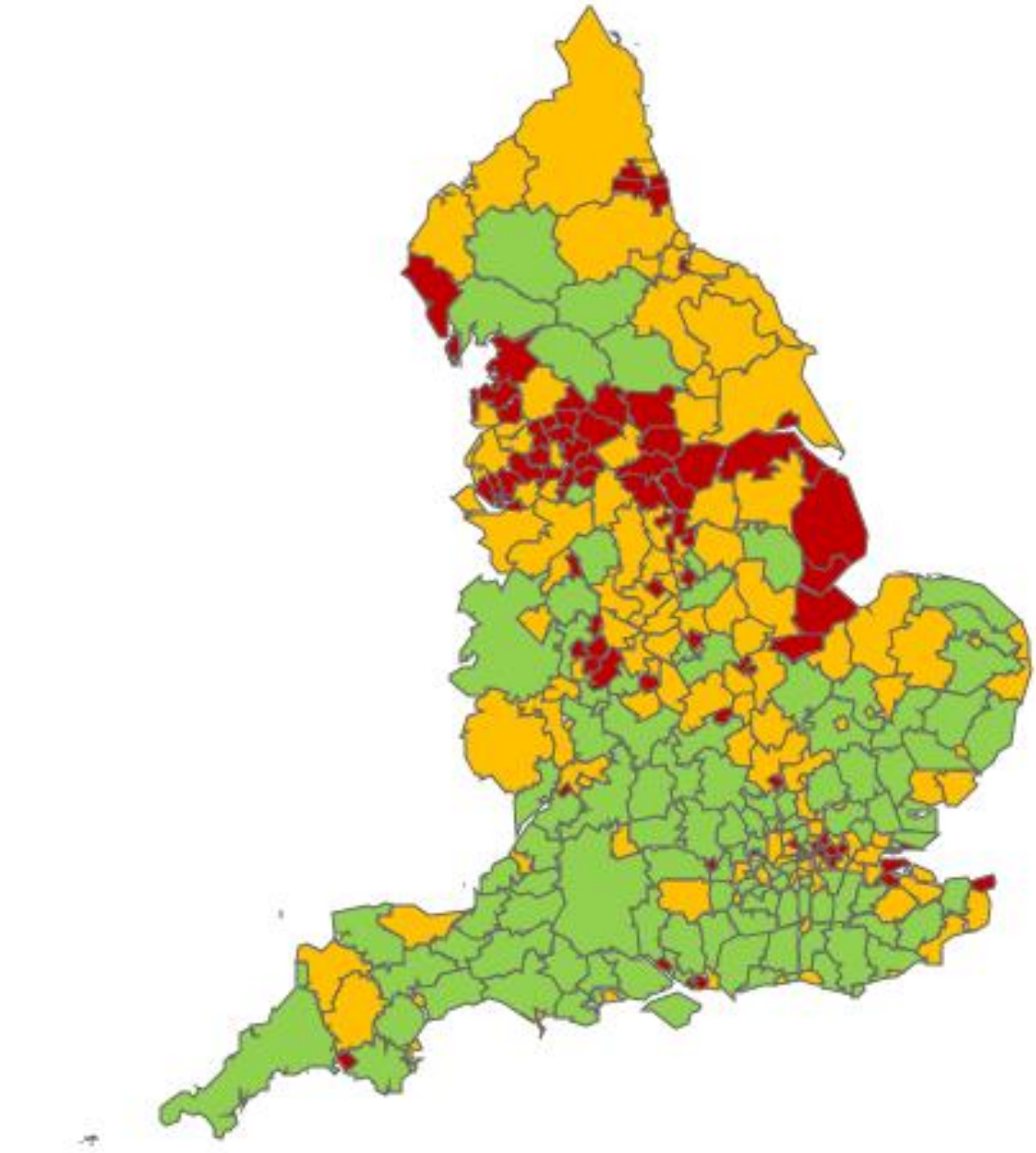
May 2016

Appendix

Under 75 mortality rate from cardiovascular diseases considered preventable (persons). Directly standardisded rate per 100,000, 2012-14. Districts and Unitary Authorities



Compared with benchmark: Better | Similar | Worse