Department of Health

Tackling Health Inequalities:
2007 Status Report on the Programme for Action

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Tackling Health Inequalities: *2007 Status Report on the Programme for Action*

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Acknowledgements

The *Programme for Action* set out a national health inequalities strategy. Published in July 2003, the work set out in the *Programme for Action* has been taken forward across government by the 12 departments that signed up to it; these departments were as follows:

Cabinet Office

Department for Constitutional Affairs (DCA) – now Ministry of Justice (MoJ)

Department for Culture, Media and Sport (DCMS)

Department for Education and Skills (DfES) – now Department for Children, Schools and Families (DCSF) and Department for Innovation, Universities and Skills (DIUS)

Department for Environment, Food and Rural Affairs (Defra)

Department of Health (DH)

Department of Trade and Industry (DTI) – now Department for Business, Enterprise and Regulatory Reform (BERR)

Department for Transport (DfT)

Department for Work and Pensions (DWP)

HM Treasury (HMT)

Home Office (HO)

Office of the Deputy Prime Minister – now Communities and Local Government (CLG)

Foreword by Rt Hon Dawn Primarolo MP, Minister for Public Health

The *2007 Status Report* is the third and last of this series of status reports against the *Programme for Action*, the first national health inequalities strategy. This report shows some signs of progress against the health inequalities target and the set of national cross-government indicators. It also shows how we are supporting this wider agenda across government, through the very substantial achievements in delivering against almost all of the departmental commitments set out in the *Programme for Action*.

This highlights the effort, energy and commitment across government and throughout the NHS and local government to this agenda. We are under no illusions about the task. Health inequalities remain stubborn, persistent and difficult to change. Successive status reports have highlighted the nature of this challenge. Equally, they have illustrated our continuing resolve to address inequalities, to prevent them from getting wider, and ultimately, to reduce them. Our persistence is reflected in the Secretary of State's commitment to refreshing the strategy.

A key task will be learning the lessons from the *Programme for Action* and related programmes elsewhere in government. We are determined to continue the fight against health inequalities because the prize is worth winning: a fairer, more just society where a person's life expectancy or wellbeing is no longer determined by their place of birth or their social status. Better health for all is our goal, especially for those in disadvantaged and vulnerable groups and areas, who have the poorest health and the lowest life expectancy.

The potential benefits are legion if we succeed in narrowing the health gap. It offers the prospect of improvements in social, economic and environmental terms as well as in health terms for individuals and their families, for local communities and for society as a whole. We all have an interest in seeing this work through. I recognise too that the improvements necessary to narrowing the health gap and achieving a long-term sustainable reduction in health inequalities cannot be achieved by the NHS alone. Action on the wider, social determinants of health – on education, employment, poverty, housing and the environment – is crucial, and tackling health inequalities needs engagement across government.

The agenda set by the *Programme for Action* shows how we can achieve a higher level of engagement. It also emphasises the need to focus on action, including the use of available systems and processes to weave health inequalities into the mainstream business of government. This approach will be relevant in the continuing efforts to achieve a long-term, sustainable reduction in health inequalities.

I would like to thank Professor Sir Michael Marmot and the scientific reference group on health inequalities, who have overseen the development of this report. As in previous reports, their knowledge, expertise and independence has helped frame a report that, while noting progress in some areas, is clear about the challenges we continue to face.

Rt Hon Dawn Primarolo MP
Minister for Public Health

Preface by Professor Sir Michael Marmot

If evidence-based policy making were to be honoured in the observance rather than the breech what might it look like? A simple description might be: review the evidence and make recommendations; use these recommendations as a base to formulate policies; monitor their effects.

By this description, action on inequalities in health in England conforms rather well to evidence-based policy making. *The Independent Inquiry into Inequalities in Health* (the Acheson Inquiry) reviewed the scientific evidence on health inequalities. It made 39 recommendations. Importantly, Acheson took a social model of health. Thirty-six of it's (our) recommendations ranged across the whole spectrum of government policy that influences health inequalities. Only three were specifically aimed at the health service. It was then appropriate that a cross-cutting review on health inequalities was conducted by the Treasury with the participation of 18 government departments and agencies. The result was a national *Programme for Action*. Government Departments entered into 82 commitments aimed at tackling health inequalities. Targets on reduction of health inequalities, for infant mortality and life expectancy were set. A key part of the *Programme for Action* was to monitor health inequalities and a few key determinants and components. The overseeing of this monitoring task was assumed by the Scientific Reference Group on Health Inequalities.

In our first Status Report, 2005, we suggested that time was too short to see any effect of policy changes. Now, two years later, that is still a major issue. It is simply too early to say if too little has been done or the right actions were not taken. Whatever actions were taken between 2003 and 2006 there would be little short-term impact on health inequalities. Nevertheless it is important to keep close watch on what has been happening both to important policy areas such as housing, child poverty and education, as well as to health inequalities.

Going further back in time to the mid-1990s, this report shows a very welcome improvement in life expectancy for all social groups but no narrowing of the gap. In 1995-97, life expectancy in the most deprived areas (the spearhead group) was 72.7 years for men and 78.3 years for women. Few observers would have predicted that this worst off group would have life expectancy of 75.3 (men) and 80.0 (women) in 2004-6. There was, however, a similar improvement in England as a whole.

So, too with infant mortality. Babies born to families in the "routine and manual" social groups have the same infant mortality rate in the latest figures, 5.6 per 1000 live births, as the average seven years earlier – a welcome improvement. But, the average rate improved and the gap did not narrow.

We are of the firm belief that there should be two central aims for health policy: improve overall health and reduce inequalities. The evidence shows success in the first but, as yet, not in the second, despite the welcome improvement in health of the worst off.

There are nevertheless encouraging signs. The original health inequalities target was set as relative differences and these are reported here. There is also a good case to monitor absolute differences in health between social groups and these are also reported here. They show reductions in absolute health inequalities in two big killers: cancer and heart diseases.

Another point to draw out of the Report is that policy makes a difference. In the seven years from 1998/99, 600,000 fewer children are living in poverty. It will be challenging to meet the government's target of halving child poverty by 2010/11 but the health benefits for children now and in the future will be substantial.

My work as chair of the WHO Commission on Social Determinants of Health has underlined the importance and relevance of this work internationally. This country has shown leadership through its pioneering approach of reviewing the evidence, setting targets, developing a comprehensive strategy across government, and monitoring progress. There is clearly more to do. The Secretary of State's commitment to build on this work is not only important for this country but is a most important model for others. These are important steps in the achievement of social justice.

Professor Sir Michael Marmot
Chair of the scientific reference group on Health Inequalities

Executive summary

1. *Tackling Health Inequalities: A Programme for Action* (2003) included a commitment to produce a regular report on the Public Service Agreement (PSA) target on health inequalities, and in particular the 12 national cross-government headline indicators. The target is:

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

2. This report focuses on the steps being taken to narrow the health gap. It summarises developments against the target, the headline indicators and the departmental commitments set out in the *Programme for Action*.

3. Taking account of the latest Office for National Statistics (ONS) figures for 2004–06 on life expectancy and infant mortality, the report shows:

   - a further slight narrowing of the infant mortality gap, little change in the gap in male life expectancy and a widening of the gap in female life expectancy since 2003–05

   - an encouraging picture on the cross-government indicators, with long-term progress in reducing child poverty and narrowing inequalities in housing quality, educational attainment and uptake of flu vaccinations. Cancer and circulatory (heart) disease mortality, child road accident casualties and teenage conceptions show a narrowing of inequalities in absolute terms (but not in relative terms); other areas, for example smoking, show a general reduction in prevalence but no narrowing of the gap between social groups

   - almost all departmental commitments set out in the *Programme for Action* and due for delivery by the end of 2006 have been wholly or substantially achieved.

4. The headline indicators provide a summary of what is happening in key areas linked to the target. There are some omissions – in policy areas, such as mental health, and in other dimensions of inequality such as ethnicity.

Life expectancy

5. The latest data for 2004–06 show that the relative gap in life expectancy between England as a whole and the fifth of areas with the worst health and deprivation indicators was wider than at the baseline (1995–97) for both males and females.

6. For males, the relative gap is 2% wider than at the baseline (the same as 2003–05) and for females it is 11% wider than at the baseline (compared with 8% wider in 2003–05).

Infant mortality

7. The latest data for 2004–06 show a further slight narrowing of the infant mortality gap between the routine and manual socioeconomic group and the population as a whole.

8. The infant mortality rate (IMR) in 2004–06 (for all babies with father's occupation stated) was 4.8 deaths per 1,000 live births, and the rate for those in the routine and manual group was 5.6 deaths per 1,000 live births.

9. The IMR among the routine and manual group was 17% higher than for the total population in 2004–06, compared with 18% higher in 2003–05 and 19% higher in 2002–04. It was 13% higher in the baseline period of 1997–99.

Headline indicators

10. The key has been to match overall improvements in health and social circumstances as measured by the headline indicators with faster-than-average improvements in the target groups and areas, that help narrow the gap. There has been good progress in four areas – reducing child poverty and narrowing inequalities in housing quality, educational attainments and uptake of flu vaccinations. There has been a narrowing of inequalities in absolute terms (but not in relative terms) in four other important areas – circulatory (heart) disease and cancer mortality, child road accidents casualties, and teenage conceptions. Other areas, like smoking, show a general reduction in prevalence but no narrowing of the gap between social groups. A summary of progress against the indicators is set out in Box 1.

Departmental commitments

11. The *Programme for Action* featured 82 departmental commitments across government until 2006. Almost all of these have been fully or substantially realised. A summary of the commitments is included in Chapter 3 of this report.

Box 1: Summary of progress against national indicators

1. **The big killers** – There have been improvements in cancer and circulatory disease death rates since 1995–97 (including for the most disadvantaged areas), with a narrowing of inequalities in absolute terms for both. There has been no significant change in relative terms for cancer, but there has been a widening in inequalities in relative terms for circulatory diseases.

2. **Teenage pregnancy** – There has been a 13.3% drop in the rate of under-18 conceptions between 1998 and 2006 (with the average rate for the most disadvantaged areas also falling), with a slight narrowing of inequalities in absolute terms but no significant narrowing in relative terms.

3. **Road accident casualties** – There have been improvements in child road accident casualty rates since 1998 (including for the most disadvantaged areas). There has been a narrowing of inequalities in absolute terms, but no significant change in relative terms.

4. **Primary care services** – There have been improvements in the number of full-time equivalent (fte) GPs per 100,000 weighted population since September 2002 (including for the most disadvantaged areas), but there has not been a significant narrowing of inequalities – with some signs of a widening in absolute terms by September 2006. The number of deprived primary care trusts (PCTs) who are more than 10% below the England average number of fte GPs per 100,000 weighted population has increased since September 2002.

5. **Flu vaccinations** – Between 2002 and 2005 the percentage uptake of flu vaccinations by older people increased (including for the most disadvantaged areas), accompanied by a slight narrowing of inequalities in absolute and relative terms. This narrowing of inequalities was maintained in 2006 for the set of deprived PCTs for which comparison is possible with earlier data. This does not mean that all of the most deprived PCTs are improving relative to the least deprived PCTs. However, more deprived PCTs achieved the 70% uptake target in 2005 than in 2002.

6. **Smoking** – Since 1998, smoking prevalence among all adults has fallen (including among manual groups), but there has been no significant change in inequalities for manual groups compared to non-manual groups or all adults in absolute terms, with some signs of a widening in relative terms.

   Between 2000 and 2005, the overall prevalence of smoking throughout pregnancy decreased slightly, including a large fall in prevalence among women in the 'never worked' category but a slight increase among routine and manual groups. There were some signs of a widening of inequalities for routine and manual groups.

7. **Educational attainment** – Between 2002 and 2007, the proportion of pupils achieving five or more A*–C grades at GCSE increased (including among pupils eligible for free school meals), with signs of a narrowing of the attainment gap between pupils eligible for free school meals and all pupils.

Box 1: Summary of progress against national indicators *(continued)*

8. **Fruit and vegetable consumption** – Between 2001 and 2006, consumption of five or more portions of fruit and vegetables per day increased (including for households with the lowest incomes), but there was no significant change in inequalities between households with the lowest incomes and households with the highest incomes or the average for all households.

9. **Housing** – Between 1996 and 2006, the proportions of vulnerable private sector households and of social sector tenants living in non-decent housing (based on the fitness definition) decreased, with a narrowing of inequalities between these groups and non-vulnerable private sector households in both absolute and relative terms.

10. **PE and school sport** – In 2006/07, participation in PE and school sport in School Sport Partnership schools with a high proportion of pupils eligible for free school meals is, on average, almost the same as in other schools. Latest data for 2006/07 are not directly comparable with available data for earlier years.

11. **Poor children** – The proportion of children in England living in low-income households has fallen since the baseline of 1998–99. This fall is shown for both relative and absolute low-income measures, and on both before and after housing cost measures.

12. **Homeless families** – Since March 2002 there has been a reduction in the number of homeless families with children in bed and breakfast accommodation; the number of homeless families with children living in all temporary accommodation is higher than at March 2002, but numbers have been falling recently and are at their lowest since March 2003.

Chapter 1: Introduction

KEY MESSAGE

This Status Report is the final report on the *Programme for Action*, the first national health inequalities strategy. It provides a platform for building the new national strategy.

1.1 *Tackling Health Inequalities: A Programme for Action* (2003), the cross-government national health inequalities strategy, was a three-year plan that laid the foundations for meeting the 2010 target and the wider challenges set by the underlying causes of health inequalities. It also included details of departmental commitments to support the strategy to the end of 2006. The strategy has continued to inform the health inequalities agenda and the Secretary of State announced his intentions to refresh the strategy later in 2008.

1.2 Status reports on the *Programme for Action* have been published annually since 2005 to meet the public commitment for monitoring developments against the strategy. The scientific reference group (SRG) on health inequalities chaired by Professor Sir Michael Marmot has overseen the development of these reports.

1.3 This is the third and final status report on the *Programme for Action*. Like previous reports, it provides data relevant to the health inequalities target and a range of other indicators.

THE NATIONAL TARGET

by 2010 to reduce the inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth.

1.4 The priority the government has given to tackling health inequalities is rooted in the fact that health and life expectancy are linked to social circumstance in adulthood and childhood and, despite overall improvement, the health gap between the top and bottom ends of the social scale remains. For many people, these inequalities mean poorer health, reduced quality of life and avoidable early death.

1.5 The *Programme for Action* emphasised that health inequalities are persistent, stubborn and difficult to change, and sought to lay the foundations for addressing them. There has been progress in understanding how to tackle health inequalities and in sharpening the focus for action, with some local and national successes in achieving change. But the challenge posed by the health inequalities gap remains.

1.6 The aim of the target is to close the health gap by reducing the relative differences between disadvantaged groups and areas and the rest of the country in two dimensions of the health inequalities target:

- *starting with children under one year, by 2010 to reduce by at least 10 per cent the gap in mortality between the routine and manual group 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 worst health and deprivation indicators (the spearhead group) and the population as a whole*

1.7 The *Programme for Action* looked beyond the target and took a broad view of disadvantage. It acknowledged that to reduce health inequalities 'will require us to improve the health of the poorest 30–40% of the population where the greatest burden of disease exists'. This meant improving the health of disadvantaged groups or areas – including socially excluded groups – faster than that of the rest of the population.

1.8 This strategy was informed by an approach that was about:

- driving the target – identifying what works in terms of key interventions and the target groups and areas, developing tools and levers to promote the agenda at local level and learning from and sharing good practice
- learning the lessons from the evidence – understanding the causes, extent and depth of health inequalities and the evidence on what works
- working with others – balancing action in the NHS with action elsewhere, and developing partnerships across government at local, regional and national level
- matching the short and long term – addressing the 2010 target and promoting a longer-term vision of long-term, sustainable reduction in health inequalities.

1.9 The development of closer links between the NHS and local government will be crucial in delivering this agenda. The new local performance framework, set out in the 2006 local government *Strong and Prosperous Communities* White Paper, offers new opportunities for partnership working to tackle local priorities. Local partners will need to learn the lessons from the *Programme for Action* if they are going to strengthen their future efforts through Local Area Agreements (LAAs) and other vehicles.

1.10 While the target has been a key driver for action, securing wider recognition of the target has not been straightforward. Promoting the idea that the target is realistic and achievable has been a challenge, partly because of other competing priorities, partly because of challenge in getting health inequalities recognised as a priority and partly because of the need for clarity about what needs to be done, how it should be done and who should do it.

1.11 The emphasis on a target-driven approach within a wider strategy designed to achieve a long-term sustainable reduction in health inequalities has gained international recognition. This is due to the emphasis on action following on from analysis, using the available systems and processes, and partly because of the stress on partnership working and intersectoral collaboration.

1.12 This Status Report provides an audit of developments, mostly to 2006, across the target, the 12 cross-government headline indicators and the 82 government commitments included in the *Programme for Action*.

Chapter 2: Some issues in tackling health inequalities

KEY MESSAGES

- **Action on a broad front and across a range of health determinants is necessary to halt and narrow the health inequalities gap.**
- **Improvements in overall health status are a major achievement but do not necessarily narrow the gap.**
- **Long-term and short-term approaches in tackling health inequalities can create tensions that need to be reconciled, but the target has been a spur to action.**

2.1 The *Programme for Action* was built on the work of the *Independent Inquiry into Inequalities in Health* – the Acheson report (1998) – and the HM Treasury-led cross-cutting review on health inequalities (2002). Acheson provided evidence of a widening health gap and identified possible approaches for action on a broad front to tackle health inequalities, and the review explored the implications of a Public Service Agreement (PSA) health inequalities target for action across government. The target flagged the importance of health inequalities and the strategy set out the means to systematically deliver it. England has become a world-leader in policy development and practical action in health inequalities. This leadership was implicit in the decision to make health inequalities one of two health themes of the UK presidency of the EU in 2005, and is recognised today in a full and continuing engagement with the social determinants and health inequalities agenda of the World Health Organization (WHO) and the EU.

2.2 Securing visible change on the ground by narrowing the health inequalities gap has not been easy. From the first, it was recognised that change would only be possible in the long term, not least because of the way the health gap had widened since the 1970s. The first step was to stop the gap widening further. The *Programme for Action* stressed the time lag between interventions and the achievement of results. This notion of a time lag was amplified in the first *Status Report* (2005), which also highlighted the differential impact of 'lead times' between different diseases, the gap between changes in exposure and changes in disease rates – most notably cancer rates. Action today would not readily undo the accumulated effects of such exposure from 20 years ago or more.

2.3 Time lags and lead times provide part of the explanation for the lack of more rapid progress. One consequence of this concern, was an audit and review of the measures in place to deliver the target, not least the gap between national policy and local action. As a result, key interventions were identified and modelled and further action was suggested to sharpen policy responsiveness and local performance.

2.4 This chapter explores some issues around the national target and the health inequalities strategy, including:

- impact – is the strategy having any effect on the target and the wider determinants that shape health inequalities?
- focus – does the strategy match the challenge and is it reflected in action on the ground?
- scope – does the strategy address the right groups to have an impact on the target and reduce health inequalities in the long term?

Impact

THE CHALLENGE

Meeting the 2010 target will depend on the targeted groups and areas keeping up with and exceeding the rate of the overall improvements in health in the rest of the population.

2.5 Life expectancy is continuing to improve and infant mortality rates are at an all-time low level, but the health inequalities gap – as measured by the target – is wider than at the baseline. Death rates from cardiovascular disease (CVD) and cancer have fallen rapidly for all parts of the population in the last 10 years, including the most disadvantaged groups, yet the overall health gap remains.

2.6 Improved health in England is tempered by the continuing challenge of health inequalities. This situation partly reflects the ambition of the target. It is not concerned simply with improving the health standards of the most deprived part of the population, but in highlighting the relative differences in health standards between some social groups and the rest of the population.

2.7 There have been real improvements in health and social standards in recent years, which have improved the lives of almost all individuals and families. The relative basis of the target highlights the relationship between different groups in the population. Absolute improvements in health may not, by themselves, narrow the gap. Well-intended policies can improve average health but may have no effect on inequalities and may even widen them by having greater impact on better-off groups. The evidence suggests that health improvements among better-off groups may have occurred at a faster rate than in other groups in the population. The result has been that the gap has not narrowed for life expectancy in disadvantaged areas; indeed, the gap has widened, particularly for women. This is a challenge for a health inequalities strategy that seeks to improve the health of disadvantaged groups faster than other groups in the population.

2.8 Different targets show a different impact on the health gap, depending on what they measure. This can give apparently conflicting pictures about what is happening to the health gap, such as in differences between targets based on relative and absolute gap measures. There are also other factors at play. The health inequalities life expectancy target gap shows a stable or slightly widening trend, whereas the CVD and cancer death rate trends – major contributors to life

expectancy – show a falling trend in the gap. These different pictures are partly explained by measurement issues: the life expectancy target relates to all ages, whereas the CVD and cancer death rate targets relate to the under-75 population. Inequalities in cancer death rates are increasing in those over the age of 75. The difference also relates to the scope of the target. While CVD and cancer are important contributors to reducing the gap, they are not the only factors. Combined, all other causes of death contribute a significant part of the gap, and the gap in some specific elements – such as respiratory and digestive disease – has been increasing.

2.9 It has already been noted that some aspects of health inequalities have continued to widen in line with long-term trends, while other aspects have stabilised. This is likely to be linked to the fact that the long-term trend of widening inequalities in many of the social determinants of health has yet to be reversed, including behavioural factors like cigarette smoking (where evidence suggests that the socioeconomic gradients have steepened across 50 years) and wider determinants like educational qualifications and income (where inequalities have widened across the last 25 years). The national headline indicators do, however, show signs of narrowing the gap in some areas.

2.10 Improving life expectancy, reducing the rates of infant mortality and the falling rates of CVD and cancer deaths for all groups are major achievements, but are no guarantee that the 2010 health inequalities target will be met. There is much more to be done in ensuring that the benefits of better health and longer, healthier life expectancy are shared by all.

Focus

THE CHALLENGE

to promote effective action that embraces the target and the wider social determinants of health.

2.11 Health inequalities stem from inequalities in people's early life experience, their education and occupational status, exposure to lifestyle and the environmental risks and diseases to which their life course predisposes them. People in disadvantaged groups and areas tend to experience the poorest health but health inequalities exist across the population as a whole.

2.12 The *Programme for Action* emphasised the importance of a balance between meeting the 2010 target and achieving a long-term sustainable reduction in health inequalities.

2.13 It set out four themes to reflect the breadth of its concerns. These themes were:

- supporting families, mothers and children
- engaging communities and individuals
- preventing illness and providing effective treatment and care
- addressing the underlying determinants of health.

2.14 The role of the NHS lies in addressing issues of equity in access and service quality by tackling the inverse care law, as well as promoting public health and prevention measures. The 2004 Wanless report, *Securing Good Health for the Whole Population* underlined the crucial importance of tackling health inequalities and promoting good health, particularly among disadvantaged groups as part of a 'fully engaged' scenario. If it is to be effective and have an impact of the health status of individuals, families and communities, NHS action should be complemented by action across the wider, social determinants of health.

2.15 This section will explore a number of issues that relate to this challenge of effective action by reviewing:

- the contribution of the NHS to the target
- the contribution of the wider social determinants of health
- the dimension of ethnicity
- the dimension of area and the impact of population change.

The contribution of the NHS to the target

NHS action is crucial to meeting the target. This requires working with partners, including local government. NHS priorities and systems increasingly recognise health inequalities.

2.16 Meeting the 2010 target requires a particular focus on NHS interventions. This was the conclusion of the 2002 cross-cutting review on tackling health inequalities and was confirmed by the recent target reviews. A longer-term ambition to reduce health inequalities more broadly will require a stronger emphasis on the wider determinants and the engagement of many more players. Effective action on health inequalities can help the NHS to meet many of its targets.

2.17 For the life expectancy aspect of the target, the elements contributing to the current gap have been identified and prospective interventions modelled against the gap. This modelling, which focused on 'downstream' determinants, suggested that across the country as a whole, a large part of the gap could be closed by action on smoking cessation and on the primary and secondary prevention of coronary heart disease (CHD) and stroke. For infant mortality, a similar exercise showed the importance of taking action on smoking in pregnancy, on maternal obesity, on sudden unexpected deaths in infancy and teenage pregnancy in narrowing the gap, together with action on 'upstream' interventions, including those such as poverty, housing and overcrowding.

Figure 2.1: Causes of the male life expectancy gap and relevant interventions

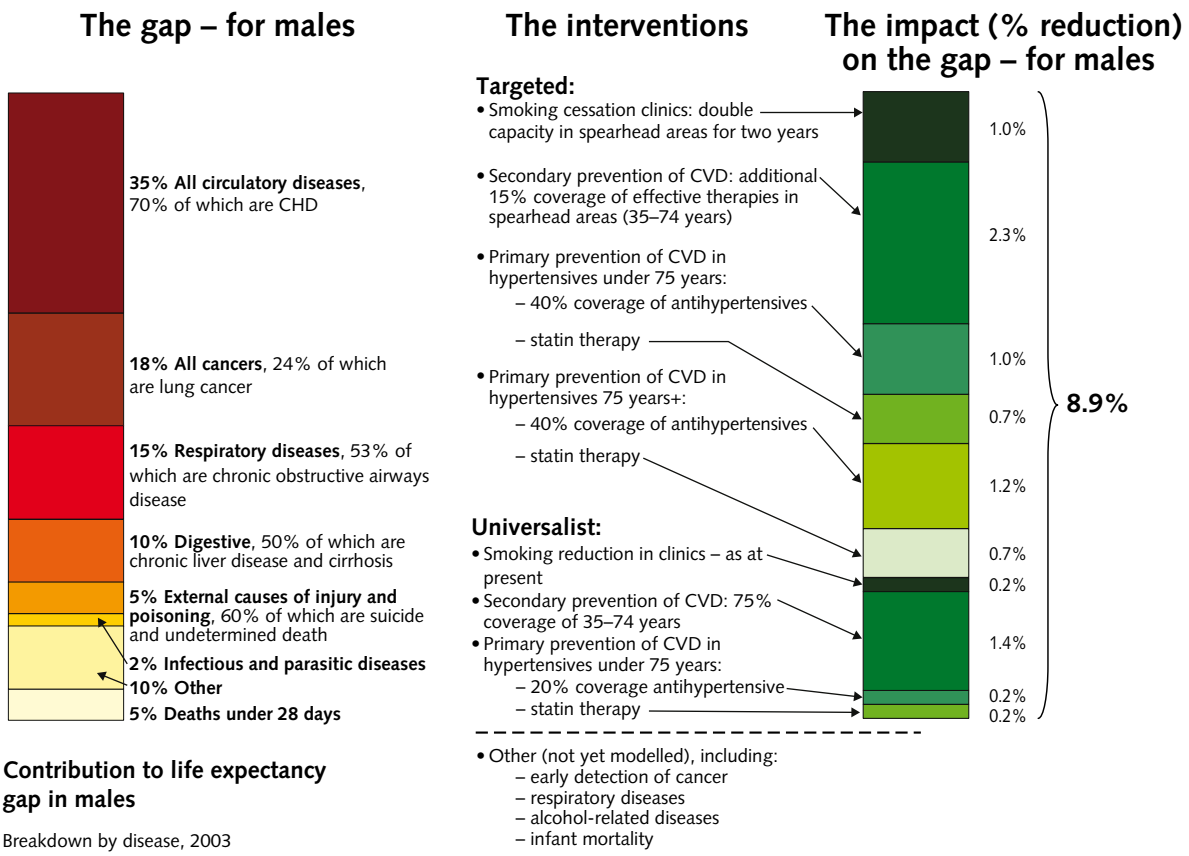
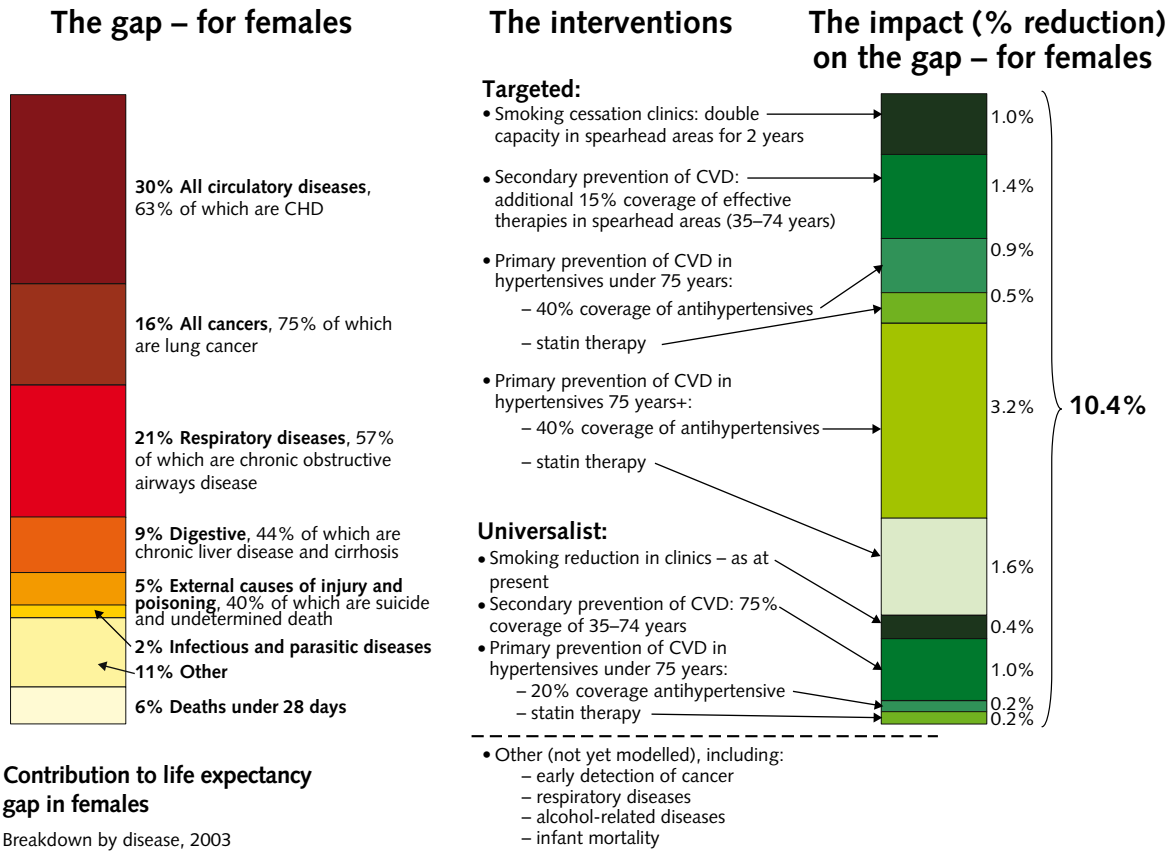


Figure 2.2: Causes of the female life expectancy gap and relevant interventions



2.18 Figures 2.1 and 2.2 show the breakdown of the life expectancy gap for males (Figure 2.1) and females (Figure 2.2) in terms of causes of death. The right-hand side shows the impact of the modelled interventions and their contribution to meeting the life expectancy target. The relevance and impact of these interventions can vary significantly between different areas.

2.19 These modelled interventions reflect the heavy reliance on NHS interventions to deliver the target. It underlines the importance of the call in the *Programme for Action* for mainstreaming health inequalities in the planning and development of NHS services. Building on the changes in the NHS structure and operational arrangement since 2003, health inequalities have become more central to NHS systems.

2.20 Developments that have offered opportunities to the NHS to improve their services and address the needs of disadvantaged groups and areas include the *Commissioning Framework for Health and Well-being* (2007). This approach has put people at the centre of commissioning by promoting the use of information across boundaries to enable a better understanding of the needs of individuals and communities. The new duty of Joint Strategic Needs Assessment (JSNA) will underpin local needs assessment between the NHS and local government, providing a vehicle for tackling health inequalities at local level.

2.21 In primary care, tackling the correlation between areas with fewest primary care clinicians and those with worse health outcomes and highest levels of deprivation – a dimension of the inverse care law – has assumed new urgency. First set out in the *Our health, our care, our say* White Paper, this approach is at the heart of the interim Darzi review, which outlined a package of new measures to improve access to primary care, including £250 million to deliver at least 100 new GP practices in the most deprived areas with fewest GPs and nurses.

2.22 The new maternity indicator, which will 'measure the percentage of women who have been seen by a midwife or a maternity health professional for a health and social care assessment of needs, risk and choices by 12 completed weeks of pregnancy', will help to address health inequalities and improve outcomes for all women, including the most vulnerable, by improving the rates of early antenatal booking.

2.23 Practice-based commissioning has also sought to give clinicians the tools to plan and shape the nature and range of local services available to their practice population. This would allow these services to be tailored to improve health outcomes, to better meet local needs and to contribute to tackling health inequalities.

2.24 Health inequalities was confirmed as a national priority in the latest *Operating Framework for the NHS for 2008/09* (2007). This framework highlights the still unacceptable variations in health status within and between different communities and the need for action. It states that:

'Primary care trusts (PCTs), working with local authorities and other partners, will also need to consider how their local plans focus on ill-health prevention and on promoting good health … and on ensuring that health inequalities are reduced. This includes tackling lifestyle issues such as obesity … and other areas where we know inequalities exist.'

2.25 Health inequalities are a long-term NHS priority. This was confirmed by the Secretary of State's announcement in September 2007 of his intention to develop a comprehensive strategy for reducing health inequalities to succeed the *Programme for Action*.

Wider determinants – the role of income, tax and benefits

Action on wider determinants will contribute to meeting the target and is central to achieving a long-term sustainable reduction in health inequalities.

2.26 Departmental action across government has helped to address the underlying social determinants of health through a range of different programmes and initiatives. For example, improving educational attainment and tackling low basic skills, improving the quality of poor housing, improving the accessibility, punctuality, reliability and use of local transport, tackling worklessness and inactivity and improving access to social and community facilities and services. This section looks at the role of income, tax and benefits, including child poverty.

Child poverty

2.27 There are close links between poverty and poor health outcomes, lower life expectancy and high rates of self-reported long-standing illness. Persistent family and childhood poverty is also damaging to future generations. Action on child poverty has been underpinned by efforts to redress income inequalities through the national minimum wage, Welfare to Work, tax credits and other programmes.

2.28 The impact of meeting the child poverty target for 2010 on the infant mortality aspect of the health inequalities was recently modelled, and showed a significant impact. Meeting the child poverty target – to halve the number of children in relative low-income households between 1998–99 and 2010–11 – by increasing the income in the routine and manual group by an average of 18% is estimated to narrow the infant mortality gap by about three percentage points.

2.29 Action on child poverty has succeeded in arresting and reversing the rising long-term trend in child poverty. In 1997, there were 3.4 million children in poverty – or one in three children. By 2005/06, there were 600,000 fewer children in relative low-income households than in 1998/99.

2.30 Further action will be required if the child poverty targets are to be met and the full effect is to be felt by the health inequalities target. Tax credit measures announced in the 2007 budget will lift a further 300,000 children out of poverty from April 2008. To make further progress towards the 2010 target, the following approach has been developed by Department for Work and Pensions (DWP):

- to help lone parents into work
- to ensure people stay in work and progress in their jobs
- to develop a family focus in the Department's work with all parents.

The new Health in Pregnancy Grant will be available to every mother-to-be from April 2009, and will provide flexible financial help to support the general health and wellbeing of women in the later stages of pregnancy.

2.31 A joint Department for Children, Schools and Families/DWP Child Poverty Unit has recently been established to ensure a clear cross-government approach to tackling child poverty, working closely with key stakeholders to drive forward the child poverty agenda.

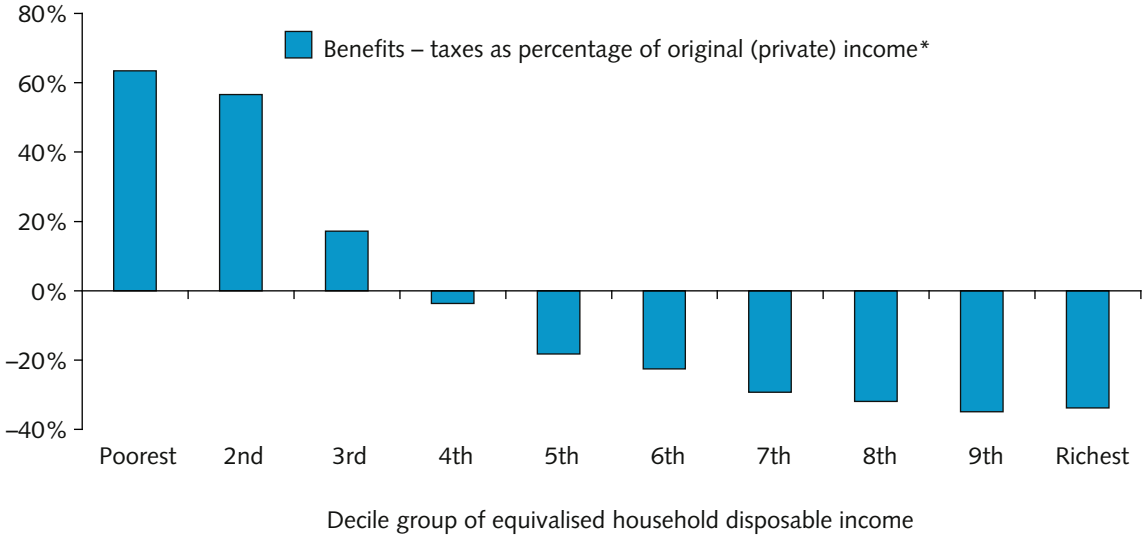
Income inequalities

2.32 Recent work from the Office for National Statistics (ONS) on income inequality trends shows that inequalities in disposable income increased rapidly in the second half of the 1980s, reaching a peak in 1990. After 1990, the trend was downwards, although inequalities did not return to the levels seen before the increase of the late 1980s. After 1995/96, inequalities actually began to rise again, reaching a peak in 2001/02 – at a level similar to that seen in 1990. From 2001/02, there was a small reduction in income inequality, although the latest figure for 2005/06 shows an increase over the previous year.

2.33 Cash benefits play the largest part in reducing income inequality. The majority of these benefits go to the households in the lowest part of the distribution, with the poorest two-fifths receiving 59% of the total. Cash benefits make up 61% of gross income for the bottom quintile. Figure 2.3 shows the distributional effect of wider tax and benefit changes and their impact in improving the incomes of poorer households.

2.34 The introduction of the national minimum wage has also contributed to the reduction in the gap in income inequalities after 2001/02 through the impact on the earnings distribution. The adult minimum wage increased by 27.4% between October 2002 and October 2006 compared with an increase of 16.7% in average earnings. The tax credit system also had some effect, through increasing the incomes of non-retired households – particularly those with children. Notwithstanding these improvements in the income of disadvantaged groups, significant inequalities in wealth remain.

Figure 2.3: Distributional effects of the tax and benefits system, 2004/05



* excluding most business taxes

Source: Stuart Adam and James Browne, Institute of Fiscal Studies (IFS), authors' calculations from ONS (2006)

Other dimensions of health inequalities – ethnicity and area

A sustainable approach requires action on other dimensions of health inequality, including ethnicity, area, age and gender.

2.35 While the *Programme for Action* focused on the socioeconomic differences between groups, it noted the influence of other powerful factors on health status, including ethnicity and area factors – not least the impact of population change. These influences have an impact on the health gap and on delivering the target.

Ethnicity

2.36 The number of people from a non-white black and minority ethnic (BME) group in Great Britain grew by 53% between 1991 and 2001 – from three to 4.6 million. These numbers have continued to grow. While there is a strong association between ethnicity, deprivation and poor health, this is not true for all groups. For example, higher levels of educational attainment have been achieved among Indian and Chinese groups than in white groups. However, there are groups where this effect is strongly marked. Bangladeshi and Pakistani groups make up a four-times-higher proportion of the population in the most deprived local areas than in England as a whole; the proportion for black Caribbean and black African groups is two-and-a-half times higher.

2.37 Thus, ethnicity is relevant to the target because of this match between some BME groups and the groups and areas covered by the target. For the life expectancy element of the target, the spearhead areas cover 28% of the population as a whole, but include 44% of BME groups (based on data from the 2001 census).

2.38 More recently, the arrival of new communities, including those from the enlarged EU area and asylum-seekers, has added to some of the challenges for disadvantaged and other areas. This is clear in the pressure on NHS services – particularly maternity services, where the proportion of births to women born outside the UK is higher than the average of one in five births to women born outside the UK across the country as a whole (in 2006).

2.39 The health inequalities infant mortality target review also highlighted the strong association between some ethnic groups, disadvantage and their potential contribution to the target. It identified two kinds of approach: action through the NHS, tackling issues around access and service delivery and specific issues around congenital anomalies and wider action on disadvantaged groups. The implementation plan that followed on from the review observed that:

'Tackling disadvantage among BME groups with higher rates of infant mortality is a major challenge for delivery of the target. Evidence from the Family Resources Survey makes clear that, compared with children in households in which the head of the household is white, children in BME households are much more likely to be in the lowest income quintile. In the Millennium Cohort Study, white and

Indian mothers were at much lower risk of living in disadvantaged circumstances than mothers from other ethnic groups. The link between ethnicity and socioeconomic disadvantage is particularly strong for Bangladeshi and Pakistani mothers and their partners who have migrated relatively recently to the UK.'

Area

2.40 Area inequalities in health reflect people's socioeconomic circumstances. These circumstances influence both where they live and their health. As a result, higher levels of area deprivation are associated with higher rates of mortality.

2.41 Area inequalities in health are long standing and the spatial distribution of social disadvantage and poor health has remained broadly stable over time. Areas marked out by their high levels of deprivation and their high rates of mortality 100 years ago are similar to the areas with the poorest socioeconomic and health profiles today.

2.42 Trends in health inequalities between areas will be affected by trends in socioeconomic inequalities between areas. Thus, persisting socioeconomic inequalities between areas – for example in skills levels, employment rates, claimant counts and poverty rates – will make it harder to achieve reductions in health inequalities between areas. Widening inequalities between areas will make it harder to meet the target and achieve a long-term sustainable reduction in health inequalities.

The impact of population change

2.43 Measuring trends in health inequalities using area-based measures is complicated by the fact that the population of areas changes over time. Migration tends to be selective with respect to both socioeconomic position and health. This means that, broadly, more advantaged people in better health are more likely than their poorer and less healthy neighbours to move out of disadvantaged areas and into more prosperous areas populated by residents in better health. Equally, people moving into disadvantaged areas tend to be poorer and have poorer health than those they leave behind.

2.44 ONS data suggest that selective migration over time can contribute to a widening of health inequalities – such as in limiting long-term illness. This effect is, however, hard to capture in the tracking of trends against the life expectancy element of the health inequalities target.

2.45 Selective migration is relevant to assessing progress towards the target. Selective out-migration could moderate the positive effects of these interventions to improve circumstances in spearhead areas – those whose circumstances improve may have a greater propensity to leave. Alternatively, programmes may improve spearhead areas sufficiently to attract newcomers who are more prosperous and healthy – for example, through gentrification – thus lifting the rate of improvement in the headline indicators and in life expectancy above that achieved by the programmes alone.

2.46 As well as health inequalities trends between areas, there are inequalities in health within areas. The evidence suggests that the health of more advantaged groups within the spearhead areas is improving more quickly than less advantaged groups. This suggests that increases in life expectancy – and, potentially, progress towards the target – could be accompanied by a widening of inequalities within these PCTs, with the health of poorer groups slipping further behind that of their more prosperous neighbours. Differential uptake and effectiveness of welfare benefits, health services and targeted interventions like Sure Start and smoking cessation services, could contribute to such a trend.

2.47 This experience underlines the importance of:

- a flexible focus in tackling health inequalities
- a balance between action on the NHS and on the wider determinants (and partnership working to avoid a 'silo' mentality)
- a recognition of the impact of the other dimensions of health inequalities.

Hitting the short-term target and achieving a long-term sustainable reduction in health inequalities requires a complementary approach through a focus on specific groups and by mainstreaming good-quality services for all disadvantaged groups and areas.

Scope

THE CHALLENGE

to reach out to the target groups and areas and make health inequalities relevant for the whole population.

2.48 The health inequalities target embraces both a socioeconomic focus and an area focus. The growing pressure to meet the 2010 target has placed a strong emphasis on an area approach. This is encapsulated by the drive to reduce health inequalities in spearhead areas (which is part of the target) but it is also shared by the infant mortality aspect of the target. This has – by definition – limited the scope of action, but it is necessitated by the need to concentrate resources at the local level in disadvantaged areas. The need to identify priorities has been a powerful force in narrowing the scope of action and potential interventions. Concentrating efforts in selected areas is seen as the most likely way of achieving the greatest gains in terms of narrowing the gap contributing to the target.

2.49 The spearhead group covers the 70 local authority (single tier and district) areas with the worst health and deprivation indicators, or around 28% of the population, a substantial but specific group. A similar approach has also conditioned the handling of the infant mortality aspect of the target, compounded by the relatively small number of infant deaths in most areas. These pragmatic considerations have focused action on the 43 local authority areas with the highest number of infant deaths in the target group. Not surprisingly, there is a considerable overlap with the spearhead areas.

2.50 This targeted approach may improve the prospects of meeting the 2010 target, but it raises issues around achieving a long-term sustainable reduction in health inequalities. The risk is that disadvantaged groups and areas outside these target areas are excluded from these programmes. This includes some areas with a heavy burden of disadvantage, such as Leeds, Sheffield and Plymouth. The *Programme for Action* emphasised that more disadvantaged people were located outside areas of disadvantage than were included within them. This requires an approach that ensures that long-term sustainable reductions in health inequalities is an integral part of policy development and implementation for all.

2.51 This widening of the scope of action on health inequalities can be achieved by other means, particularly through partnership working. Thus, mainstreaming health inequalities in the delivery of public and other services is crucial to developing a longer-term perspective. Sure Start Children's Centres show how high-quality services can be delivered to disadvantaged groups and areas across the country, not only improving service delivery but also beginning to change the low expectations and aspirations that contribute to health inequalities.

A wider view – beyond the targets

2.52 The health inequalities target has stimulated action where none existed previously. Targets have many purposes: they assign – or confirm – the importance of an issue; they can be aspirational, giving legitimacy to activities even if the target itself is not achievable within the timescale set for delivery; and they can also help to measure progress towards equity and improve accountability by providing a specific focus. Initially, the national health inequalities target provided an opportunity to promote health inequalities; recently it has assumed this latter, more specific and practical role. This is reflected in the production of successive status reports.

2.53 From 2001 when the health inequalities target was first announced, there were efforts to extend action beyond the tightly defined terms of the target to the wider aspects of health inequalities, so that progress will not be 'assessed simply' in terms of the targets as formulated.

2.54 The strategy set out in the *Programme for Action* sought to reconcile the specific aims of the target with this broader concern, not least through the adoption of the 12 cross-government headline indicators to support the monitoring of the national targets and ensuring that most key aspects of the inequalities agenda were kept under review. These indicators did not cover every aspect of health inequalities. For example, they did not address the impact of alcohol-related harm on either inequalities or poverty. A more comprehensive set of indicators was to be found in the local basket of indicators and the health poverty index, which took a holistic view of health inequalities across the determinants of health.

2.55 Equally, the *Programme for Action* developed the theme of supporting families, mothers and children to support the infant mortality aspect of the target. This reflected the rationale given for the infant mortality target to mobilise efforts to reduce inequalities in early life more generally.

'Infant mortality reflects a range of influences within and outside the health services, and success in achieving the target should be a measure of progress across a much broader front than the immediate measure of mortality in a very restricted age group.'

2.56 This commitment to look beyond the specific terms of the target exposed a flaw in the structure of the target. By focusing on the routine and manual target group, it excluded other disadvantaged groups, like sole registration births (those births registered by the mother only). This group (and other disadvantaged groups) is at a high risk of adverse health outcomes, including infant mortality. The *Programme for Action* covered all disadvantaged groups as part of a wider effort to improve the health of families, mothers and children. Successive status reports have monitored the infant mortality rates of all disadvantaged groups, against the target. The infant mortality target review sought to reflect their needs in its recommendations.

Lessons from the target

2.57 The targets on infant mortality and life expectancy announced in *The NHS Plan* (2000) were the first-ever national health inequalities targets. They were devised as separate targets but subsequently consolidated. They were both clearly defined, measurable and set against a timescale, an approach taken by few – if any – other countries across the world.

2.58 The target has spurred action on the health inequalities agenda and signalled the political support for action by:

- raising the profile and priority of health inequalities
- providing a focus for work across cross-government and other organisational boundaries
- setting a timeframe to galvanise action
- diverting resources into disadvantaged areas
- developing the evidence base to support implementation of the target
- covering the life course from before birth to death.

2.59 The focus of the target raises two other issues – firstly it concentrates on NHS interventions at the expense of the wider determinants of health, which often have the biggest impact. Equally, the emphasis on specific areas and groups means that the target does not apply to all areas. While this helps to focus action, it is a drawback in reconciling short-term and long-term objectives of the strategy. The *Programme for Action*, with its four themes, has sought to provide a strategic umbrella under which action on the target co-exists with wider efforts to reduce health inequalities in the long term.

Chapter 3: Developments against the targets

KEY MESSAGES

- **Progress against the life expectancy target remains challenging but there has been a further slight narrowing of the gap in infant mortality, and life expectancy in some spearhead areas has increased faster than the national average.**
- **There has been progress in reducing child poverty, and narrowing inequalities in housing quality, educational attainments and uptake of flu vaccinations. Circulatory (heart) disease and cancer mortality, child road accident casualties and teenage conceptions have shown a narrowing of inequalities in absolute terms but not in relative terms.**
- **almost all departmental commitments set out in the *Programme for Action* and due for delivery by the end of 2006 have been wholly or substantially achieved.**

3.1 This chapter reports on the data developments against the target. It includes:

- results against the Public Service Agreement (PSA) target for 2004–06
- a detailed breakdown against the 12 headline indicators (mostly based on data for 2006)
- a summary of progress against the 82 departmental commitments.

Results against the PSA target

Infant mortality

3.2 The health inequalities PSA target for infant mortality is:

- *starting with children under one year, by 2010 to reduce by at least 10% the gap in mortality between the routine and manual group and the population as a whole.*

What the new data for 2004–06 mean for the health inequalities PSA target

3.3 Latest data for 2004–06 show a further slight narrowing in the gap between the routine and manual group and the population as a whole, compared with 2002–04 and 2003–05. Over the period since the target baseline (1997–99), the gap had widened, although there have been year-on-year fluctuations in intervening years. The slight narrowing during the latest period is encouraging; however, the target to narrow this gap by at least 10% by 2010 is still a challenging one.

3.4 The infant mortality rate among the routine and manual group was 17% higher than in the total population in 2004–06, compared with 18% higher than in the total population in 2003–05 and 19% higher than in the total population in 2002–04. This compares with 13% higher in the baseline period of 1997–99.

3.5 For the latest three-year average period, 2004–06, the overall infant mortality rate for target purposes (i.e. for all those with a valid socioeconomic group) was 4.8 deaths per 1,000 live births, and the rate for those in the routine and manual group was 5.6 deaths per 1,000 live births. The mortality rate in both of these groups has fallen since the baseline. These rates are higher than for those in the managerial and professional (3.3 deaths per 1,000 live births) and intermediate (4.4 deaths per 1,000 live births) socioeconomic groups.

3.6 In the single year 2006 (noting that single year rates can sometimes be based on small numbers of deaths, and should therefore be interpreted with caution), infant mortality rates were as follows:

- The infant mortality rate was highest among mothers aged under 20 (6.4 deaths per 1,000 live births) followed by those aged 40 and over (5.9 deaths per 1,000 live births). The infant mortality rate was lowest among mothers in the 30–34 age group (4.1 deaths per 1,000 live births).

- The infant mortality rate for very low birthweight babies (under 1,500 grams) and low birthweight babies (under 2,500 grams) were 196 and 41 deaths per 1,000 live births respectively, compared with a rate of 1.7 among normal birthweight babies (2,500 grams and over). Half of all infant deaths occurred among very low birthweight babies.

Sole registrations and 'other'

3.7 Figure 3.1 also includes trends relating to sole registrations (births registered by the mother only) and the 'other' category (including students, those who have never worked and those with occupations unclassified), in addition to the PSA target group (routine and manual). Although not explicitly part of the target, there are a substantial number of deaths in these groups, both of which show elevated rates of infant mortality compared with the population average.

Routine and manual, sole registrations and 'other' socioeconomic groups

3.8 In the latest three-year period, 2004–06, 34.5% of all live births were to parents with fathers in the routine and manual socioeconomic group. Out of the total of infant deaths, 38.5% were in the routine and manual group. Both of these percentages have decreased over the last two time periods, from 35.0% of live births and 39.5% of infant deaths in 2002–04. Sole registered births, those registered by the mother only, accounted for 7.0% of all live births in 2004–06, and 9.1% of all infant deaths. These percentages had also decreased slightly since 2002–04, with some fluctuation in between. The 2002–04 figures were 7.2% and 9.3% respectively. 'Other' socioeconomic groups (including those who were unemployed, students or never worked) accounted for 5.5% of live births and 9.4% of all infant deaths in 2004–06. These proportions had both risen slightly over the past two time periods, from 4.9% and 8.8% respectively in 2002–04.

3.9 Between 2003–05 and 2004–06 the infant mortality rate:

- fell among sole registrations from 6.8 to 6.5 deaths per 1,000 live births

- fell in the 'other' category from 8.7 to 8.6 deaths per 1,000 live births.

3.10 Examination of **single year** data – with the usual caution required for assessing year-on-year changes – indicates that between 2005 and 2006 the infant mortality rate:

- fell among sole registrations from 7.0 to 6.3 deaths per 1,000 live births
- fell in the 'other' category from 8.8 to 8.6 deaths per 1,000 live births.

Technical note: background to social classification

In 2001, changes were introduced that affected reporting of infant mortality by socioeconomic status. The National Statistics Socio-Economic Classification (NS-SEC) replaced the Registrar General's Social Class; the 10-yearly update of the standard occupational classification was implemented; and a change was made to the coding of employment status.

To take account of this change in classification, the formulation of the target was changed from manual social class to routine and manual group. Figures for 2001 were published in February 2003 for the first time using the new NS-SEC, and a time series back to 1994 was constructed to be on an equivalent basis.

Figure 3.1: 3-year average infant mortality rates* by NS SEC90 for 1994–2001, and by NS SEC for 2001 onwards, by NS SEC analytical classes

ENGLAND AND WALES

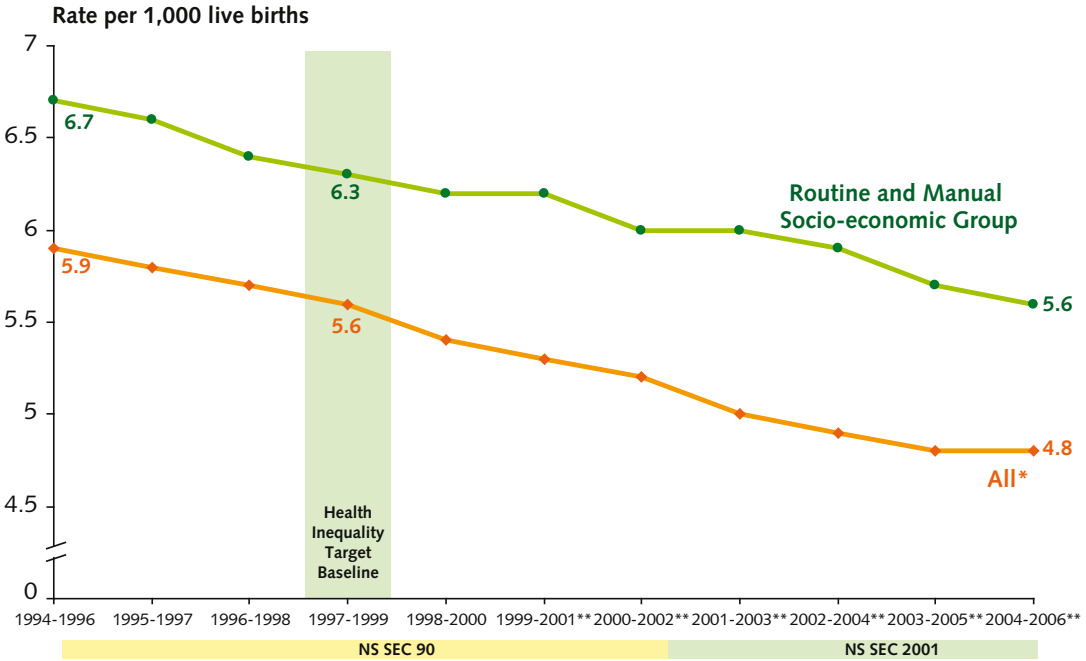
	Analytical classes	NS SEC90					NS SEC 2001**					
	Three-class version	1994–1996	1995–1997	1996–1998	1997–1999	1998–00	1999–2001	2000–2002	2001–2003	2002–2004	2003–2005	2004–2006
1	Managerial and professional	4.4	4.4	4.2	**4.1**	3.9	3.8	3.6	3.5	3.4	3.4	3.3
2	Intermediate	5.2	5.4	5.5	**5.3**	5.1	4.9	5.0	4.7	4.7	4.4	4.4
3	**Routine and manual**	**6.7**	**6.6**	**6.4**	**6.3**	**6.2**	**6.2**	**6.0**	**6.0**	**5.9**	**5.7**	**5.6**
	Other #	8.7	8.4	8.9	**8.9**	9.2	8.8	9.6	9.4	9.3	8.7	8.6
	All (inside marriage/ joint reg)***	**5.9**	**5.8**	**5.7**	**5.6**	**5.4**	**5.3**	**5.2**	**5.0**	**4.9**	**4.8**	**4.8**
	Relative gap (%) between Routine and manual and all	**15%**	**14%**	**12%**	**13%**	**14%**	**17%**	**16%**	**19%**	**19%**	**18%**	**17%**
	Sole registrations ##	7.9	7.5	7.4	**7.6**	7.6	7.6	7.3	7.2	6.7	6.8	6.5

Source: Office for National Statistics
Notes:
NS-SEC = National Statistics Socio-Economic Classification
*Infant deaths per 1,000 live births
**using NS SEC for 2001 and later years' data
Information on the father's occupation is not collected for births outside marriage if the father does not attend the registration of the baby's birth
***Infants born inside marriage or outside marriage jointly registered by both parents.
Figures for live births are a 10 per cent sample coded for father's occupation.

Students, never worked, long term unemployed, occupation inadequately described or not classifiable for other reasons
Births registered by mother alone. Not included in "All (inside marriage/joint registrations)"

Figure 3.2: Infant mortality by Socio-economic Group

Three year rolling average trend, 1994-2006, England and Wales



* "All" relate to inside marriage and joint registrations outside marriage, not including "social class not specified" for 1995 and 1999. Sole registration and unlinked births are excluded.

**using NS SEC for 2001 and later years' data

Information on the father's occupation is not collected for births outside marriage if the father does not attend the registration of the baby's birth

Figures for live births are a 10 per cent sample coded for father's occupation.

Source: Office for National Statistics

Figure 3.3: Infant mortality rate (per 1,000 live births) single year data – sole registrations and "other" social class/NS-SEC category

Infant mortality rate (per 1000 live births)	ENGLAND AND WALES										
	RG social class						NS-SEC				
	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Sole registration	7.1	7.6	7.6	7.6	7.7	7.6	6.6	7.4	6.3	7.0	6.3
"Other" social class/NS-SEC											
Inside marriage	8.3	9.0	8.5	7.3	7.7	7.1	9.1	8.4	7.2	7.7	7.0
Outside marr/joint reg.	13.8	13.3	14.7	15.4	16.8	12.5	13.3	9.4	9.6	9.9	10.1
Total "Other"	10.2	10.6	10.7	10.3	11.2	9.3	11.0	8.9	8.4	8.8	8.6

Source: ONS

2005 data from Health Statistics Quarterly 32
2006 data from Health Statistics Quarterly 36

Sole registrations: Births registered by mother alone

"Other" category: Students, never worked, long term unemployed, occupation inadequately described or not classifiable for other reasons

RG = Registrar General

Ethnic origin and mother's country of birth

3.11 It is not currently possible to provide analyses of infant mortality by ethnic origin, as this information is not collected at birth or death registration. So the results quoted below relate to mother's country of birth (which is collected at birth registration), and is used as a proxy for ethnic origin. However, from 2005 onwards, ONS has access to the NHS Numbers for Babies records, which include information on ethnicity. This will be linked to information collected at birth and death registration, and hence future analyses of infant mortality will be made available by ethnicity.

Infant mortality rates by mother's country of birth, 2004–06

3.12 For the three year period, 2004–06, babies of mothers born in the Caribbean and Pakistan had infant mortality rates of 9.4 and 9.0 deaths per 1,000 live births respectively, compared with the overall infant mortality rate of 4.9 deaths per 1,000 live births (the rate of 4.9 includes some cases without a valid socioeconomic group). Thus, the infant mortality rates for babies of mothers born in the Caribbean and Pakistan were 92% and 84% higher respectively than the average for all babies born in England and Wales in 2004–06.

3.13 For the single year, 2006, babies of mothers born in the Caribbean and Pakistan had the highest infant mortality rates, 8.8 and 9.4 deaths per 1,000 live births respectively, compared with the overall infant mortality rate of 4.8 deaths per 1,000 live births (the rate of 4.8 includes some cases without a valid socioeconomic group).

Life expectancy

3.14 The health inequalities PSA target for life expectancy (published as part of the 2004 Spending Review (SR2004)) is:

- *starting with local authorities, by 2010 to reduce by at least 10% the gap between the fifth of areas with the worst health and deprivation indicators (the spearhead group) and the population as a whole*

What the new data for 2004–06 mean for the health inequalities PSA target

3.15 **For the SR2004 target:**

- in 2004–06 the relative gap in life expectancy between England and the spearhead group is wider than at the baseline (1995–97) for both males and females
- for males the relative gap is 2% wider than at the baseline (the same as in 2003–05), for females 11% wider (compared with 8% in 2003–05)
- the 2003–05 relative gaps showed little change over the 2002–04 figures, and data are subject to year-on-year fluctuation.

The target to narrow the gap by at least 10% by 2010 is therefore still a challenging one.

3.16 As part of SR2004, the life expectancy target was revised. The previous version of the target (SR2002 PSA) was set in terms of the gap between England and the fifth of local authorities with the lowest life expectancy (rather than England and the spearhead group, as in SR2004). The SR2002 target has been largely superseded by the SR2004 target, but developments are still reported.

3.17 **For the SR2002 target:**

- for females, in 2004–06 the relative gap in life expectancy between England and the fifth of local authorities with the lowest life expectancy was 11% higher than at the baseline (1997–99) (compared with 7% on revised data in 2003–05)
- for males, in 2004–06 the relative gap was 1% higher than in the baseline year (compared with 1% lower than at the baseline on revised data for the period 2003–05). The data are subject to year-on-year fluctuation.

Figure 3.4: Life expectancy at birth (years) for England and the spearhead group

MALES	Baseline												Target
	1993–95	1994–96	1995–97	1996–98	1997–99	1998–00	1999–01	2000–02	2001–03	2002–04	2003–05	2004–06	2010
England average	74.2	74.4	**74.6**	74.8	75.1	75.4	75.7	76.0	76.2	76.5	76.9	77.3	
Spearhead group average	72.3	72.6	**72.7**	72.9	73.1	73.4	73.7	74.1	74.2	74.6	74.9	75.3	
Absolute gap (difference)	1.9	1.9	**1.9**	1.9	2.0	2.0	2.0	1.9	2.0	2.0	2.0	2.0	
Relative gap (% difference)	**2.51%**	**2.53%**	**2.57%**	**2.59%**	**2.66%**	**2.63%**	**2.62%**	**2.55%**	**2.61%**	**2.59%**	**2.61%**	**2.63%**	**2.32%**
									% change in relative gap – 1995-97 to 2004-06			**+2%**	

FEMALES	Baseline												Target
	1993–95	1994–96	1995–97	1996–98	1997–99	1998–00	1999–01	2000–02	2001–03	2002–04	2003–05	2004–06	2010
England average	79.4	79.6	**79.7**	79.8	80.0	80.2	80.4	80.7	80.7	80.9	81.1	81.6	
Spearhead group average	78.0	78.2	**78.3**	78.4	78.5	78.7	78.9	79.2	79.2	79.4	79.6	80.0	
Absolute gap (difference)	1.4	1.4	**1.4**	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.6	1.6	
Relative gap (% difference)	**1.76%**	**1.77%**	**1.77%**	**1.83%**	**1.85%**	**1.87%**	**1.85%**	**1.85%**	**1.87%**	**1.90%**	**1.91%**	**1.96%**	**1.59%**
									% change in relative gap – 1995-97 to 2004-06			**+11%**	

Figures for the period 2000-02 to 2003–05 have been revised to take into account revised population estimates for 2002–05 published by ONS in August 2007

Life expentancy data source: ONS

Life expectancy – progress in spearhead areas

3.18 There is a great deal of local variation within the spearhead areas. Life expectancy in some spearhead areas is increasing faster than the average, and if their trends were replicated in all spearhead areas, the target would be more than met. To meet the health inequalities life expectancy 2010 PSA target, we will need to reverse a long-term trend and the target remains a challenging one, with widening trends for men and women at a national level.

3.19 Figure 3.5 compares the local authority areas with the highest life expectancy at birth in England, with the local authority areas with the lowest life expectancy at birth in England.

Figure 3.5: Life expectancy at birth – range across local authorities in England

	1995–97 (target baseline)		2003–05		2004–06	
	Male	**Female**	**Male**	**Female**	**Male**	**Female**
Highest at LA level	78.2 Chiltern	83.2 East Dorset	81.7 Kensington and Chelsea	86.2 Kensington and Chelsea	83.1 Kensington and Chelsea	87.2 Kensington and Chelsea
England Average	74.6	79.7	76.9	81.1	77.3	81.6
Spearhead Group Average	72.7	78.3	74.9	79.6	75.3	80.0
Lowest at LA level	70.1 Manchester	76.9 Liverpool and Manchester (joint)	72.5 Manchester	78.0 Liverpool	73.0 Manchester	78.3 Liverpool
Difference between highest and lowest at LA level	8.1	6.3	9.2	8.2	10.1	8.9

Source: ONS data

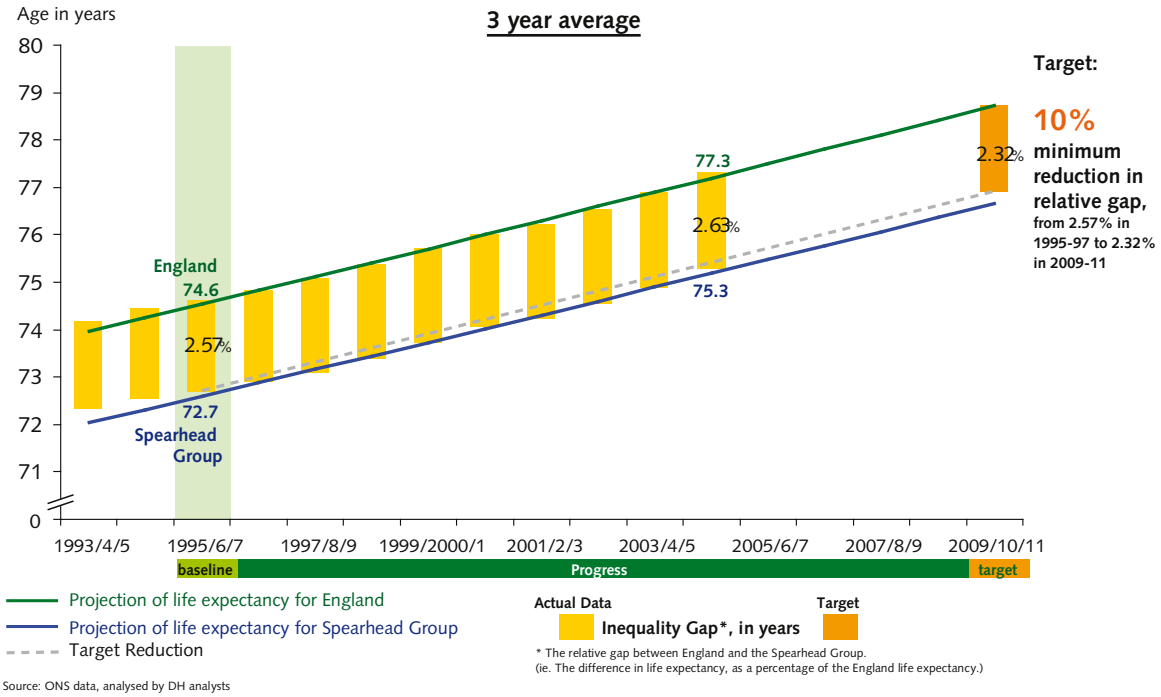
3.20 Although both the highest and lowest life expectancy at local authority (LA) level have increased since 1995–97, the areas with the highest life expectancy showed a greater improvement. So the range of life expectancy across local authorities in England has increased between 1995–97 and 2004–06 for both males and females.

3.21 However, we are seeing some early signs of progress. For life expectancy, the 2004–06 data show that 41% of spearhead areas are on track to narrow their own life expectancy with England by 10% by 2010 compared with the baseline for either males or females or both. Some 17% are on track for males only, with a further 13% on track for females and 11% on track for both.

3.22 The figure in Annex 3 shows whether the 70 spearhead local authorities are on or off track to narrow their share of the life expectancy gap by 10% for males or females, or both, by 2010 according to 2004–06 data. The table also shows a comparison with 2003–05 and 2002–04.

Figure 3.6: Male life expectancy at birth, inequality gap*

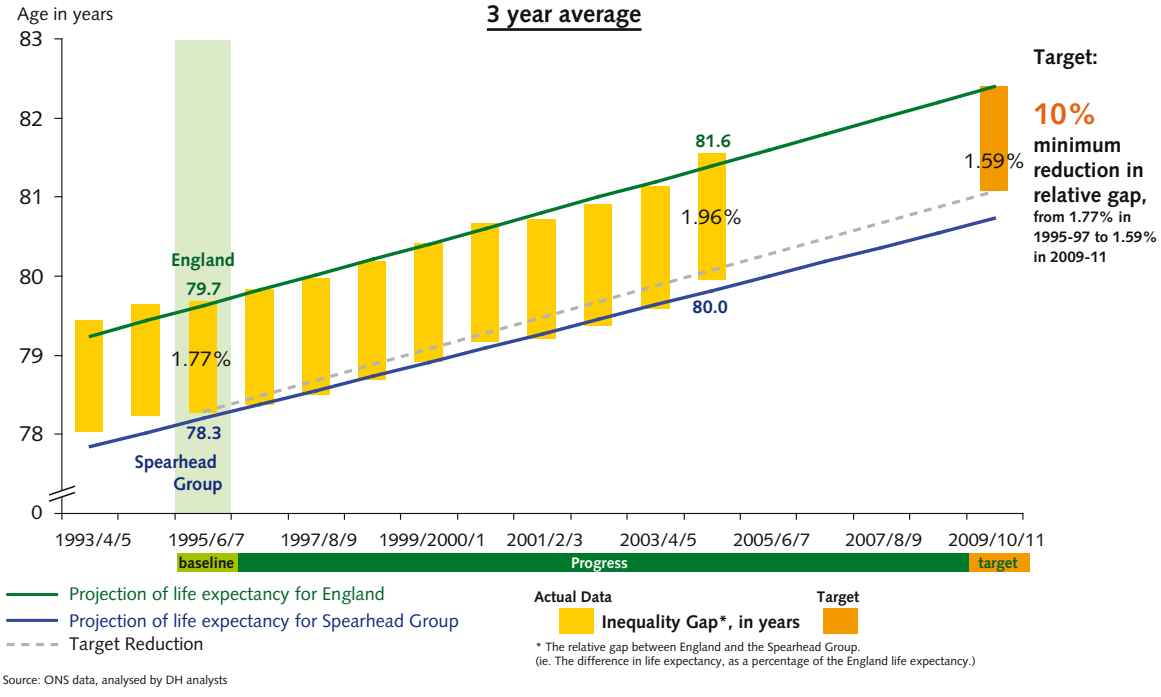
England 1993-2006 and target and projection for the year '2010'



Source: ONS data, analysed by DH analysts

Figure 3.7: Female life expectancy at birth, inequality gap*

England 1993-2006 and target and projection for the year '2010'



Source: ONS data, analysed by DH analysts

Report against the 12 national headline indicators

3.23 This section provides data against each of the 12 headline indicators, analysed to assess progress in reducing inequalities in each indicator from a given baseline to the latest data. For most of the indicators, inequalities are measured by comparing the most disadvantaged group (where possible, the most deprived fifth of local authority districts (LADs)) against the national average and against the least disadvantaged group.

The headline indicators

- death rates from the big killers – cancer and heart disease
- rate of under-18 conceptions
- road accident casualty rates in disadvantaged communities
- numbers of primary care professionals
- uptake of flu vaccinations
- smoking among manual groups and among pregnant women
- educational attainment
- consumption of fruit and vegetables
- proportion in non-decent housing
- PE and school sport
- children in poverty
- homeless families living in temporary accommodation

A note on data

3.24 The use of indicators for quantitative monitoring is limited by the availability of data. Data may not be available for all areas relevant to tackling health inequalities. Even where data are available, there will be limitations due to the time it takes for the figures to become available after the period to which they relate. Qualitative monitoring of action taken is also required, to supplement quantitative monitoring of indicators.

3.25 Data are presented for the national headline indicators, focusing on measures of inequality in relation to the indicators. This includes an assessment of progress in reducing inequalities since the baseline period.

Measures of inequality

3.26 For most of the indicators, the inequality measures presented are the absolute and relative gap between the most disadvantaged group and a reference group (the least disadvantaged group and/or the whole population). That is, the position of the most disadvantaged group is compared with the least disadvantaged group and/or the national average.

3.27 The most and least disadvantaged groups are identified using socioeconomic measures (area deprivation, occupation-based socioeconomic status, income) or suitable proxy measures (vulnerable households, eligibility for free school meals). Limitations of data availability mean it is not possible to identify the comparison groups in the same way for all the indicators.

3.28 The absolute gap is measured by the difference between indicator values in the groups compared. Differences closer to 0 indicate lower inequality. The relative gap is measured by the ratio between indicator values in the groups compared. Ratios closer to 1 indicate lower inequality.

3.29 The gap between comparison groups measures the inequality between the average levels of the indicator in each group, based on aggregate data for each group as a whole. There are likely to be inequalities within each group as well as between groups. (Where groups are defined by geographical areas, there will be inequalities within the areas – i.e. at a smaller area level – as well as between the areas.) Within-group inequalities are not measured by the gap between groups, but could be revealed by data at a lower level of aggregation.

3.30 A narrowing of the gap between comparison groups indicates a reduction in inequality between the average levels of the indicator in each group. However, the picture at a lower level of aggregation may be more complex. For the gap to narrow, some parts of the disadvantaged group must improve relative to the reference group. But this does not mean that all parts of the disadvantaged group will improve relative to the reference group, and the gap between groups can narrow while inequalities within the disadvantaged group widen. For example, the average death rate for the most deprived fifth of LADs may improve faster than the England average, while the gap in death rates between particular LADs within the most deprived fifth widens and some LADs improve more slowly than the England average (so improvements in service delivery designed to narrow inequalities between areas may leave within-area inequalities unchanged or potentially widen them).

3.31 Analysis of the gap between groups is presented in this report as a high-level summary measure of inequalities between groups at aggregate level.

3.32 For two indicators, data are not analysed using the gap between comparison groups. For indicator 11, the extent of child poverty is monitored (as measured by the proportion of children living in low-income households). For indicator 12, the extent of homelessness is monitored (as measured by the number of homeless families with children living in temporary accommodation). For both indicators, a reduction in extent indicates a reduction in inequality.

Baselines

3.33 For each of the indicators, baseline periods have been selected against which progress is measured. While it is desirable to have a consistent baseline period across the indicators, this is not possible because of data availability. Where possible, baselines have been set at or close to 1997. However, for many of the indicators, data are not available prior to more recent years, or comparable data are only available for more recent years, due to changes in the data collection.

Assessment of change

3.34 Data are presented for the latest year and for the baseline period. An assessment is made of whether inequalities are narrower in the latest year compared to the baseline on each of the inequality measures presented.

3.35 The statistical significance of any change in the inequality measures is taken into account in assessing progress. Approximate 95% confidence intervals have been calculated for many of the inequality measures, to give an indication of the extent of possible sampling error (for those indicators based on sample surveys) or of expected random variation over time (for those indicators not based on sample surveys). Assessment of significant change is based on whether the confidence intervals for the differences and ratios between the baseline and latest year overlap. Confidence intervals for some of the measures based on sample surveys are quite wide, so it is difficult to make a robust assessment of progress.

Headline indicators summary tables

Indicator 1a: Age-standardised death rates per 100,000 population for the major killer diseases (cancer, circulatory diseases), ages under 75 – cancer

Overall summary: There have been improvements in cancer death rates since 1995–97 (including for the most disadvantaged areas), with a narrowing of inequalities in absolute terms but no significant change in relative terms.

Figure 3.8: Age-standardised death rates per 100,000 population for cancer, ages under 75, by area deprivation

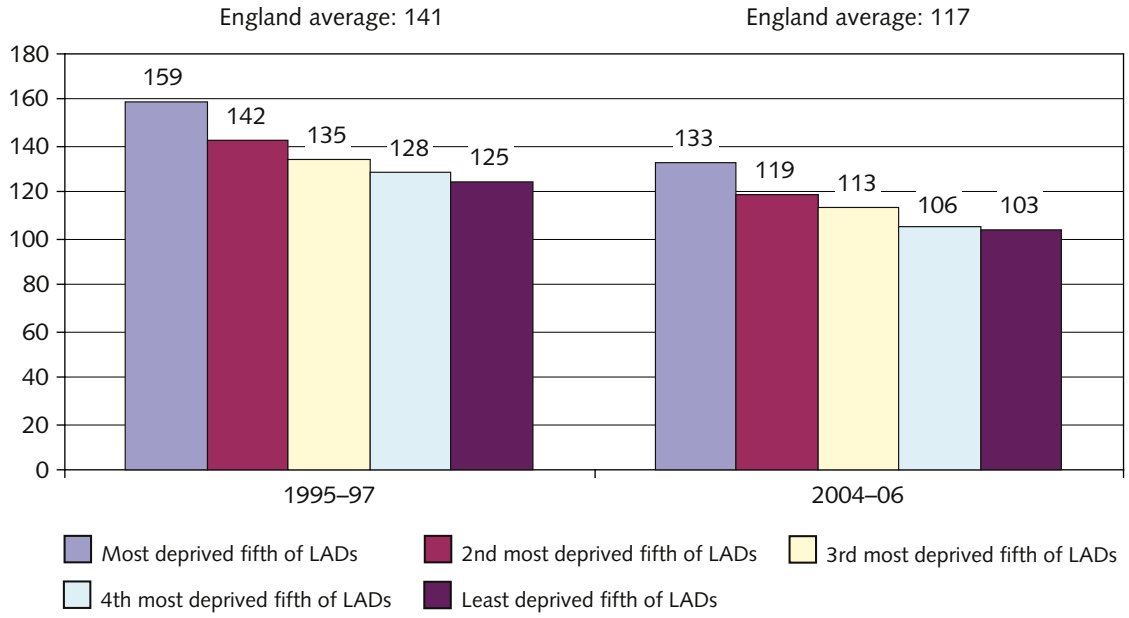
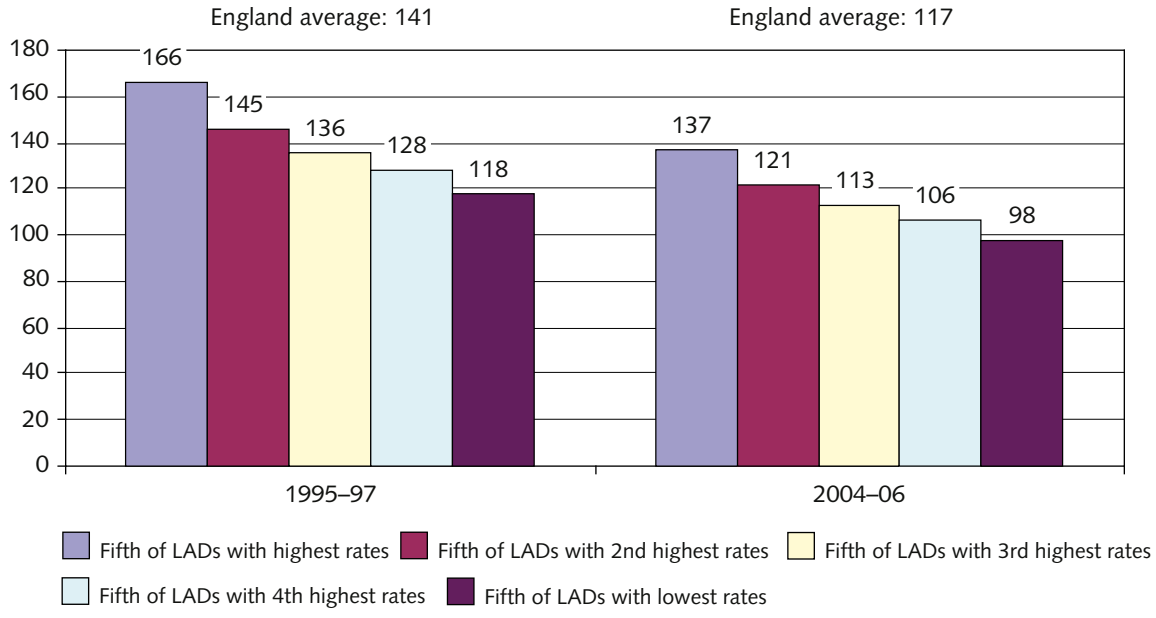


Figure 3.9: Age-standardised death rates per 100,000 population for cancer, ages under 75, by area



COMPARISON	ABSOLUTE GAP (DIFFERENCE) BASELINE 1995–97	LATEST 2004–06	TREND	RELATIVE GAP (RATIO) BASELINE 1995–97	LATEST 2004–06	TREND
Area deprivation						
Most deprived fifth of LADs vs England	18.0 *(17.1, 19.0)*	15.9 *(15.0, 16.8)*	✓	1.13 *(1.12, 1.13)*	1.14 *(1.13, 1.14)*	●
Most deprived fifth of LADs vs least deprived fifth	34.7 *(32.8, 36.6)*	29.6 *(28.0, 31.3)*	✓	1.28 *(1.26, 1.30)*	1.29 *(1.27, 1.31)*	●
Area						
Fifth of LADs with highest death rates vs England	24.9 *(23.8, 26.1)*	20.1 *(19.1, 21.1)*	✓	1.18 *(1.17, 1.19)*	1.17 *(1.16, 1.18)*	●
Fifth of LADs with highest death rates vs fifth with lowest rates	48.2 *(46.3, 50.2)*	39.3 *(37.7, 41.0)*	✓	1.41 *(1.39, 1.43)*	1.40 *(1.38, 1.42)*	●

COMMENTARY

- There is a gradient in cancer death rates (ages under 75) by area deprivation, with the most deprived fifth of LADs having the highest death rates and the least deprived fifth the lowest death rates.
- For example, in 2004–06 the cancer death rate (ages under 75) in the most deprived fifth of LADs was 30 deaths per 100,000 higher than in the least deprived fifth. In relative terms, the cancer death rate (ages under 75) in the most deprived fifth of LADs was 1.29 times the rate in the least deprived fifth, i.e. 29% higher.
- Since 1995–97 the gap in cancer death rates between the most deprived fifth of LADs and the England average has decreased in absolute terms, but with no significant change in relative terms. This also applies to the gap between the most deprived fifth of LADs and the least deprived fifth.
- The gap between the fifth of LADs with highest death rates and the England average has decreased in absolute terms since 1995–97, but with no significant change in relative terms. This also applies to the gap between the fifth of LADs with highest death rates and the fifth with lowest rates.
- DH has set a PSA target to reduce the absolute gap in cancer death rates (ages under 75) between the fifth of areas with the worst health and deprivation indicators (known as the spearhead group) and the population as a whole. Between 1995–97 and 2004–06, the absolute gap between the spearhead group and the England average cancer death rate narrowed by 11% (but with no narrowing of the relative gap).

Data notes:
Source: ONS (death registrations and mid-year population estimates).
Death rates are directly age-standardised rates, standardised to the European Standard Population, for ICD10 C00-C97 (for 1995 to 1997, ICD9 140-208 adjusted for comparability with ICD10).
Area deprivation is measured by the Index of Multiple Deprivation 2004, LA summary (average score) (Department for Communities and Local Government (CLG)).

KEY: ✓ = decreasing inequality ✖ = increasing inequality
● = no significant change — = insufficient data

Indicator 1b: Age-standardised death rates per 100,000 population for the major killer diseases (cancer, circulatory diseases), ages under 75 – circulatory disease

Overall summary: There have been improvements in circulatory disease death rates since 1995–97 (including for the most disadvantaged areas), accompanied by a narrowing of inequalities in absolute terms but a widening of inequalities in relative terms.

Figure 3.10: Age-standardised death rates per 100,000 population for circulatory diseases, ages under 75, by area deprivation

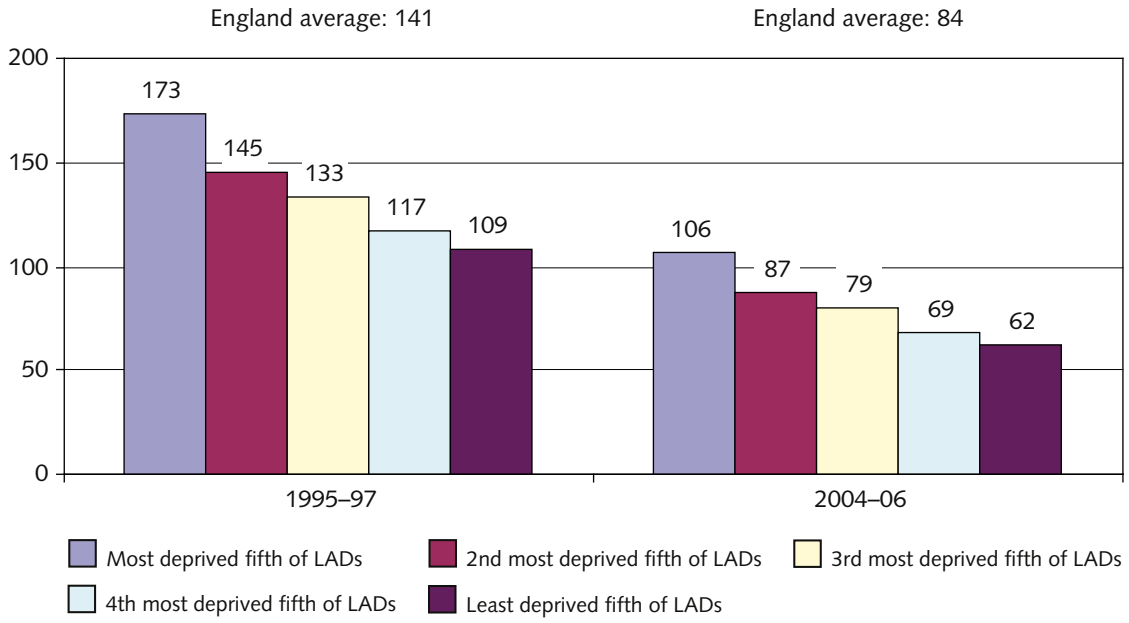
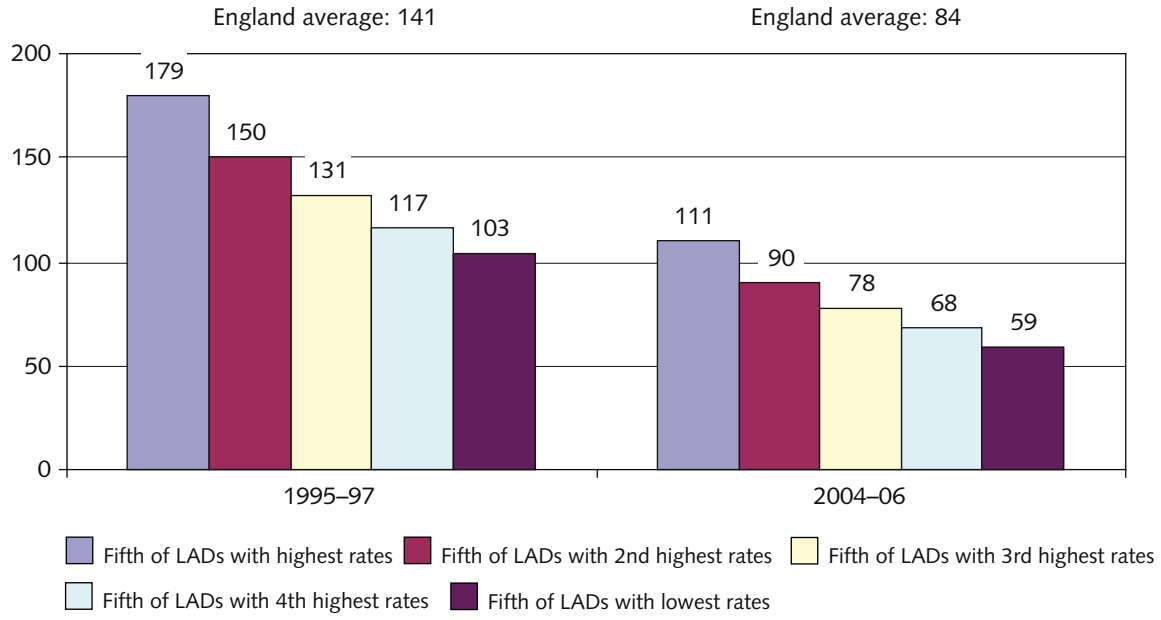


Figure 3.11: Age-standardised death rates per 100,000 population for circulatory diseases, ages under 75, by area



COMPARISON	ABSOLUTE GAP (DIFFERENCE) BASELINE 1995–97	LATEST 2004–06	TREND	RELATIVE GAP (RATIO) BASELINE 1995–97	LATEST 2004–06	TREND
Area deprivation						
Most deprived fifth of LADs vs England	31.3 *(30.3, 32.3)*	22.2 *(21.5, 23.0)*	✓	1.22 *(1.21, 1.23)*	1.26 *(1.26, 1.27)*	✖
Most deprived fifth of LADs vs least deprived fifth	63.8 *(62.0, 65.6)*	44.3 *(42.9, 45.6)*	✓	1.59 *(1.56, 1.61)*	1.71 *(1.68, 1.74)*	✖
Area						
Fifth of LADs with highest death rates vs England	37.9 *(36.8, 38.9)*	26.5 *(25.6, 27.3)*	✓	1.27 *(1.26, 1.28)*	1.31 *(1.30, 1.33)*	✖
Fifth of LADs with highest death rates vs fifth with lowest rates	76.0 *(74.1, 77.8)*	51.8 *(50.4, 53.2)*	✓	1.74 *(1.71, 1.76)*	1.88 *(1.84, 1.91)*	✖

COMMENTARY

- There is a gradient in circulatory disease (also known as cardiovascular disease) death rates (ages under 75) by area deprivation, with the most deprived fifth of LADs having the highest death rates and the least deprived fifth the lowest death rates.
- For example, in 2004–06 the circulatory disease death rate (ages under 75) in the most deprived fifth of LADs was 44 deaths per 100,000 higher than in the least deprived fifth. In relative terms, the circulatory disease death rate (ages under 75) in the most deprived fifth of LADs was 1.71 times the rate in the least deprived fifth, i.e. 71% higher.
- Since 1995–97 the gap in circulatory disease death rates between the most deprived fifth of LADs and the England average has decreased in absolute terms, but increased in relative terms. This also applies to the gap between the most deprived fifth of LADs and the least deprived fifth.
- Since 1995–97 the gap in circulatory disease death rates between the fifth of LADs with highest death rates and the England average has decreased in absolute terms, but increased in relative terms. This also applies to the gap between the fifth of LADs with highest death rates and the fifth with lowest rates.
- DH has set a PSA target to reduce the absolute gap in circulatory disease death rates (ages under 75) between the fifth of areas with the worst health and deprivation indicators (known as the spearhead group) and the population as a whole. Between 1995–97 and 2004–06, the absolute gap between the spearhead group and the England average circulatory disease death rate narrowed by 32% (but with no narrowing of the relative gap).

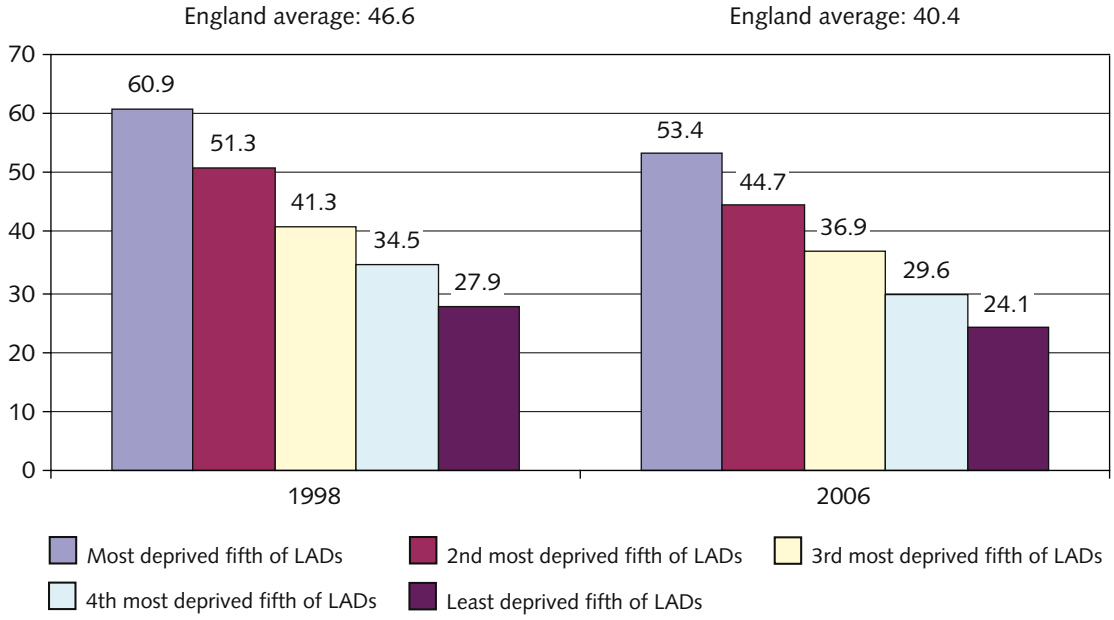
Data notes:
Source: ONS (death registrations and mid-year population estimates).
Death rates are directly age-standardised rates, standardised to the European Standard Population, for ICD10 I00-I99 (for 1995 to 1997, ICD9 390-459 adjusted for comparability with ICD10).
Area deprivation is measured by the Index of Multiple Deprivation 2004, LA summary (average score) (CLG).

KEY: ✓ = decreasing inequality ✖ = increasing inequality
● = no significant change — = insufficient data

Indicator 2: Rate of under-18 conceptions

Overall summary: There has been a 13.3% drop in the rate of under-18 conceptions between 1998 and 2006 (with the average rate for the most disadvantaged areas also falling), with a slight narrowing of inequalities in absolute terms but no significant narrowing in relative terms.

Figure 3.12: Rate of under-18 conceptions per 1,000 female population aged 15–17 by area deprivation



COMPARISON	ABSOLUTE GAP (DIFFERENCE) BASELINE 1998	LATEST 2006 p	TREND	RELATIVE GAP (RATIO) BASELINE 1998	LATEST 2006 p	TREND
Area deprivation						
Most deprived fifth of LADs vs England	14.3 *(13.6, 15.0)*	12.9 *(12.3, 13.6)*	✓	1.31 *(1.29, 1.32)*	1.32 *(1.30, 1.33)*	●
Most deprived fifth of LADs vs least deprived fifth	33.0 *(31.7, 34.2)*	29.2 *(28.1, 30.4)*	✓	2.18 *(2.11, 2.26)*	2.21 *(2.13, 2.29)*	●

COMMENTARY

- There is a gradient in under-18 conception rates by area deprivation, with the most deprived fifth of LADs having the highest conception rates and the least deprived fifth the lowest conception rates.
- For example, in 2006 the under-18 conception rate in the most deprived fifth of LADs was 29 conceptions per 1,000 women aged 15–17 higher than in the least deprived fifth. In relative terms, the under-18 conception rate in the most deprived fifth of LADs was 2.21 times the rate in the least deprived fifth.
- Between 1998 and 2006 the gap in under-18 conception rates between the most deprived fifth of LADs and the England average decreased slightly in absolute terms, but with no significant change in relative terms. This also applies to the gap between the most deprived fifth of LADs and the least deprived fifth. Note that 2006 data are provisional and the figures are subject to year-on-year fluctuation.
- The Teenage Pregnancy Strategy has agreed local conception reduction targets of between 40-60% by 2010 for each top-tier local authority in England, with the greatest reductions sought in areas with the highest rates. Achieving these targets will underpin delivery of national targets while reducing inequality between areas with the highest rates and the average by at least a quarter. Over four in five local authorities have experienced an overall decline in their under-18 conception rate from 1998 to 2006, the remaining local authorities having rates which are static or increasing since 1998. The range of progress between top-tier local authorities is wide – from a 39% decline to a 23% increase from 1998 to 2006.

Data notes:
Source: ONS (conception statistics and mid-year population estimates). Data for 2006 are provisional.
Area deprivation is measured by the Index of Multiple Deprivation 2004, LA summary (average score) (CLG).

KEY: ✓ = decreasing inequality ✖ = increasing inequality
● = no significant change — = insufficient data

Indicator 3: Road accident casualties in disadvantaged communities

Overall summary: There have been improvements in child road accident casualty rates since 1998 (including for the most disadvantaged areas). There has been a narrowing of inequalities in absolute terms, but no significant change in relative terms.

Figure 3.13: Road accident casualties per 100,000 resident population, children (ages 0–15), by area deprivation

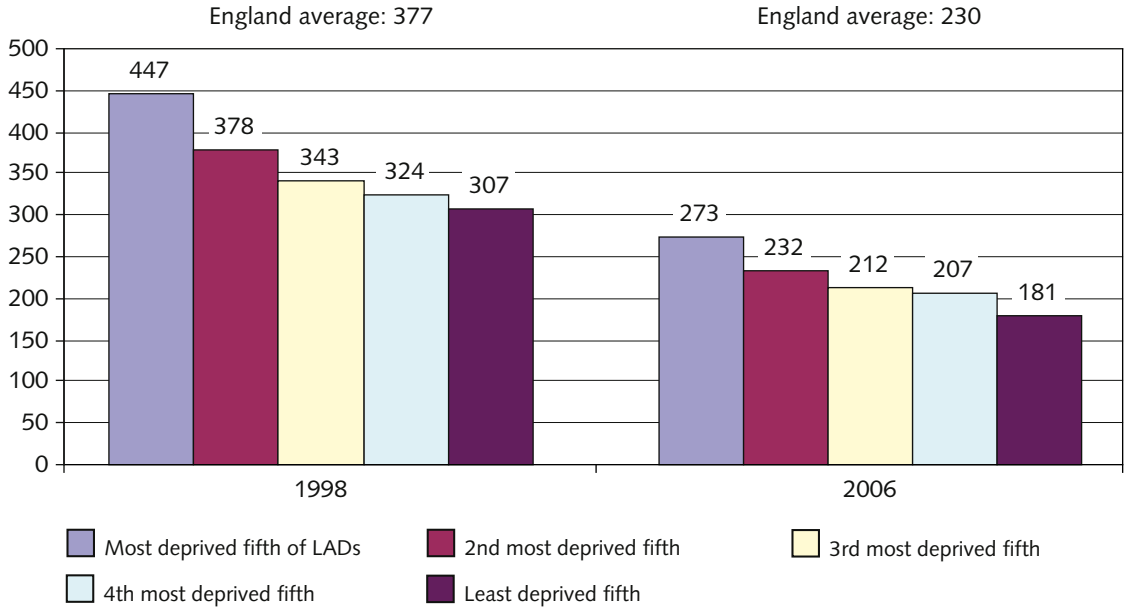
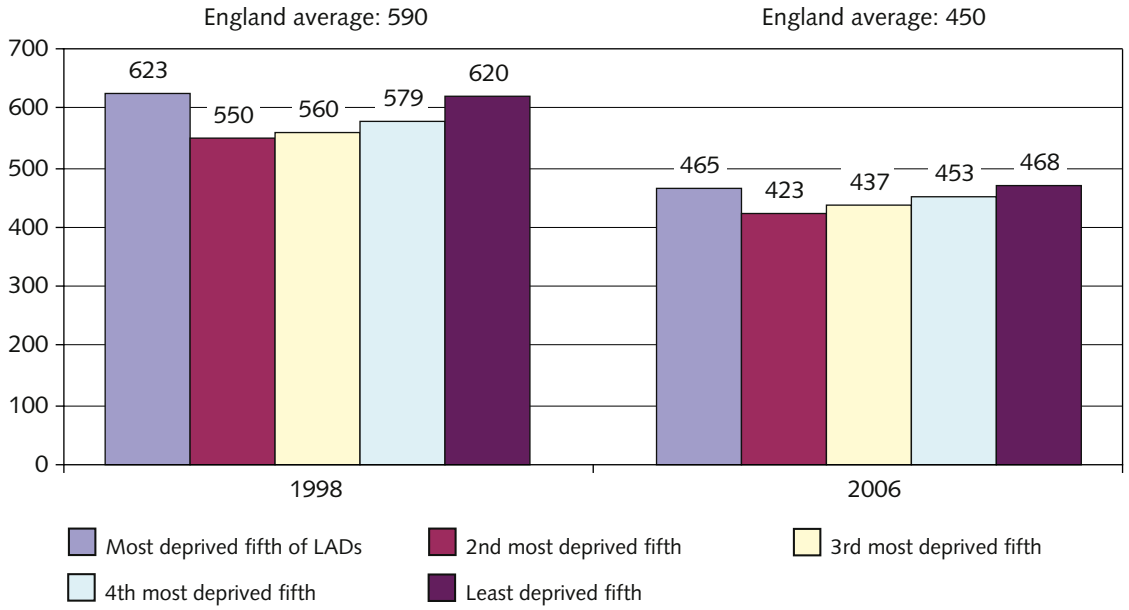


Figure 3.14: Road accident casualties per 100,000 resident population, all ages, by area deprivation



COMPARISON (based on casualty rates per 100,000 population)	ABSOLUTE GAP (DIFFERENCE) BASELINE 1998	LATEST 2006	TREND	RELATIVE GAP (RATIO) BASELINE 1998	LATEST 2006	TREND
Children (ages 0–15) – area deprivation						
Children – most deprived fifth of LADs vs England	70 *(65, 76)*	43 *(38, 47)*	✓	1.19 *(1.17, 1.20)*	1.19 *(1.17, 1.21)*	●
Children – most deprived fifth of LADs vs least deprived fifth	140 *(129, 151)*	92 *(83, 101)*	✓	1.46 *(1.41, 1.50)*	1.51 *(1.45, 1.58)*	●
All ages – area deprivation						
All ages – most deprived fifth of LADS vs England	32 *(29, 36)*	15 *(12, 17)*	✓	1.05 *(1.05, 1.06)*	1.03 *(1.03, 1.04)*	✓
All ages – most deprived fifth of LADS vs least deprived England	2 *(–4, 9)*	–3 *(–9, 3)*	●	1.00 *(0.99, 1.02)*	0.99 *(0.98, 1.01)*	●

COMMENTARY

- Note that for the casualty rates used in the analysis presented, the numerator is the number of casualties based on place of accident rather than place of residence and the denominator is the resident population. (Hence casualty rates may not reflect – and may tend to overestimate – the actual risk of injury in areas with high numbers of non-resident casualties. This is less likely to affect child casualty rates as children are more likely to be injured near home, but may affect casualty rates for all ages.)
- There is a gradient in road accident casualty rates for children (ages 0–15) by area deprivation, with the most deprived fifth of LADs having the highest casualty rates and the least deprived fifth the lowest casualty rates.
- For example, in 2006 the child road accident casualty rate in the most deprived fifth of LADs was 92 casualties per 100,000 higher than in the least deprived fifth. In relative terms, the child road accident casualty rate in the most deprived fifth of LADs was 1.51 times the rate in the least deprived fifth, i.e. 51% higher.
- The gap in child road accident casualty rates between the most deprived fifth of LADs and the England average was lower in 2006 than in 1998 in absolute terms. In relative terms, the gap was not significantly different in 2006 from 1998 (having increased above the 1998 level in intervening years). This also applies to the gap between the most deprived fifth of LADs and the least deprived fifth.
- The gradient in road accident casualty rates for all ages by area deprivation is less clear, with both the most and least deprived fifths of LADs having higher casualty rates than other areas.
- To help tackle the higher incidence of road casualties among people from disadvantaged communities, the Department for Transport (DfT) set a target for 2005 to reduce casualty numbers in disadvantaged areas (identified as Neighbourhood Renewal Fund areas) by more than the percentage decline across England as a whole. This target was met in 2005. Latest data for 2006 show there continued to be a greater reduction since the baseline year (1999–2001) in the number of road accident casualties in disadvantaged districts than in England as a whole (23% compared with 19% – figures are for all ages).

Data notes:
Source: DfT (STATS19 road casualty data), ONS (mid-year resident population estimates).
Area deprivation is measured by the Index of Multiple Deprivation 2004, LA summary (average score) (CLG).

KEY: ✓ = decreasing inequality ✖ = increasing inequality
● = no significant change — = insufficient data

Indicator 4: Number of primary care professionals per 100,000 population

Overall summary: There have been improvements in the number of full-time equivalent (fte) GPs per 100,000 weighted population since September 2002 (including for the most disadvantaged areas), but there has not been a significant narrowing of inequalities (with some signs of a widening in absolute terms by September 2006). The number of deprived primary care trusts (PCTs) more than 10% below the England average number of fte GPs per 100,000 weighted population has increased since September 2002.

Figure 3.15: Number of fte GPs per 100,000 weighted population by area deprivation

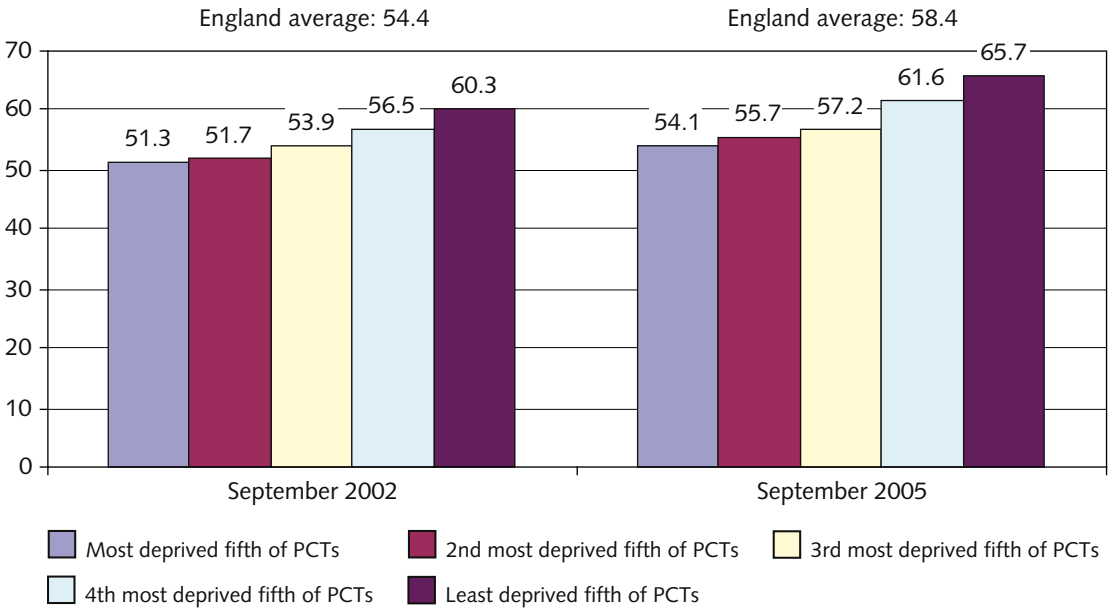
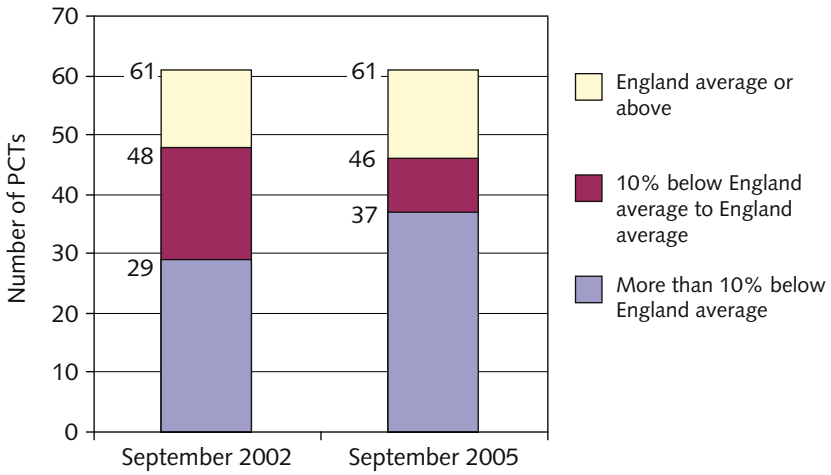


Figure 3.16: PCTs in the most deprived fifth by fte GPs per 100,000 weighted population band



COMPARISON	ABSOLUTE GAP (DIFFERENCE) BASELINE Sept 2002	LATEST Sept 2005 p	TREND	RELATIVE GAP (RATIO) BASELINE Sept 2002	LATEST Sept 2005 p	TREND
Area deprivation						
Most deprived fifth of PCTs vs England	–3.1 *(–4.3, –2.0)*	–4.4 *(–5.6, –3.2)*	●	0.94 *(0.92, 0.96)*	0.93 *(0.90, 0.95)*	●
Most deprived fifth of PCTs vs least deprived fifth	–9.0 *(–11.2, –6.9)*	–11.6 *(–13.8, –9.4)*	●	0.85 *(0.82, 0.88)*	0.82 *(0.79, 0.85)*	●

COMMENTARY

- The figures up to September 2005 are based on the number of fte GPs per 100,000 population weighted for age and need, for PCTs prior to the reorganisation of October 2006. September 2005 figures are provisional.
- In September 2005, there was a gradient in the number of fte GPs per 100,000 weighted population by area deprivation, with the most deprived fifth of PCTs having the fewest fte GPs per 100,000 and the least deprived fifth of PCTs the most fte GPs per 100,000.
- Between September 2002 and September 2005 there was no significant change in the gap in the number of fte GPs per 100,000 weighted population between the most deprived fifth of PCTs and both the England average and the least deprived fifth of PCTs.
- Although some deprived PCTs have a relatively high number of fte GPs per 100,000 weighted population, at September 2005 a high proportion of PCTs in the most deprived fifth (46 out of 61) were below the England average level. Nearly two-thirds of PCTs in the most deprived fifth (37 out of 61) were more than 10% below the England average level (an increase from September 2002, when 29 out of 61 PCTs were more than 10% below the England average level).
- In general, area deprivation analysis by PCT for 2006 is not comparable with data for earlier years, as September 2006 data are based on new PCT boundaries following the October 2006 reorganisation (when the number of PCTs was reduced from 303 to 152, some PCTs remaining unchanged but with several splits and mergers). However, a subset of the most deprived fifth of PCTs maps exactly to an equivalent set on new PCT boundaries (40 out of 61 PCTs in the most deprived fifth on old boundaries, mapping to 30 PCTs on new boundaries), and direct comparisons can be made for this set of deprived PCTs. September 2006 data are provisional.
- The number of fte GPs per 100,000 weighted population in this subset of the most deprived PCTs increased between September 2002 and September 2006 (from 51.8 to 56.2 per 100,000, with an increase in the most recent year from 54.2 in September 2005). Between September 2002 and September 2006 the gap in the number of fte GPs per 100,000 weighted population between this set of deprived PCTs and the England average widened in absolute terms (the absolute gap difference changing from –2.6 per 100,000 to –5.3), with no significant change in relative terms. For this set of deprived PCTs, the 2006 position represents a further widening of the gap in absolute terms over 2005 (when the absolute gap was wider than in September 2002, but not significantly so).

Data notes:
Source: Census of General and Personal Medical Services, The Information Centre for health and social care.
GP retainers and registrars are excluded. The population is the GP-relevant population constrained to ONS population estimates, weighted for age and to reflect need for GP consultations. For September 2002 figures, the population is based on GP lists in the ADS2003 reconciled to mid-2002 ONS population estimates; for September 2005 and September 2006 figures, the population is based on GP lists in the ADS2004 reconciled to 2003-based ONS population projections for 2005 and 2006 respectively. September 2005 and September 2006 figures are provisional, as population projections are used. Age and need weightings are based on the method used for the 2006/07 PCT revenue allocations for primary medical services.
Area deprivation is measured by the Index of Multiple Deprivation 2004, PCT summary (average score) (produced by the Healthcare Commission for PCT boundaries pre-October 2006 reorganisation).

KEY: ✓ = decreasing inequality ✖ = increasing inequality
● = no significant change — = insufficient data

Indicator 5: Percentage uptake of flu vaccinations by older people (aged 65+)

Overall summary: Between 2002 and 2005 the percentage uptake of flu vaccinations by older people increased (including for the most disadvantaged areas), accompanied by a slight narrowing of inequalities in absolute and relative terms. This narrowing of inequalities was maintained in 2006, for the set of deprived PCTs for which comparison is possible with earlier data. This does not mean all of the most deprived PCTs are improving relative to the least deprived PCTs. However, more deprived PCTs achieved the 70% uptake target in 2005 than in 2002.

Figure 3.17: Percentage uptake of flu vaccinations among over-65s by area deprivation

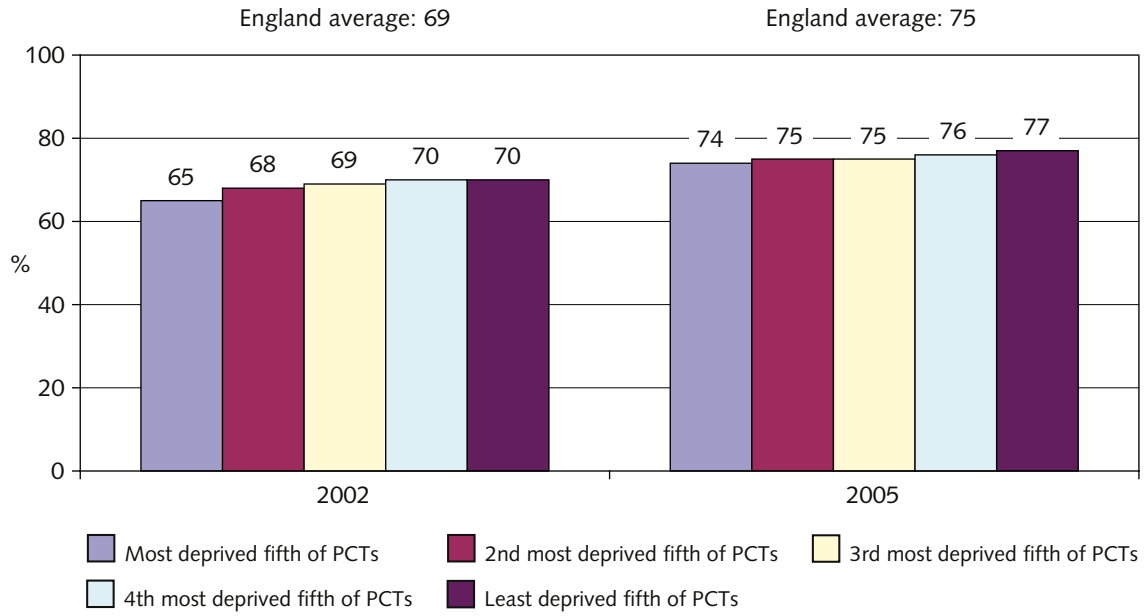
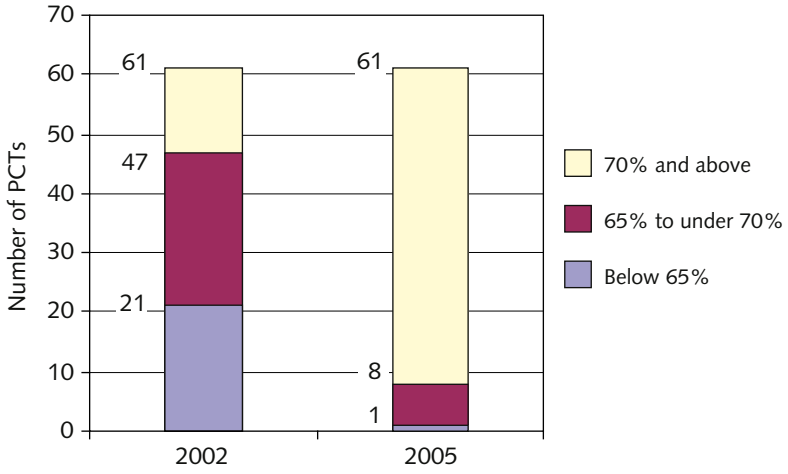


Figure 3.18: PCTs in the most deprived fifth by percentage uptake band for flu vaccinations among over-65s



COMPARISON	ABSOLUTE GAP (DIFFERENCE) BASELINE 2002	LATEST 2005	TREND	RELATIVE GAP (RATIO) BASELINE 2002	LATEST 2005	TREND
Area deprivation						
Most deprived fifth of PCTs vs England	–3.6 *(–3.7, –3.5)*	–1.7 *(–1.8, –1.7)*	✓	0.95 *(0.95, 0.95)*	0.98 *(0.98, 0.98)*	✓
Most deprived fifth of PCTs vs least deprived fifth	–5.4 *(–5.5, –5.3)*	–3.3 *(–3.3, –3.2)*	✓	0.92 *(0.92, 0.92)*	0.96 *(0.96, 0.96)*	✓

COMMENTARY

- In 2005 there was a slight gradient in the uptake of flu vaccination among over-65s by area deprivation, with the most deprived fifth of PCTs having the lowest uptake and least deprived fifth having the highest uptake.
- Between 2002 and 2005 the gap in flu vaccination uptake between the most deprived fifth of PCTs and both the England average and the least deprived fifth of PCTs narrowed in absolute and relative terms.
- Although some deprived PCTs achieved the target uptake of flu vaccinations by older people of at least 70%, in 2002 the uptake in a high proportion of PCTs in the most deprived fifth (47 out of 61) was below 70%. Uptake in around a third of PCTs in the most deprived fifth (21 out of 61) was below 65%. In 2005 more PCTs in the most deprived fifth achieved 70% uptake. Only 8 out of the 61 PCTs in the most deprived fifth had uptake below 70%, with only 1 PCT in the most deprived fifth having uptake below 65%.
- In general, area deprivation analysis by PCT for 2006 is not comparable with data for earlier years, as 2006 data are based on new PCT boundaries following the October 2006 reorganisation (when the number of PCTs reduced from 303 to 152, some PCTs remaining unchanged but with several splits and mergers). However, a subset of the most deprived fifth of PCTs maps exactly to an equivalent set on new PCT boundaries (40 out of 61 PCTs in the most deprived fifth on old boundaries, mapping to 30 PCTs on new boundaries), and direct comparisons can be made for this set of deprived PCTs.
- Flu vaccination uptake among over-65s in this subset of the most deprived PCTs increased between 2002 and 2006 (from 64% to 72%, with a slight fall in the most recent year from 73% in 2005). Between 2002 and 2006 the gap in flu vaccination uptake between this set of deprived PCTs and the England average narrowed in absolute terms (the absolute gap difference changing from –4.5 percentage points to –2.0 percentage points) and in relative terms (the relative gap ratio changing from 0.93 to 0.97). For this set of deprived PCTs, the 2006 position represents a further narrowing of the gap in absolute terms over 2005, with no change in the relative gap between 2005 and 2006.

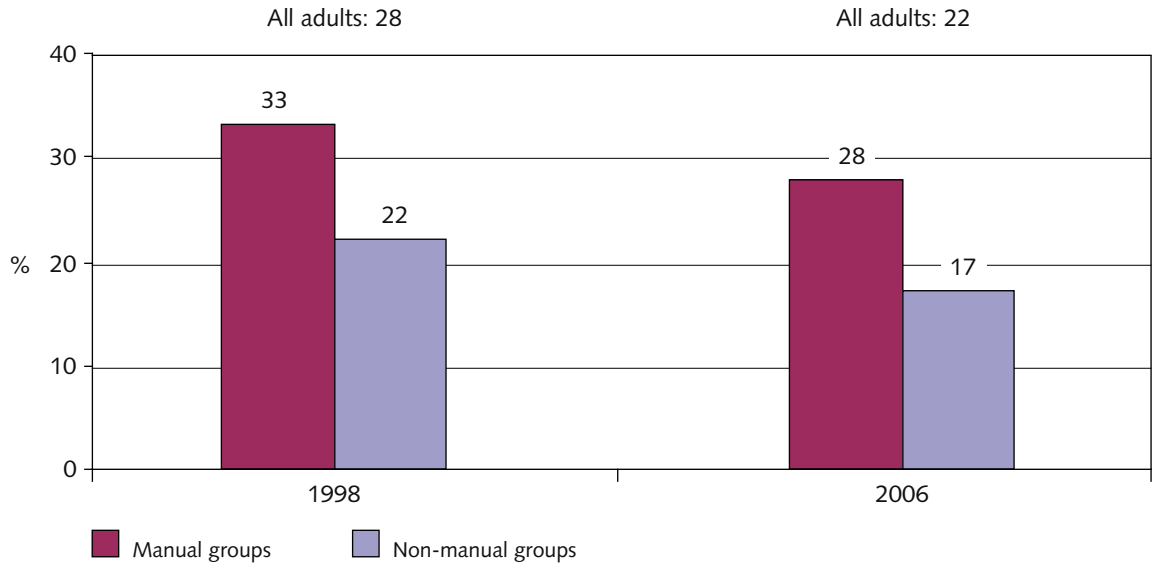
Data notes:
Source: Data collection from GPs, managed by the Centre for Infection (CfI) – part of the Health Protection Agency – on behalf of DH. Area deprivation is measured by the Index of Multiple Deprivation 2004, PCT summary (average score) (produced by the Healthcare Commission for PCT boundaries pre-October 2006 reorganisation).

KEY: ✓ = decreasing inequality ✖ = increasing inequality
● = no significant change — = insufficient data

Indicator 6a: Prevalence of smoking among people in manual social groups (Part 1 of: Prevalence of smoking among people in manual social groups, and among pregnant women)

Overall summary: Since 1998 smoking prevalence among all adults has fallen (including among manual groups), but there has been no significant change in inequalities for manual groups compared with non-manual groups or all adults in absolute terms, with some signs of a widening in relative terms.

Figure 3.19: Smoking prevalence (aged 16 and over) by socioeconomic group, England (weighted data)



	ABSOLUTE GAP (DIFFERENCE)			RELATIVE GAP (RATIO)		
COMPARISON	**BASELINE** 1998	**LATEST** 2006	**TREND**	**BASELINE** 1998	**LATEST** 2006	**TREND**
Socioeconomic group						
Manual groups vs all adults	5 *(4, 6)*	6 *(5, 7)*	●	1.19 *(1.16, 1.22)*	1.28 *(1.24, 1.32)*	✖
Manual groups vs all non-manual groups	11 *(9, 12)*	11 *(9, 12)*	●	1.49 *(1.40, 1.58)*	1.63 *(1.52, 1.73)*	●

COMMENTARY

- Smoking prevalence among manual groups is consistently higher than in non-manual groups and in the adult population as a whole.
- For example, in 2006 smoking prevalence in manual groups was 11 percentage points higher than in non-manual groups. In relative terms, smoking prevalence in manual groups was 1.63 times the prevalence in non-manual groups, i.e. 63% higher.
- Smoking prevalence fell steadily from 1974 to 1992, and remained broadly flat between 1992 and 1998. Since 1998 smoking prevalence among all adults has fallen, including a fall in prevalence among manual groups.
- Since 1998 the gap in smoking prevalence between manual groups and the average for all adults has not changed significantly in absolute terms, but has widened in relative terms (particularly since 2004). The gap in smoking prevalence between manual and non-manual groups has not changed significantly in absolute or relative terms.
- This pattern is also shown in data by the new socioeconomic classification (NS-SEC). Smoking prevalence has fallen since 2001 both for those in routine and manual occupations and for those in managerial and professional occupations, but the gap in smoking prevalence between the two groups has not narrowed in absolute or relative terms.

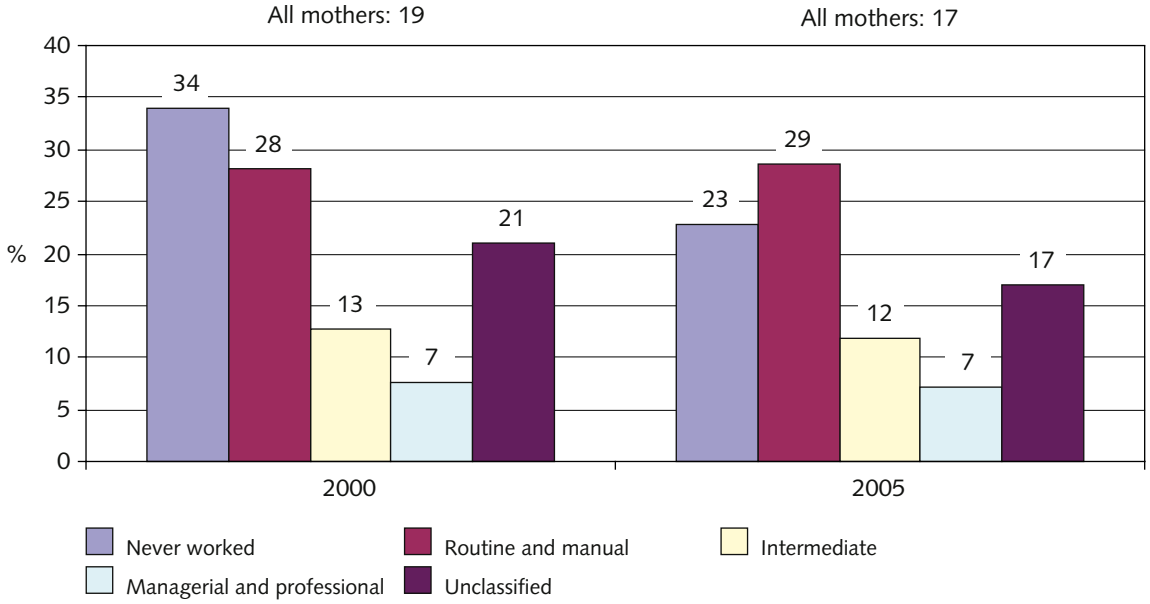
Data notes:
Source: General Household Survey (GHS) (ONS).
GHS data were weighted from 2000 onwards and retrospectively for 1998 for comparative purposes. Data were weighted to compensate for non-response in the sample and also to match known population distributions. Weighted data cannot be reliably compared with the unweighted data for 1998 and previous years. (For 1998 both weighted and unweighted data were calculated, to give an indication of the effect of weighting – it increased smoking prevalence for all adults and for manual and non-manual groups by 1 percentage point.)
From 2001 onwards figures by SEG (i.e. manual/non-manual groups) are based on the new NS-SEC classification recoded to produce SEG, and so should be treated with some caution.
Approximate 95% confidence intervals for the gap measures have been calculated assuming a simple random sample. As the GHS does not use a simple random sample, this may slightly underestimate the size of the confidence intervals.

KEY: ✓ = decreasing inequality ✖ = increasing inequality
● = no significant change — = insufficient data

Indicator 6b: Prevalence of smoking among pregnant women (Part 2 of: Prevalence of smoking among people in manual social groups, and among pregnant women)

Overall summary: Between 2000 and 2005, the overall prevalence of smoking throughout pregnancy decreased slightly, including a large fall in prevalence among women in the 'never worked' category but a slight increase among the routine and manual group. There were some signs of a widening of inequalities for the routine and manual group.

Figure 3.20: Percentage of women who smoked throughout pregnancy by socioeconomic group (NS-SEC), England



COMPARISON	ABSOLUTE GAP (DIFFERENCE) BASELINE 2000	LATEST 2005	TREND	RELATIVE GAP (RATIO) BASELINE 2000	LATEST 2005	TREND
Socioeconomic group (NS-SEC) (England data)						
Routine and manual group vs all mothers	9 *(7, 11)*	12 *(10, 14)*	●	1.48 *(1.35, 1.60)*	1.73 *(1.64, 1.82)*	✖
Routine and manual group vs managerial and professional group	21 *(18, 24)*	22 *(19, 24)*	●	3.77 *(3.06, 4.63)*	4.05 *(3.42, 4.79)*	●

COMMENTARY

- As in 2000, data from the 2005 Infant Feeding Survey show clear variation by socioeconomic group in the prevalence of smoking throughout pregnancy in England, with prevalence decreasing from the routine and manual group to the intermediate group, and from the intermediate group to the managerial and professional group. In 2005 the ratio of prevalence of smoking throughout pregnancy in the routine and manual group to the managerial and professional group was 4.05.
- Between 2000 and 2005, the prevalence of smoking throughout pregnancy in the routine and manual group increased by 1 percentage point. There was no significant change in the gap in prevalence between the routine and manual group and the managerial and professional group, in absolute or relative terms. For the gap between the routine and manual group and all mothers, there was no significant change in the absolute gap, but a widening of the relative gap. (Although both relative gap measures indicate a widening of inequalities, this is within the bounds of expected sampling error for the gap between the routine and manual group and the managerial and professional group. Confidence intervals are wide for the inequality measures as data are based on a sample survey.)
- There was a large improvement in the prevalence of smoking throughout pregnancy in the 'never worked' group between 2000 and 2005, with a larger fall in prevalence than for any other socioeconomic group. In 2000, the 'never worked' socioeconomic group had the highest prevalence of smoking throughout pregnancy (34%); by 2005 this had fallen to 23%, lower than the routine and manual group.

Data notes:
Source: Infant Feeding Survey (carried out by BMRB Social Research on behalf of the UK Health Departments, published by The Information Centre for health and social care).

KEY: ✓ = decreasing inequality ✖ = increasing inequality
● = no significant change — = insufficient data

Indicator 7: Proportion of pupils at Key Stage 4 who get qualifications equivalent to five GCSEs at grades A* to C

Overall summary: Between 2002 and 2007 the proportion of pupils achieving five or more A*–C grades at GCSE increased (including among pupils eligible for free school meals), with signs of a narrowing of the attainment gap between pupils eligible for free school meals (FSM) and all pupils.

Figure 3.21: Percentage of pupils† achieving five or more GCSE grades A*–C (or equivalent) by FSM eligibility, England (†at age 16 for 2002, at Key Stage 4 for 2007)

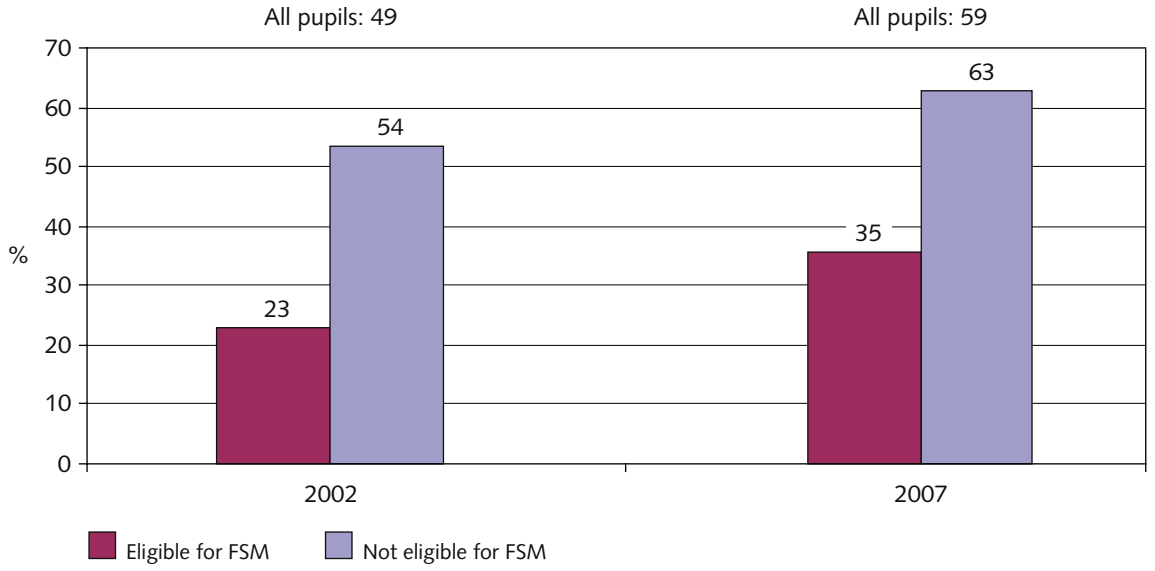
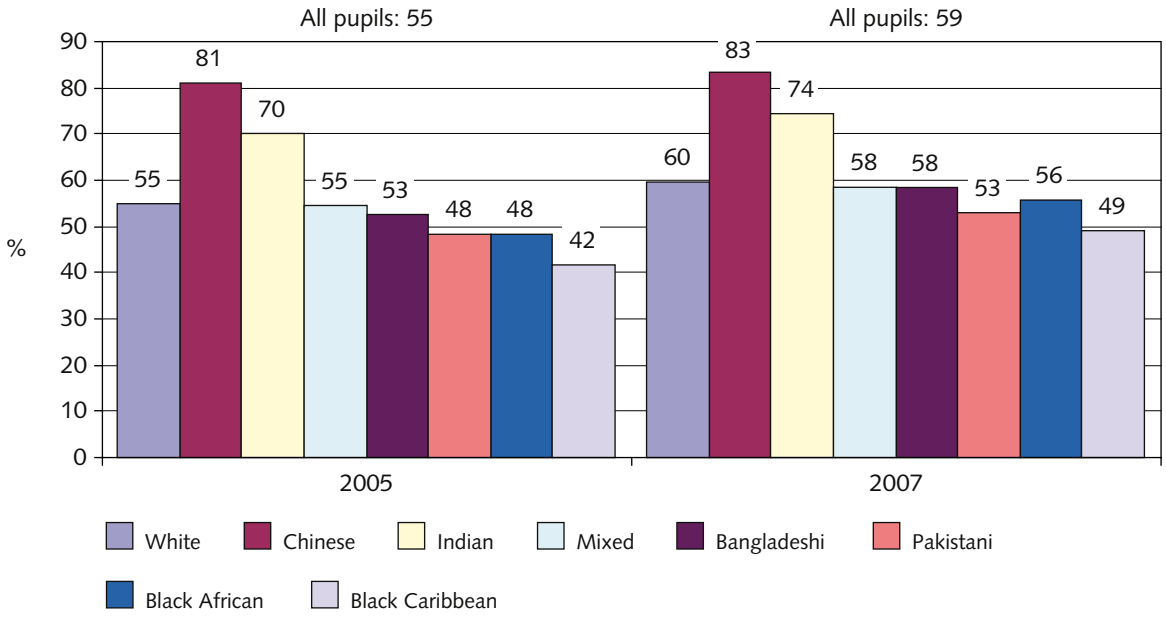


Figure 3.22: Percentage of pupils at Key Stage 4 achieving five or more GCSE grades A*–C (or equivalent) by selected ethnic groups, England



	ABSOLUTE GAP (DIFFERENCE)			RELATIVE GAP (RATIO)		
COMPARISON *aged 16 for 2002 data, at Key Stage 4 for 2007 data	**BASELINE** 2002*	**LATEST** 2007*	**TREND**	**BASELINE** 2002*	**LATEST** 2007*	**TREND**
Eligibility for free school meals (FSM)						
Eligible for FSM vs all pupils	–26 *(–26, –26)*	–24 *(–24, –23)*	✓	0.47 *(0.46, 0.47)*	0.60 *(0.59, 0.60)*	✓
Eligible for FSM vs not eligible for FSM	–31 *(–31, –30)*	–27 *(–28, –27)*	✓	0.43 *(0.42, 0.43)*	0.56 *(0.56, 0.57)*	✓

COMMENTARY

- This indicator has been revised to cover all pupils who have reached the end of Key Stage 4 (i.e. who have completed Year 11), rather than pupils aged 16 at the end of the academic year. Key Stage 4 reporting allows for more flexible rates of learning – most pupils at the end of Year 11 are aged 16, but some may be slightly older or younger. Data for the baseline (2002) at Key Stage 4 are not available, so the baseline data continue to be for pupils aged 16. As a result, care should be taken when comparing the latest data with the baseline. At a national level for maintained schools, the move from aged 16 to end of Key Stage 4 represents a 0.5 percentage point difference in the indicator value for all pupils.
- The proportion of pupils achieving five or more A*–C grades at GCSE is lower among pupils who are eligible for FSM than among pupils who are not eligible for FSM.
- For example, in 2007 the proportion of pupils at Key Stage 4 achieving five or more A*–C grades at GCSE among pupils eligible for FSM was 27 percentage points lower than the proportion among pupils not eligible for FSM. In relative terms, the proportion among pupils eligible for FSM was 0.56 times the proportion among pupils not eligible for FSM, i.e. 44% lower.
- Between 2002 and 2007 the proportion of pupils achieving five or more A*–C grades at GCSE among pupils eligible for FSM increased. In addition, the attainment gap between pupils eligible for FSM and all pupils overall narrowed in both absolute and relative terms. This also applies to the gap between pupils eligible for FSM and pupils not eligible for FSM. (Note that this is based on comparison of results at age 16 with results at Key Stage 4; however, comparison of results at age 16 for 2002 and 2004 and separately of results at Key Stage 4 for 2005 and 2007 indicate a narrowing of inequalities in both time periods.)
- GCSE attainment varies between minority ethnic groups. For example, Chinese and Indian pupils perform above the England average attainment of five or more A*–C grades at GCSE, whereas Black African, Black Caribbean, Pakistani and Bangladeshi pupils perform below the England average. However, between 2005 and 2007 attainment of five or more A*–C grades at GCSE improved faster among Black African and Black Caribbean pupils than the England average. (This complements analysis presented in the Department for Children, Schools and Families (DCSF) Statistical Bulletin *Statistics of Education: Trends in Attainment Gaps: 2005* (June 2006) which suggested that between 2003 and 2005 attainment of five or more A*–C grades at GCSE improved faster among Black African, Black Caribbean, Pakistani and Bangladeshi pupils than the England average.)

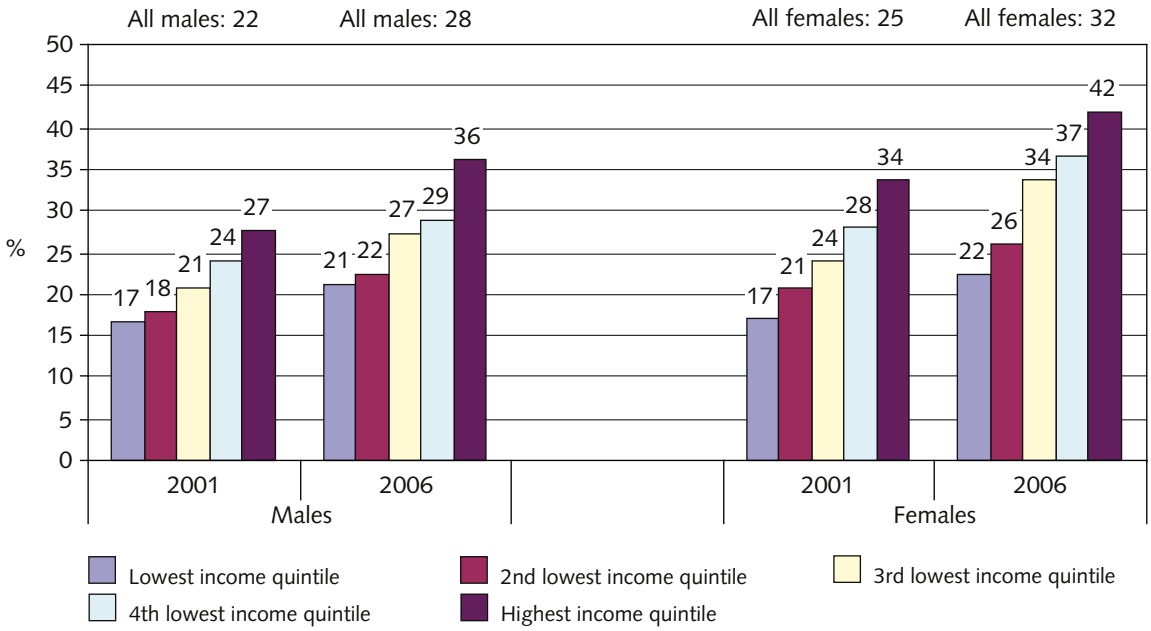
Data notes:
Source: Matched data in the National Pupil Database (DCSF). Data are for pupils in maintained schools only.

KEY: ✓ = decreasing inequality ✖ = increasing inequality
● = no significant change — = insufficient data

Indicator 8: Proportion of people consuming five or more portions of fruit and vegetables per day in the lowest quintile of household income distribution

Overall summary: Between 2001 and 2006, consumption of five or more portions of fruit and vegetables per day increased (including for households with lowest income), but there was no significant change in inequalities between households with lowest income and households with highest income or the average for all households.

Figure 3.23: Percentage of adults (aged 16 and over) consuming five or more portions of fruit and vegetables per day, England, by household income quintile



COMPARISON	ABSOLUTE GAP (DIFFERENCE) BASELINE 2001	LATEST 2006	TREND	RELATIVE GAP (RATIO) BASELINE 2001	LATEST 2006	TREND
Household income						
Adults, male – lowest income quintile vs England	–6 *(–8, –3)*	–7 *(–10, –4)*	●	0.75 *(0.65, 0.86)*	0.75 *(0.64, 0.86)*	●
Adults, female – lowest income quintile vs England	–8 *(–10, –6)*	–9 *(–12, –7)*	●	0.69 *(0.62, 0.77)*	0.71 *(0.63, 0.79)*	●
Adults, male – lowest income quintile vs highest income quintile	–11 *(–14, –7)*	–15 *(–20, –10)*	●	0.61 *(0.51, 0.72)*	0.58 *(0.49, 0.70)*	●
Adults, female – lowest income quintile vs highest income quintile	–17 *(–20, –13)*	–19 *(–23, –15)*	●	0.51 *(0.44, 0.58)*	0.54 *(0.47, 0.62)*	●

COMMENTARY

- There is a gradient in the proportion of adults consuming five or more portions of fruit and vegetables per day by household income quintile, with the lowest income quintile having the lowest proportion consuming 'five a day' and the highest income quintile the highest proportion.
- For example, in 2006 the proportion of adult females consuming five or more portions of fruit and vegetables per day in the lowest household income quintile was 19 percentage points lower than the proportion in the highest household income quintile. In relative terms, the proportion of adult females consuming five or more portions of fruit and vegetable per day in the lowest household income quintile was 0.54 times the proportion in the highest household income quintile, i.e. just under 50% lower.
- Between 2001 and 2006, inequalities in consumption of five or more portions of fruit and vegetables per day did not change significantly in absolute or relative terms. (Confidence intervals are wide for the inequality measures as data are based on a sample survey, so it is difficult to make a robust assessment of change over time.)

Data notes:
Source: Health Survey for England (carried out by the Joint Health Surveys Unit of the National Centre for Social Research (NatCen) and the Department of Epidemiology and Public Health at the Royal Free and University College Medical School (UCL), on behalf of The Information Centre for health and social care).

KEY: ✓ = decreasing inequality ✖ = increasing inequality
● = no significant change — = insufficient data

Indicator 9: Proportion of households living in non-decent housing

Overall summary: Between 1996 and 2006, the proportions of vulnerable private sector households and of social sector tenants living in non-decent housing (based on the fitness definition) decreased, with a narrowing of inequalities between these groups and non-vulnerable private sector households in both absolute and relative terms.

Figure 3.24: Percentage of households living in non-decent housing (based on fitness definition) by sector/vulnerable household status

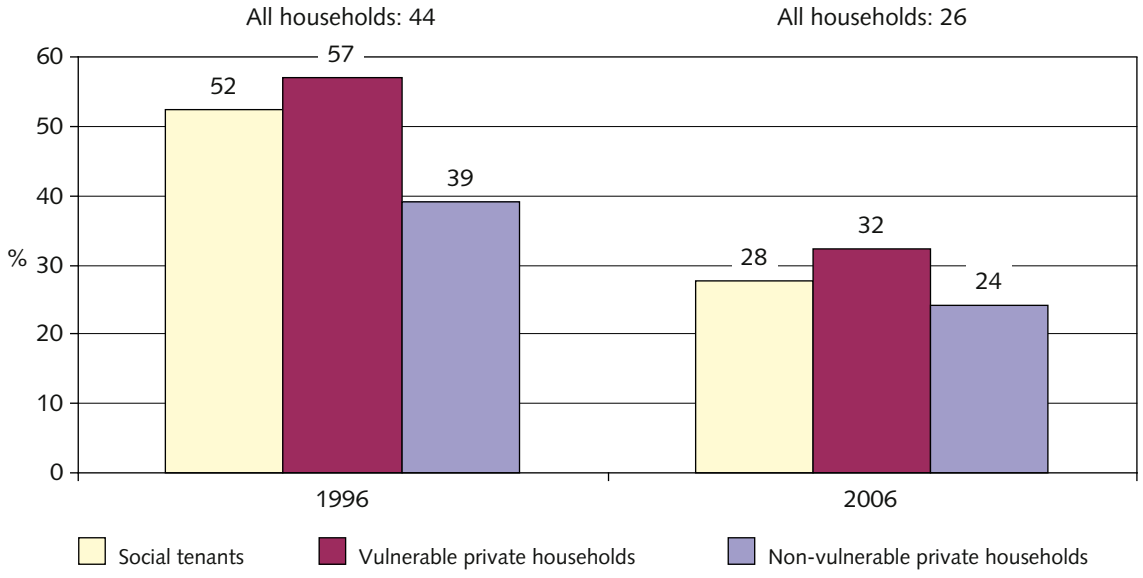
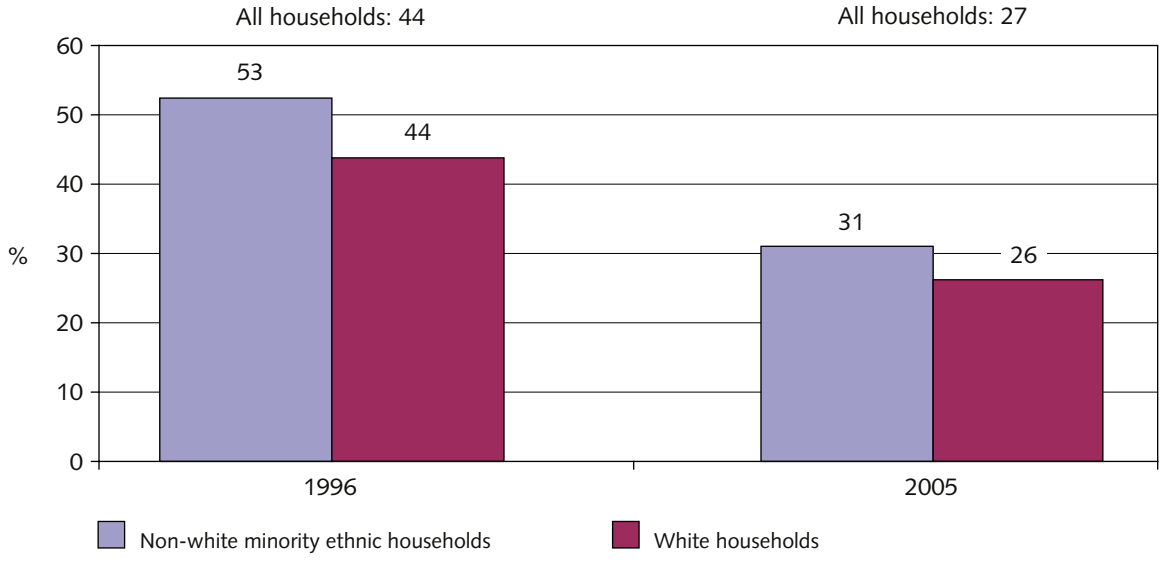


Figure 3.25: Percentage of households living in non-decent housing (based on fitness definition) by ethnic identity, England



COMPARISON	ABSOLUTE GAP (DIFFERENCE) BASELINE 1996	LATEST 2006	TREND	RELATIVE GAP (RATIO) BASELINE 1996	LATEST 2006	TREND
Sector/vulnerable household status						
Vulnerable private sector households vs non-vulnerable private sector households	18	7	✓	1.49	1.31	✓
Social tenants vs all non-vulnerable private sector households	14	4	✓	1.38	1.19	✓

COMMENTARY

- Vulnerable households are those in receipt of income- or disability-related benefits. Both vulnerable private sector households and social sector tenants are more likely to live in non-decent housing than non-vulnerable private sector households. In 2006 the proportion of vulnerable private sector households living in non-decent housing (based on the fitness definition) was 1.31 times the proportion of non-vulnerable private sector households, i.e. 31% higher. The proportion of social sector tenants living in non-decent housing was 1.19 times the proportion of non-vulnerable private sector households, i.e. 19% higher.
- The proportion of households living in non-decent housing fell substantially for all groups between 1996 and 2006.
- Between 1996 and 2006 the gap between the proportion of vulnerable private sector households and non-vulnerable private sector households living in non-decent homes narrowed in both absolute and relative terms. The gap between the proportion of social tenants and non-vulnerable private sector households living in non-decent homes also narrowed in absolute and relative terms.
- Although the majority of households living in non-decent homes are white, ethnic minority households are more likely to live in non-decent homes. In 2005, 31% of non-white minority ethnic households lived in non-decent homes, compared with 26% of white households. This compares with 53% of non-white minority ethnic households and 44% of white households living in non-decent homes in 1996. While this suggests there has been greater improvement since 1996 for ethnic minority households than for white households, this is not yet statistically significant.
- The definition of what is a decent home was updated in April 2006, when the Housing Health and Safety Rating System (HHSRS) came into force and replaced the fitness standard as the statutory element of the decent homes standard. Trend data are not available based on the updated definition of decent homes, so the data presented here are based on the previous fitness definition enabling progress since 1996 to be reported on a consistent and comparable basis. (The change in definition resulted in more homes being classified as non-decent – based on the updated definition, in 2006 43% of vulnerable private sector households lived in non-decent homes, as did 33% of social sector and 36% of non-vulnerable private sector households. This does not represent any decline in housing conditions, but is solely the result of the change in definition).

Data notes:

Source: English House Condition Survey (EHCS) (CLG).

The EHCS was carried out five yearly until 2001, from when the survey was reorganised with the introduction of continuous fieldwork from April 2002 to provide annual results from 2003.

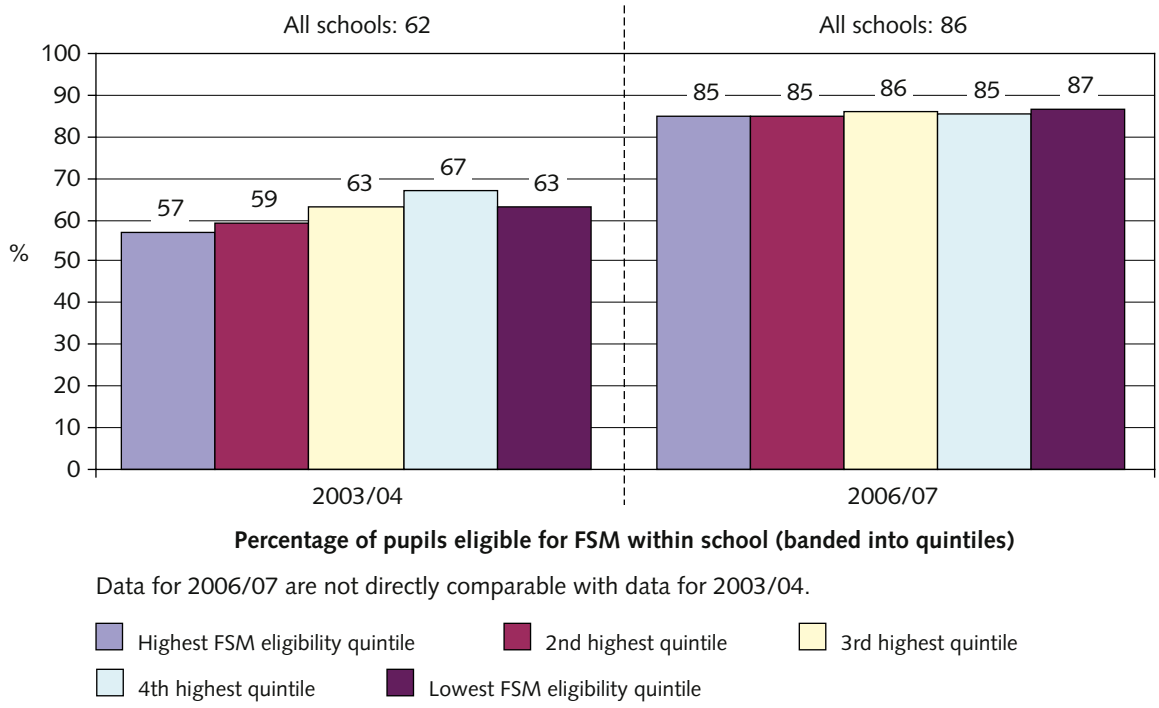
The absolute and relative gap measures are calculated using modelled estimates based on fitting a linear model to survey data from across the whole time period, rather than using direct survey estimates based on data from each particular year only (hence the gap measures for all time periods are usually revised each year as the model is updated). Confidence intervals have not been calculated for the absolute and relative gap measures, but the significance of the change in the gaps (at the 95% confidence level) was assessed using a statistical test applied to the linear model.

KEY: ✓ = decreasing inequality ✖ = increasing inequality
● = no significant change — = insufficient data

Indicator 10: Percentage of schoolchildren who spend a minimum of two hours each week on high-quality PE and school sport within and beyond the curriculum

Overall summary: In 2006/07, participation in PE and school sport in School Sport Partnership schools with a high proportion of pupils eligible for free school meals (FSM) is on average almost the same as in other schools. Latest data for 2006/07 are not directly comparable with available data for earlier years.

Figure 3.26: Percentage of schoolchildren who spend a minimum of two hours in a typical week on high-quality PE and school sport by level of eligibility for FSM within school



COMPARISON	ABSOLUTE GAP (DIFFERENCE) BASELINE 2003/04	LATEST 2006/07	TREND	RELATIVE GAP (RATIO) BASELINE 2003/04	LATEST 2006/07	TREND
Eligibility for FSM (schools banded into quintiles by % of pupils eligible for FSM)						
Highest FSM eligibility quintile vs all schools	–5	–1	—	0.92	0.99	—
Highest FSM eligibility quintile vs lowest FSM eligibility quintile	–6	–2	—	0.90	0.98	—

COMMENTARY

- In 2006/07, participation in PE and school sport in School Sport Partnership schools with a high proportion of pupils eligible for free school meals is on average almost the same as in other schools. The fifth of Partnership schools with the highest proportion of pupils eligible for free school meals has 85% of pupils participating in at least two hours of PE and school sport in a typical week. This compares with 87% of pupils in the fifth of Partnership schools with the lowest proportion of pupils eligible for free school meals.
- Data for 2006/07 are not directly comparable with data for 2003/04, as the number of schools covered by School Sport Partnerships increased between the two years. (2006/07 is the first year for which data are based on all maintained schools in England, which from September 2006 are all within the School Sport Partnership programme.) However, the data for 2006/07 show higher participation in PE and school sport both for all schools and in each free school meal eligibility quintile of schools. The data for 2006/07 show little variation between quintiles of schools with higher and lower levels of free school meal eligibility (in contrast to 2003/04).
- DCSF and the Department for Culture, Media and Sport have a PSA target to enhance the take-up of sporting opportunities by 5- to 16-year-olds so that the percentage of schoolchildren in England who spend a minimum of two hours each week on high-quality PE and school sport within and beyond the curriculum increases to 75% by 2006 and to 85% by 2008, and to at least 75% in each School Sport Partnership by 2008.

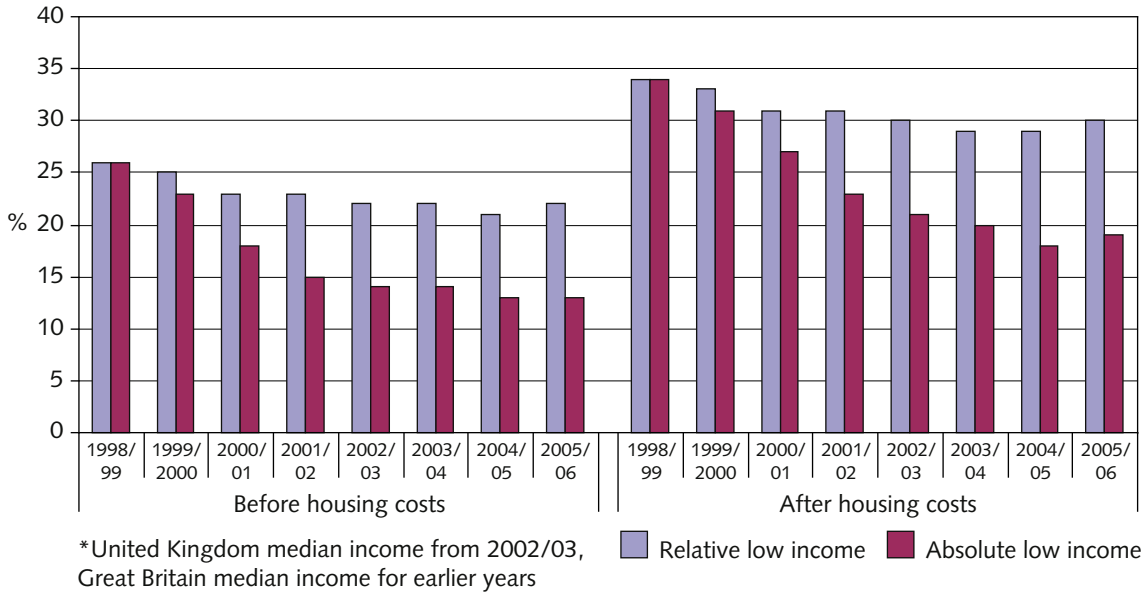
Data notes:
Source: Annual survey of School Sport Partnerships (DCSF).
The survey only covers School Sport Partnerships. The number of schools covered by School Sport Partnerships increased between 2003/04 and 2006/07 – full coverage of maintained schools in England was achieved in September 2006 (so 2006/07 is the first year for which data are based on all maintained schools in England).

KEY: ✓ = decreasing inequality ✖ = increasing inequality
● = no significant change — = insufficient data

Indicator 11: Proportion of children living in low-income households

Overall summary: The proportion of children in England living in low-income households has fallen since the baseline of 1998/99. This fall is shown for both relative and absolute low-income measures, and on both before and after housing cost measures.

Figure 3.27: Percentage of children in England living in low-income households (below 60% of median income*)



MEASURE	BASELINE 1998/99	LATEST 2005/06	TREND
Relative low income (before housing costs)	26%	22%	✓
Absolute low income (before housing costs)	26%	13%	✓
Relative low income (after housing costs)	34%	30%	✓
Absolute low income (after housing costs)	34%	19%	✓

COMMENTARY

- The data shown are for the percentage of children in England living in low-income households (the low-income threshold being 60% of median household income – the United Kingdom median is used from 2002/03, the Great Britain median for earlier years). For relative low income, the threshold moves each year. For absolute low income, the threshold is fixed at 1998/99 levels in real terms (i.e. the threshold is 60% of 1998/99 median income, uprated for inflation as appropriate). The time series has been revised since previous reports and is based on a new methodology (see data notes below).
- The proportion of children in England living in low-income households has fallen since the baseline of 1998/99 (for both relative and absolute low-income measures, on both before and after housing cost measures). However, the trend for relative low income has levelled off in the last few years.
- In addition to the improvement on the relative and absolute low-income measures, the proportion of children in England living in households with persistent low incomes (below 60% of the Great Britain median) has fallen from 20% in the period 1991 to 1994 to 13% in the period 2001 to 2004. (Persistent low income is defined as low income – before housing costs – in three out of the four years in each period.)

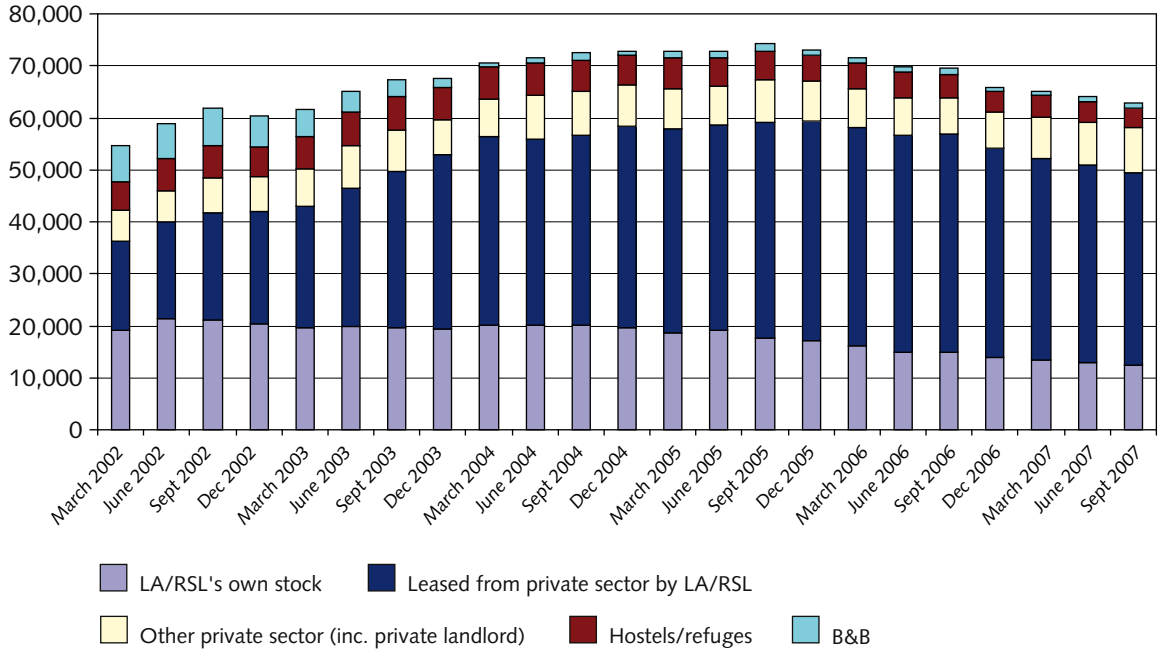
Data notes:
Source: *Households Below Average Income* (Department for Work and Pensions (DWP)).
For relative and absolute low-income measures, the time series has been revised since previous reports and is based on a new methodology. The OECD equivalisation scale is now used for deriving the figures (in previous reports, the McClements scales were used – in addition, previous figures used the Great Britain median income for all years and the absolute low-income threshold was fixed at 1996/97). For further details see the *Households Below Average Income 1994/95–2005/06* report at www.dwp.gov.uk/asd/hbai/hbai2006/contents.asp. The persistent low-income figures are based on the same methodology as in previous reports (and continue to use the McClements scales).

KEY: ✓ = decreasing inequality ✖ = increasing inequality
● = no significant change — = insufficient data

Indicator 12: Number of homeless families with children in temporary accommodation

Overall summary: Since March 2002 there has been a reduction in the number of homeless families with children in bed and breakfast (B&B) accommodation; the number of homeless families with children living in all temporary accommodation is higher than at March 2002, but has been falling recently and is at its lowest since March 2003.

Figure 3.28: Homeless families with children in temporary accommodation arranged by local authorities by type of accommodation, England



MEASURE	BASELINE Mar 2002	LATEST Sept 2007	TREND
Number in temporary accommodation (including B&B)	54,660	62,830	✖
Number in B&B accommodation	6,960	900	✓

COMMENTARY

- The number of homeless families with children in B&B accommodation fell from 6,960 at the end of March 2002 to 900 at the end of September 2007 (i.e. reduced by 87%).
- The number of homeless families with children in all forms of temporary accommodation (including B&B) was higher at the end of September 2007 than at the end of March 2002 (62,830 compared with 54,660). However, the number in temporary accommodation levelled off from September 2004, has fallen in each quarter since September 2005, and is at its lowest level since March 2003.
- People from different black and minority ethnic groups continue to be over-represented among those accepted as homeless. Of the 73,360 households accepted as homeless during 2006/07, 21% were from a black or minority ethnic background (the same as in 2004/05 and 2005/06). (There were a further 5% where the ethnic origin was not known.)
- Although the number of homeless families with children in all forms of temporary accommodation is higher than at the end of March 2002, the proportion in shared accommodation such as B&B hotels, hostels or women's refuges is lower. At the end of September 2007, over 90% of families with children in temporary accommodation were in self-contained homes, compared with around 75% at the end of March 2002.

Data notes:
Source: Data collected by CLG's Housing and Communities Analysis (HCA) and Housing Strategy and Support (HSS) teams from P1E forms returned by local authorities.
'Homeless families with children' means homeless households with dependent children and/or an expectant mother.
Figures are grossed (imputed) national totals based on local authority returns. Data from June 2006 are provisional.

KEY: ✓ = decreasing inequality ✖ = increasing inequality
● = no significant change — = insufficient data

Summary of progress against 82 departmental commitments

3.36 The *Programme for Action* identified 82 cross-departmental commitments to support the national strategy by 12 government departments, chiefly the Department of Health, the Department for Children, Schools and Families, Communities and Local Government and the Department for Work and Pensions. For the most part, these commitments covered the period 2003–06.

3.37 A summary of the progress, included below shows that 75 out of 82 commitments (91%) had been wholly or substantially achieved, by December 2006.

		Owner	Status
	SUPPORTING FAMILIES, MOTHERS AND CHILDREN		
	Maternal and child health, and child development		
	Support poorer families and children by:		
1	– expanding Sure Start services for children under 6 and their families, Sure Start local programmes to reach 400,000 children living in disadvantaged areas, including a third of children under 4 living in poverty	DCSF	**Green**
2	– developing a network of Children's Centres in 20% of the most disadvantaged wards, reaching up to 650,000 children and their families	DCSF	**Green**
3	– creating a further 250,000 new childcare places by 2006, 180,000 in the 20% of most disadvantaged wards	DCSF	**Green**
4	– establishing 45,000 new daycare places through the Neighbourhood Nursery Initiative	DCSF	**Green**
5	– providing free nursery education for all 3-year-olds	DCSF	**Green**
6	– ensuring that 800,000 children, pregnant women and mothers from low-income families have a healthy diet through the reformed Welfare Food Scheme and provide better support for breastfeeding mothers.	DH	**Green**
	Improving life chances for children and young people		
7	Support children and young people at risk aged 5–13 through the Children's Fund, with spend of £150 million for each of three years to 2006.	DCSF	**Green**
8	Address mental health needs of children by establishing a comprehensive child and adolescent mental health service (CAMHS) in all areas by 2006, with an extra £250 million to 2006.	DH	**Amber/ Green**
9	Improve the quality of life of marginalised young people using sport to raise their aspirations and connect them back to education, training and employment through Positive Futures projects.	HO	**Green**
10	Develop and improve sports facilities for around 2,300 schools and raise standards of physical education in disadvantaged areas.	DCMS DCSF	**Green**
11	Expand the specialist sports college and School Sport Co-ordinator Programmes to create a network of 400 school sports co-ordinator partnerships. Spend of £339 million to 2006.	DCSF, DCMS	**Green**
	Meet the needs of disadvantaged individuals, groups and areas at school through mainstream education services and targeted action by 2004, specifically by:		
12	– establishing a GCSE floor target to ensure that 25% of pupils in every school gain five A*–C GCSEs	DCSF	Amber

		Owner	Status
13	– improving education of children in care to substantially narrow the gap between educational attainment and participation of their peers by 2006	DCSF	Amber
14	– improving behaviour and school attendance in the worst areas through the £470 million National Behaviour and Attendance programme	DCSF	**Green**
15	– improving learning outcomes for pupils in disadvantaged areas through the Creative Partnership programme. Spend £27 million in 2003/04 rising to £45 million in 2005/06	DCSF, DH	**Green**
16	– improving the social and health context of school life by targeting the Healthy Schools programme on the most deprived communities	DCSF	**Green**
17	– reducing the number of 16–18-year-olds not engaged in education, employment or training by 10% in established Connexion partnerships.	DCSF	**Green**
	Reducing teenage pregnancy and supporting teenage mothers		
18	Raise the quality of education in schools by the introduction of a certification programme on sex and relationship education for teachers and equivalent programmes for school and community nurses.	DCSF	**Green**
19	Share learning and best practice from the Sure Start Plus teenage pregnancy pilot programmes with Connexions personal advisers and others.	DCSF	**Green**
20	Improve access for young parents to antenatal and postnatal care.	DCSF, DH	**Amber/ Green**
21	Improve access to learning and employment opportunities through the Connexions programme.	DCSF	**Amber/ Green**
	ENGAGING COMMUNITIES AND INDIVIDUALS		
22	Continue to support the reshaping and redirecting of mainstream services to tackle the problems faced in disadvantaged neighbourhoods through the National Strategy for Neighbourhood Renewal supported by the Neighbourhood Renewal Fund.	CLG	**Green**
23	Encourage greater communities involvement in actions to improve the local environments and make them healthier places to be.	CLG	**Green**
24	Support existing and new health initiatives through further investment to PCTs in Health Action Zone areas to 2006.	DH	**Green**
25	Use schools to improve services for local people through the creation of up to 240 full-service Extended Schools by 2006, targeted initially at areas of deprivation and offering a set of services including health and social care, childcare adult education and sports activities.	DCSF	**Green**
26	Deliver services for 'hard to reach' groups through the 257 healthy living centres clustered round areas of deprivation from 2003.	DH	**Green**
27	Support vulnerable groups through the Supporting People programme, including teenage parents, victims of domestic violence and ex-offenders, as well as independent living within communities for older, disabled and vulnerable people.	CLG	**Green**
	Enterprise		
28	Promote the provision of business support and finance for entrepreneurs from disadvantaged groups through the Phoenix Fund and the work of the Regional Development Agencies.	BERR	**Green**
29	Encourage community-based enterprises to provide services to the public sector through the development of a 'good corporate citizen' approach in the NHS and local authorities.	DH, CLG, BERR	**Green**

		Owner	Status
	Crime/drug misuse		
30	Increase participation of problem users in treatment programmes, maintain the proportion successfully completing treatment programmes, further expand the drug treatment workforce, and improve access to treatment programmes, driving down the waiting lists across all treatments.	DH/HO	**Green**
	Older people		
31	Involve older people in both high-level policy direction at a national level of policy, and service development at a local level outlined in the National Service Framework (NSF) for Older People.	DH	**Green**
32	Improving access to, the effectiveness of, and the integration of, falls prevention services through the direct involvement of older people and their representative organisations in local health communities and falls collaborative actions.	DH	**Green**
	Homeless people		
	Tackle and prevent homelessness through homelessness strategies and meeting the Government's targets to:		
33	– ensure no homeless family with children is in bed and breakfast accommodation by March 2004, unless for urgent cases and even then no longer than for six weeks	CLG	**Green**
34	– sustain or reduce the numbers of people sleeping rough at 600 people or fewer.	CLG	**Green**
	People with mental Illness		
35	Reduce the duration of untreated psychosis to three months by 2004 by establishing intervention teams and provide support for the first three years for all young people who develop an episode of psychosis.	DH	**Green**
36	Provide access crisis resolution services from 2005, either from the teams or trained NHS Direct staff.	DH	**Green**
	Prisoners' health		
37	Address prisoners' mental health needs by providing all prisoners with severe mental health problems with a care plan by 2004.	DH	**Green**
	Asylum seekers and refugees		
38	Assess health needs through a network of induction centres, all of which will include the provision of a health assessment.	DH	**Green**
39	Meet the language needs of this group through developing an online resource of health information in key languages and a national scoping study on models of providing interpreting services for NHS Direct.	DH	**Green**
	PREVENTING ILLNESS AND PROVIDING EFFECTIVE TREATMENT AND CARE		
	Reducing risk through effective prevention		
	Reduce smoking, particularly among manual groups by:		
40	– expanding PCT smoking cessation services	DH	**Green**
41	– expanding tailored tobacco education campaigns, for example in prisons, hospitals and factories	DH	**Green**
42	– ending tobacco advertising, promotion and sponsorship	DH	**Green**
43	– running extended mass media education campaigns	DH	**Green**
44	– enforcing a ban on under-age sales of tobacco	DH	**Green**

		Owner	Status
45	– putting new health warnings and advice on tobacco products to achieve 800,000 quitters at the four-week stage by 2006, and reducing smoking in pregnancy by 1 percentage point a year 2003–06.	DH	**Green**
	Improve diet and nutrition among disadvantaged groups and children by implementing the Food and Health Action Plan across Government and other sectors and:		
46	– further develop the 5 A DAY programme targeting both the 66 PCTs in the most deprived areas of the country funded by the New Opportunities Fund until 2005, and in disadvantaged areas in all PCTs	DH	**Green**
47	– expanding the National School Fruit Scheme to reach all children aged 4–6 by 2004.	DH	**Green**
48	Increase participation in physical activity through the introduction of Local Exercise Action Pilots.	DH, DCMS	**Green**
49	Reduce accidental injury, especially among children and young people in disadvantaged areas, through the environmental improvements, public education campaigns and projects to reduce child road casualties.	DfT, HO, DCSF	**Green**
50	Reduce deaths and injuries from house fires through national awareness campaigns and targeted fire service risk-management strategies.	CLG	**Green**
51	Develop co-ordinated local action programmes that improve the health and wellbeing of older people through the NSF for Older People.	DH	**Amber**
	Early detection, intervention and treatment		
52	Increase resources available to the NHS to take account of unmet need through the new NHS resource allocation formula and devolved PCT budgets.	DH	**Green**
53	Improve primary care facilities, especially in inner cities and urban areas, by £1 billion programme of refurbishing or replacing 3,000 family doctor's premises and establishing 500 one-stop centres.	DH	**Green**
54	Raise the quality of service in disadvantaged areas by establishing 20 teaching PCTs by 2004.	DH	**Green**
55	Improve access to rural services by establishing 100 one-stop primary care centres or mobile service units by 2004.	DH	**Green**
	Further improve mainstream primary care services by:		
56	– providing guaranteed access to a primary care professional within one working day, and to a GP within two working days by December 2004. NHS Walk-In Centres are one of the services available to PCTs to improve access to primary care	DH	**Amber/ Green**
57	– creating coronary heart disease (CHD) practice-based patient registers to ensure systematic treatment regimes for those at most risk by March 2006	DH	**Green**
58	– extending breast cancer screening to women aged 65–70 by 2004 and agreeing local protocols to address inequalities in service provision	DH	**Amber/ Green**
59	– meeting the target of 70% uptake in flu immunisation in people aged 65 years and over, especially in areas of lowest life expectancy	DH	**Green**
60	– quality assuring screening programmes to ensure uptake is equitable and reaching those most in need.	DH	**Amber/ Green**
	Implement the NSF for Older People by:		
61	– supporting action to identify and eliminate age discrimination in access to health and social care	DH	**Amber/ Green**
62	– developing a local Single Assessment Process with shared information and assessment mechanisms across health and social care covering stroke care, falls services and mental health.	DH	**Green**

		Owner	Status
	Improving access to effective treatment		
63	Respond to local needs and raise standards of service through NHS Foundation Trusts – hospitals in some of the most deprived areas have expressed interest in being among the first trusts, and all hospitals will be given help to become a trust over the course of the next four to five years.	DH	**Green**
64	Improve access to health facilities by PCTs working in partnership with local authority transport planners to conduct accessibility planning, reform of patient transport services and the hospital travel costs scheme.	DH	**Green**
65	Improve access to cancer services by treating all cancer patients within a month of diagnosis and within two months of urgent referral by 2005.	DH	**Amber**
66	Improve access to CHD services by setting a two-week wait standard for rapid access chest pain clinics and a three-month maximum wait for angiography and revascularisation by 2005.	DH	**Green**
67	Promote rehabilitation and supported discharge from hospital with 150,000 additional people receiving intermediate care services by March 2004.	DH	**Green**
	ADDRESSING THE UNDERLYING DETERMINANTS OF HEALTH		
	Child poverty		
68	Reduce the number of children in low-income households by a quarter by 2004/05 from 1998/99 as a contribution to the broader target of halving child poverty by 2010 and eradicating it by 2020.	DWP, HMT	**Amber**
	Housing and environment		
69	Improve the quality of social housing and raise 370,000 homes above the decent homes standard by 2006.	CLG	**Green**
70	Address the needs of poor households in the private sector and raise 80,000 households to the decent homes standard by 2005/06.	CLG	**Green**
71	Eradicate fuel poverty in England among vulnerable households by 2010 and by 2016 for all other households as far as reasonably practicable.	Defra, BERR	**Amber/ Red**
72	Reduce fuel poverty by improving the energy efficiency of homes for 800,000 vulnerable households through the Warm Front programme by 2004.	Defra	**Green**
73	Work for cleaner, safer and greener local environments and thriving sustainable communities through *Living Places: Cleaner, Safer, Greener and Sustainable Communities: building for the future.*	CLG	**Green**
	Training and skills		
74	Improve the basic skills of 750,000 adults through the continued expansion of the Skills for Life programme by 2004.	DCSF	**Green**
75	Develop and deliver literacy, numeracy and English language training for 20,000 health and social care staff through the NHS University by 2006.	DH	Amber
	Jobs and income		
76	Enable people with health problems and disabilities to move into work through the Pathways to Work programme.	DWP	**Green**
77	Provide extra support for people in work, families and older people through the working and child tax credits, and pension credit.	DWP, HMT	**Green**
78	Help people who are unemployed (but available to work) to return to the labour market through Jobcentre Plus. The implementation of new-style Jobcentre Plus offices throughout its local office network to be complete by 2006.	DWP	**Green**

		Owner	Status
	Transport		
79	Oversee the implementation of the Social Exclusion Unit action plan to improve access to jobs and key services, to March 2005.	DfT	**Amber/ Green**
80	In areas that produce Local Transport Plans, transport planners will lead work to improve access to jobs and key services. This process, accessibility planning, will be incorporated into authorities' second Local Transport Plans by 2005.	DH/DfT	**Amber/ Green**
81	Encourage more children to walk and cycle, through a package of measures to promote sustainable travel to school.	DfT	**Green**
82	Forthcoming changes to the bus registration system will make it easier to register flexibly routed, demand-responsive services. This will allow the provision of dedicated door-to-door bus services tailored to meet passenger needs.	DfT	**Green**

KEY

Green

GREEN – Commitment achieved in full and on time, or currently on target to deliver on time

Amber/Green

AMBER/GREEN – Commitment substantially achieved, but not full coverage or slightly late

Amber

AMBER – Commitment partly achieved or substantially delayed

Amber/Red

AMBER/RED – Commitment mostly not achieved, but action has some impact

Red

RED = Commitment not achieved

Black

BLACK = No response

Chapter 4: Lessons for delivery

KEY MESSAGES

- **The priority for health inequalities needs to be supported by relevant local action that is supported by organisational systems, processes and tools, and needs to be delivered systematically and on an appropriate scale.**
- **The emerging evidence and lessons of good practice need to be harnessed through shared learning and implementation.**
- **Active partnership with local government and other organisations in delivering this agenda is the best hope for effective local action on a broad front to narrow the gap.**

4.1 This chapter explores issues around the delivery of the target, in particular the tools, systems and processes that inform and support delivery. These issues include the following:

- priority – does the planning and delivery system give priority to health inequalities and promote action in partnership with others ? How does the evidence support this?
- action – are the tools and levers in place at local level to deliver the necessary action? Are they sufficient for purpose?
- scale – is good practice recognised and shared on the ground? Is it applied on an appropriate scale to effect change ?

4.2 Partnership working is crucial to success. The leadership of local government is vital to this agenda through Local Strategic Partnerships (LSPs), Local Area Agreements (LAAs) and the recently developed Beacon councils. Tools and levers can inform local action, by clarifying roles and responsibilities, including through planning and performance. Developing and sharing good practice is a powerful way of replicating the learning of others. The health inequalities National Support Team (NST) has an important role and has already recognised that applying effective interventions on a suitable scale to effect change is a key challenge at local level.

Priority – delivery and evidence

4.3 Evidence about what works needs to inform priority-setting processes and plans for delivery, but there are gaps in the evidence base. Work continues in building this base, but the lack of evidence is no excuse for inaction. Some well-documented examples of evidence exist, such as the Sheffield city-wide initiative for reducing cardiovascular disease (CVD).

4.4 Examples of good practice can also help fill the evidence gap – including examples drawn from abroad – and provide a guide to the advantages and disadvantages of certain actions, which will help delivery.

Delivery

4.5 The nature of the challenge to deliver the target was exposed in the *Review of the Health Inequalities Infant Mortality PSA Target* (Department of Health, 2007). The review showed that the infant mortality aspect of the target was not known or understood, despite individual examples of leadership and good practice. The five delivery challenges identified were:

- no recognition of the infant mortality aspect of the target or gap, even where health inequalities were recognised as important
- services were not fully delivering to the target group, and some areas showed poor organisation of healthcare services, including a lack of effective cross-sector working
- lack of leadership and systems to support delivery, with no priority for the target and no accountability for delivering it
- lack of knowledge and understanding of the target across many of the different stakeholders
- poor handling and use of data and gaps in the evidence base, with many areas lacking robust data collection and information technology (IT) infrastructure.

4.6 Similar challenges confront the delivery of the life expectancy element of the target. The focus of the target on relative changes between social groups and areas has meant chasing a moving target but it has provided a stimulus for further action. The target review also highlighted the lack of clarity about what actions are needed, by whom and when, in order to meet the target within the timescale. This encouraged the development of a series of high-impact changes for both the life expectancy and infant mortality aspects of the target, to shape the responses to these challenges and promote action.

PROMOTING ACTION

The high-impact changes for the life expectancy target are as follows:

- know your gap – to meet their contribution to the target, each spearhead area must know their own life expectancy gap in relation to the England average before they can reduce it
- make smoking history – smoking remains the single biggest factor contributing to differences in life expectancy between social groups
- target CVD prevention – circulatory diseases account for the largest proportion of deaths in the spearhead areas
- improved cancer detection in deprived communities – cancer is often detected later in spearhead areas, thus reducing the opportunity to provide effective interventions
- use health trainers – health trainers can provide advice, direct people to the services they need and empower people to take responsibility for their own health
- raise expectations – people need to know that they can expect high standards from their local services and that they really can take action to improve their own health.

4.7 The *Implementation Plan for Reducing Health Inequalities in Infant Mortality: A Good Practice Guide* (2007) amplified this message. It showed how to meet some of the delivery challenges set out in the review. The promotion of the health inequalities target as mainstream business has provided the foundation on which to meet these challenges. The plan also advocated:

- focusing on the key evidence-based interventions that will have the greatest impact in the target (and other) disadvantaged groups
- developing more effective partnerships, particularly with local authorities
- targeting areas which have the greatest number of infant deaths
- learning from effective good practice across a range of areas.

ACTION AND EVALUATION

New Deal for Communities

The New Deal for Communities (NDC) programme, launched in January 1999, provides 39 of the poorest neighbourhoods with the resources and support to tackle their problems and regenerate their communities in an intensive way through local partnerships comprising key local bodies and organisations, such as public agencies, local businesses, voluntary bodies and residents. The programme formed a major plank of the 2001 National Strategy for Neighbourhood Renewal.

Interventions

The 39 NDC areas share a £2 billion budget (approximately £50 million each) over 10 years to develop projects to tackle theme-related problems in their neighbourhoods (worklessness, crime, education, health, housing and physical environment) through the provision of local facilities and services, and resident engagement and empowerment. Populations in NDC areas tend to have worse self-reported health than the national average but the degree to which health inequalities exist varies.

The NDC partnerships are working with others, notably primary care trusts (PCTs), to improve health standards among NDC residents. Around 8% of the budgets has been devoted to health interventions.

Outputs

Outputs between 1999/2000 and 2005/06 include an additional 223 new or improved health facilities used by over 135,000 people and over 1.8 million instances of health advice or provision. Expenditure to 2005/06 has amounted to a relatively modest £203 per capita.

Outcomes

There were modest and positive improvements between 2002 and 2006 in relation to smoking and those feeling that their health was good or fairly good, with:

- small reductions (down 3 percentage points) in the number of people who smoke (2001/02 to 2005/06)
- small reductions (down 3 percentage points) in the number of people who feel their health is not good.

These changes tend to mirror both reductions nationally but more in disadvantaged areas. Overall, to date, the NDC evaluation has found more evidence of positive change for 'place-based' outcomes (physical/environmental outcomes) than for 'people-based' outcomes. However, by 2006 it was possible to identify positive statistical relationships between NDC spend across a range of interventions including health. This suggests, as expected, a considerable time lag between these interventions and evidence of improved outcomes becoming available.

Partnership and co-ordination of local action

4.8 The recent NHS boundary changes mean that many more PCTs and local authorities are coterminous, helping joint working and the delivery of targets. Many directors of public health are jointly appointed across PCTs and local authorities, assuring that joint leadership and planning structures are in place, with a delivery system that will be underpinned by the new duty of Joint Strategic Needs Assessment (JSNA).

4.9 From April 2008, all PCTs and local authorities will have to undertake a JSNA to identify the current and future needs of their local population as the basis for the effective commissioning of services. JSNA guidance released in December 2007 makes it clear that the JSNA must identify local health inequalities.

GOOD PRACTICE IN ACTION

Local partnership working on smoking cessation in black and minority ethnic groups

To promote effective local partnership working on health inequalities across local black and minority ethnic (BME) populations, the Department for Communities and Local Government (CLG) is developing guidance on smoking cessation for BME communities. The guidance proposes a systematic four-step approach that links with National Institute for Health and Clinical Excellence (NICE) guidelines and complementary Department of Health work. These steps are:

- mapping, planning, delivering and evaluating smoking cessation interventions for BME communities
- targeting services, improving accessibility
- service delivery, working with existing networks
- monitoring and evaluation, building it into programme design.

While shortage of evidence is a challenge and many case studies may not have been rigorously evaluated, partners should recognise this challenge without being discouraged by it. There is evidence for the value of a systematic approach to public health and monitoring ethnicity, and generic guidance on what works in smoking cessation. Furthermore, where local initiatives are properly evaluated, the information gained makes a vital contribution to the evidence base.

4.10 New LAAs offer further incentives for partnerships to work together to tackle local priorities. The structure of new LAAs, to be signed off in June 2008, has been streamlined. Local authority funding will mainly be allocated through a single fund. There will be a small number of statutory education and early years targets that will sit alongside LAAs. It will, therefore, be for local partnerships to negotiate their local priorities with the regional Government Office. Although the previous mandatory health inequalities target has been removed along with other mandatory targets, a wide range of indicators in the set, which will be used for the priority negotiations, are related either directly to health inequalities or to the wider determinants of health.

4.11 Monitoring delivery against LAAs is carried out at strategic health authority (SHA) and Government Office level. A memorandum of understanding has set the foundation for delivery by better aligning planning and service objectives to drive further improvements in health inequalities.

4.12 Specific cross-government programmes can also act as a catalyst for further local action by bringing together a range of services for disadvantaged groups and areas such as childcare, parenting support, early years' education and maternal, infant and child health.

PARTNERSHIP IN ACTION

Working through Sure Start Children's Centres

Working in partnership with Sure Start Children's Centres is crucial to tackling health inequalities in disadvantaged families, mothers and children. For example, the midwifery team in Southampton University Hospitals NHS Trust worked in conjunction with local Sure Start Centres to enable women from vulnerable groups and their families to access Sure Start services, provide easier access to midwifery services in the community and provide continuity of care throughout pregnancy, birth and afterwards for up to six weeks. One of the primary aims was to reduce the incidence of low-birthweight babies.

For women cared for by these teams, there was a substantial reduction in the incidence of low-birthweight babies from 12.6% to 7.9% between 2003 and 2006. In addition, the midwifery teams attached to Sure Start were able to support 31% of women to give birth in a birth centre or at home, compared with 25% of women cared for by other teams.

Evidence

4.13 The evidence about health inequalities is limited and the relationship between the different dimensions of health inequalities – such as ethnicity, age and gender – is not always well understood. There is a lack of evidence about what works with relatively few assessments of interventions or cost effectiveness. Evidence-based actions to improve health can also inadvertently widen health inequalities; this was one of the reasons for adding health inequalities to health Public Service Agreement (PSA) targets on cancer and CVD in 2004.

4.14 The national health inequalities strategy set out in the *Programme for Action* acknowledged the difficulties about evidence. The Wanless Report, Securing Good Health for the Whole Population (2004) emphasised the lack of evidence, as it is clear that the lack of evidence, including a lack of evidence of effectiveness, should not be a barrier to action. To remove the blight on people's lives caused by health inequalities, policy, action and evidence has been developed simultaneously. There is a need to carry on working and evaluating action while continuing to generate more evidence so that these complex and persistent problems can be resolved in the future.

4.15 In terms of the NHS, the distribution of care remains an issue and, even where it is known that certain interventions are cost-effective, uptake is uneven, with the most disadvantaged groups often unable to access appropriate services. Recognition of the different costs of access for different groups means that more specific targeting of interventions is required. This may involve, for example, additional incentives in primary care to improve access for the most vulnerable groups reaching out through communities to promote greater engagement, advice and support.

4.16 Improving access to healthcare interventions (particularly in relation to primary and secondary prevention) that work and are known to be cost-effective will help contribute to reducing health inequalities. In the long term, gains will depend on understanding the process of implementing evidence, systematically and on an appropriate scale, recognising the opportunity for using and the barriers to change.

4.17 Major issues of workforce capacity and capability will also need to be addressed if the strategy for tackling health inequalities is to be realised. This includes developing health intelligence and change management competencies as well as front-line care and expertise to enable people to make informed decisions about their health and wellbeing.

Working with local government and Local Strategic Partnerships

4.18 LSPs are central to tackling health inequalities effectively at local level. They bring together a range of players, including the NHS and local government, and offer an opportunity to reshape local services in a way that will narrow the gap. In Bradford, effective LSP working established an Infant Mortality Commission which delivered a report that was underpinned by community engagement and thorough needs analysis. It resulted in a series of evidence-based recommendations to address one of the key health inequalities challenges faced by the community (www.bdimc.bradford.nhs.uk).

4.19 Health inequalities are also a key theme of the Beacon Council Scheme. This scheme disseminates best practice across local government. Beacon status is awarded to local authorities that can demonstrate clear vision, excellent services and a willingness to innovate. They will have a role sharing good practice based on their own experience and encouraging its adoption. The successful councils that have achieved Beacon status in health inequalities in the 2008 round are listed below.

- Coventry City Council
- Derwentside District Council
- London Borough of Greenwich
- Merseyside Fire and Rescue Authority
- Sheffield City Council
- Sunderland City Council

Action – tools and levers

4.20 Guidance on planning and performance is a key tool for promoting action. Health inequalities feature in the new health and wellbeing PSA 18, the NHS Operating Framework and local tools, such as LAAs and the new JSNA. Health inequalities is also reflected in the National Indicator Set, with an indicator on all age all cause mortality.

TRACKING THE TARGET

Tracking all-age, all-cause mortality informs performance

The health inequalities national target is set in terms of life expectancy until 2010, and life expectancy is a very good measure for monitoring health inequalities at the national level. However, a review of action to meet the target found that life expectancy at birth is sometimes not well understood as a concept and these misconceptions affected delivery strategies.

All-age, all-cause mortality (AAACM) is being used as a proxy to measure progress. AAACM is a more locally relevant measure, closely related to life expectancy and based on the same death data. AAACM data are being made available more frequently than annually in order to allow monitoring closer to real time.

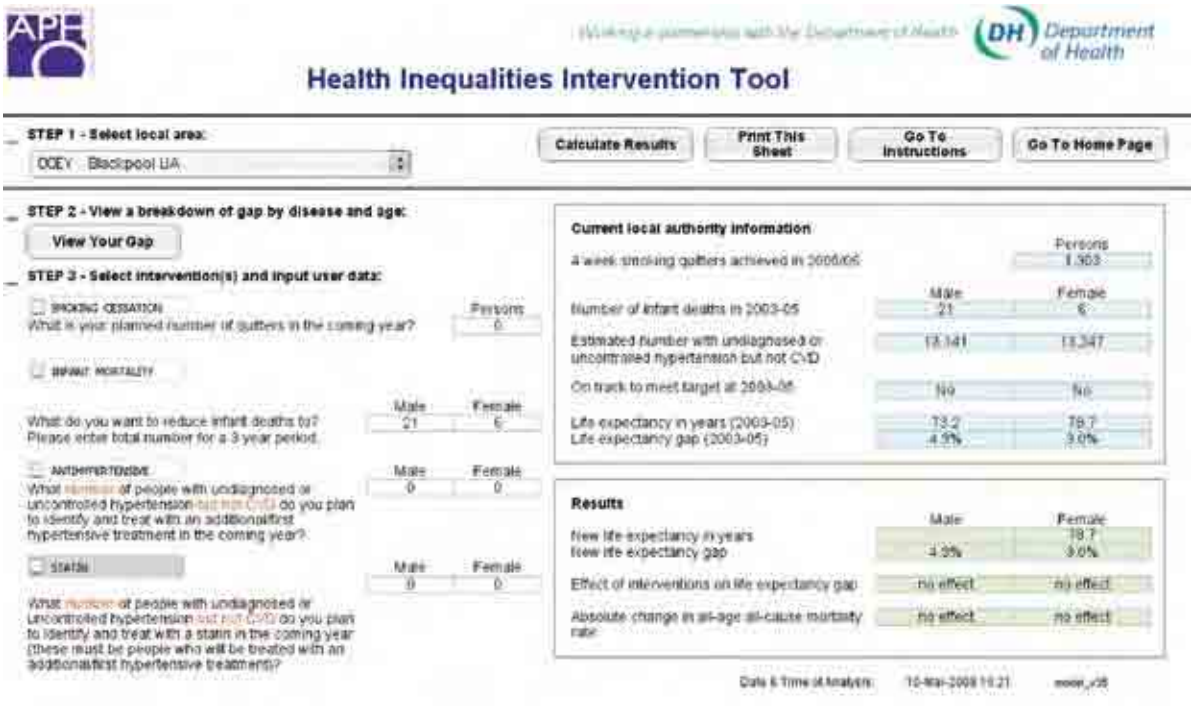
The Department of Health has worked with partners across government, aligning incentives for the NHS and local authorities to encourage partnership working. The AAACM rate per 100,000 population is an indicator in the *NHS Operating Framework for 2008/09*, *Vital Signs* and *The New Performance Framework for Local Authorities and Local Authority Partnerships: Single Set of National Indicators*. The Department of Health has provided indicative AAACM trajectories for spearhead local authorities and PCTs that are designed to add up to a 10% reduction in the life expectancy gap with England.

Health inequalities intervention tool

4.21 Other indicators and measures can inform an initial assessment of local health inequalities and help track progress, such as the health poverty index and the local basket of indicators. More recently, a bespoke health inequalities intervention tool has been developed by the Department of Health through the Association of Public Health Observatories. The work was led by the London and Yorkshire and Humber Public Health Observatories.

4.22 The tool is designed to assist commissioners in spearhead PCTs with their Local Delivery Plans (LDPs) and commissioning, and to assist spearhead local authorities with the delivery of LAAs. It highlights key areas for spearhead PCTs and local authorities to consider in order to achieve the life expectancy element of the national health inequalities target.

Figure 4.1: The main page of the tool



4.23 This tool is an interactive resource which draws together key data and modelling. It has been designed as a 'ready reckoner' to allow commissioners, PCTs and local authorities in spearhead areas to understand the potential impact of increasing simple, effective, evidence-based measures on their life expectancy gap. The tool can be used as part of a comprehensive, long-term strategy to reduce health inequalities. The initial focus is on CVD and infant mortality.

4.24 The tool has two main parts:

- dividing up the local gap by age and disease. The tool breaks down the contribution of each of the main disease groups to the life expectancy gap in each spearhead area. In most areas, the three major killers making up the gap will be the same as elsewhere. However, there may be specific spearhead areas with other important causes of death. The tool will assist in developing an additional commissioning focus if necessary

- applying evidence-based interventions to show their effect on the gap. This part has four key elements:
  - interventions to reduce infant mortality
  - smoking cessation
  - antihypertensive prescribing in people without diagnosed CVD
  - statin prescribing in people without diagnosed CVD.

4.25 Users can select to model using any local authority (LA), and can model the effect of each of the four interventions independently or in combination.

4.26 Health Impact Assessment (HIA) is now a specific impact test within the government impact assessment process. This makes consideration of health and health inequalities more explicit in assessments of government policies. Further work is being done to strengthen and support the use of HIA both in DH and with other government departments following the publication of the Council for Science and Technology report *Health impacts – A strategy across Government* which stated that the overarching objective of government policy making should be 'improving the health of the whole population whilst reducing health inequalities especially for those with the poorest health'.

4.27 The Health Trainers Programme has been implemented since April 2006 and health trainers are a key tool in addressing health inequalities. This programme is not about support for those who already enjoy good health. Health trainers work with those communities in highest need of action to tackle health deprivation and reduce inequalities. Their function is to help people improve their health by making positive changes to their behaviour and help them access information and/or services. The programme was developed to help implement *Choosing Health*, and more than 1,200 health trainers have now been trained and are in post. These numbers are in line with original plans and demonstrate the commitment of local teams to the concept.

GOOD PRACTICE

Building Community Capacity for Health through Health Trainers

Background

Bolsover District is ranked 31 in the bottom 50 (most deprived) local authorities (IMD, 2004) in England. With such high rates of deprivation and ill health within its boundaries, the populations of Shirebrook, Creswell and Langwith experience the worst health outcomes within the district. The area has rates higher than the national rates of coronary heart disease and smoking-related illness, and the district as a whole has 25% more people with long-term illness than the UK average.

Programme

Health trainers and the development of a network of community volunteers for health have been seen as a positive step in improving lifestyle within the district and a key strand in driving down the heart attack rate in North East Derbyshire (for further details, see the Chief Medical Officer's Annual Report 2006, page 64).

Health trainers are a new workforce either employed through the NHS or volunteering to act as health champions within their work role or local community.

Health trainers must have experience and an understanding of what it means to live in, or be part of, their community and reflect the diversity of the area they work in. It's a common sense approach, giving communities ownership for health.

Clients receive:

- clear, up-to-date information about lifestyle and health, including what might affect their health and wellbeing
- help to identify things to improve their health and wellbeing
- help to identify services/people who might be able to help them, by signposting or referring on
- opportunities to develop their knowledge and skills about health and wellbeing by enabling access to information, advice and support
- help to identify how their way of life might affect their health and wellbeing and how they can make the changes they want to.

The support of all sectors is integral to the development of health trainers within local communities. Bolsover LSP has been hugely supportive throughout.

Service user comments

Client: Tammy. 'Jane has supported me from the beginning of my referral programme. Without Jane's presence and guidance, I would have felt unable to attend to begin with because of my low self-esteem. With her help I feel able to reach my goals of improved health and fitness.'

Client: Janet. 'Jane has helped me in my programme by supporting me in the gym and chair-based class, giving me confidence to attend on my own so I can improve my health and fitness. My health is much improved as my fibromyalgia is a lot better. My weight has also decreased, which is an added bonus.'

For more information, please contact judy.derricott@derbyshirecountypct.nhs.uk.

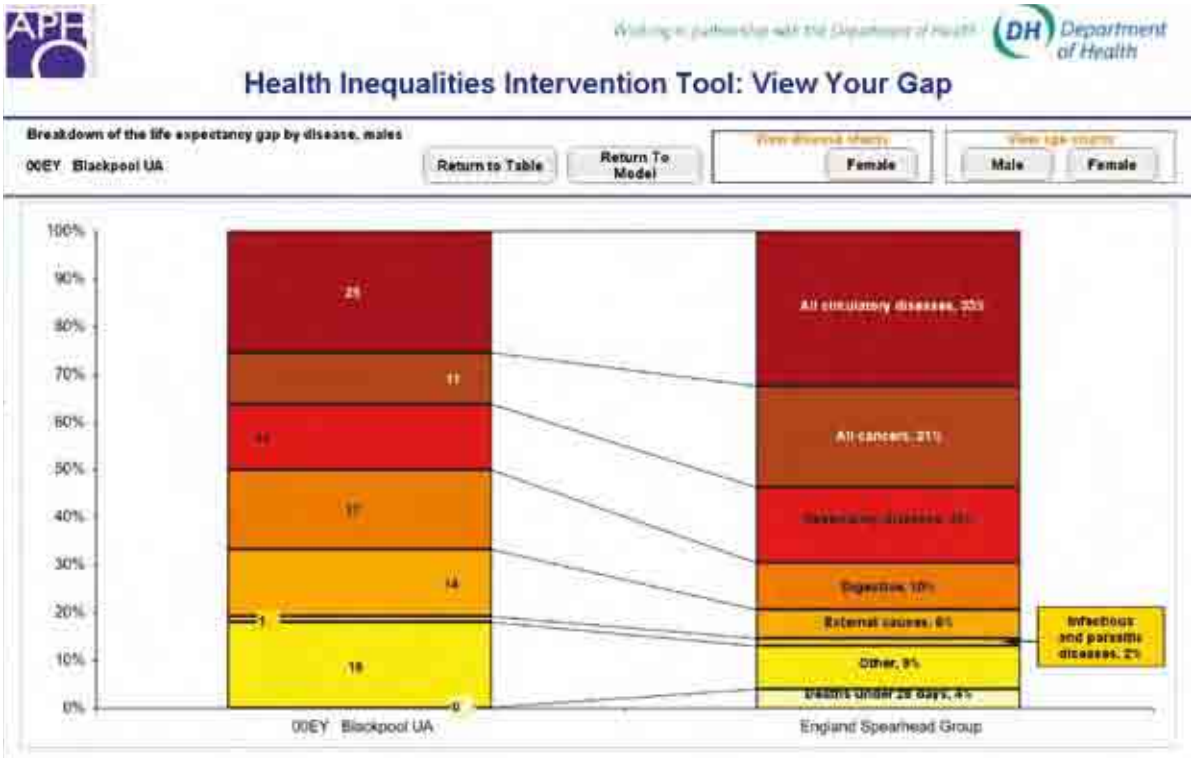
4.28 NHS Early Years LifeCheck is an online tool that is aimed at parents and carers of babies aged between five and eight months, which aims to help give their baby the best start in life. The tool gives the opportunity to answer questions about milestones in their baby's first year, and then provides personalised information about things they can do to help keep their baby healthy, happy and safe. Information is provided on:

- development
- playing and learning
- talk
- protecting against disease
- safety
- teething
- sleeping
- feeding
- becoming a parent.

4.29 Between February and April 2008, NHS Early Years LifeCheck is being piloted in Sure Start Children's Centres through the NHS Choices Learning Network areas of Humber, Derby, Hull, North East Lincolnshire, North Lincolnshire, Warwickshire and Coventry. Participating Children's Centres will have facilitators on hand to help people access the website and show them what to do. Parents and carers can also do their NHS Early Years LifeCheck on their own at www.nhs.uk/lifecheck.

4.30 Subject to assessment of the results of the pilot evaluation, consideration will be given to a national launch of the NHS Early Years LifeCheck in 2008.

Figure 4.2: Example of a local life expectancy gap break down, with a comparison against the spearhead average



Scale and support

Promoting what works

4.31 Promoting what works needs robust evidence of good practice to highlight what works and encourage its adoption elsewhere. The systematic development of effective practice through shared learning also shows health professionals and other front-line staff how this approach can make a difference in their local areas and can be used to highlight achievement and the recognition of the efforts of individual staff and organisations. This section will explore these issues by:

- taking account of the available evidence of what works.
- sharing and learning through good practice, including reviewing the different models of what works (progressive universalism)
- working together across organisations.

GOOD PRACTICE – Evidence and learning from overseas

Building on a successful evidence-based programme in the United States, a pilot Family Nurse Partnership (FNP) programme is being tested in 10 sites across England. The programme seeks to:

- improve pregnancy outcomes by engaging women in good health practices
- improve child health and development and future readiness and achievement by helping parents provide responsible and competent care
- improve parents' economic self-sufficiency by helping them develop a vision for their own future, plan for future pregnancies, continue education and find work.

Derby signed up as one of the pilot programmes, working with teenage mothers. This joint PCT and LA project provides intensive home visiting to 100 of the most vulnerable first-time mothers aged under 20 from the 14th week of pregnancy until the child is two years old. Families, and family support systems, are often included in the visits and help in assessing the needs of the family.

The FNP programme's long-term aims are to improve antenatal health, reduce subsequent unplanned pregnancies, increase breastfeeding rates, improve school readiness and reduce child abuse and neglect. After seven months, 90% of the families offered FNP have accepted and enrolled on the programme, helped by the excellent working relationship between health visiting and midwifery services.

Early indicators suggest:

- the project is well accepted by teenage parents with very few drop-outs so far
- an increase in the number of young parents who stop smoking in pregnancy
- an increase in the self-esteem of young parents on the programme
- involvement from young fathers and other family members in the programme
- a willingness to develop a long-term therapeutic relationship with the family nurse and to learn about and try breastfeeding
- a willingness to learn about the development of babies and health-related issues.

The experience in Derby will help serve as a catalyst for change and play a key role in renewing and reshaping health-led child and family support services to reflect the needs and aspirations of local families.

Further information about the pilot can be found at: www.everychildmatters.gov.uk/parents/healthledsupport/.

For more information, please contact: Chris.tully@derbycitypct.nhs.uk.

National Support Team

4.32 The NST for health inequalities has been commissioned to support the spearhead areas, focusing on those with the most challenge in hitting the 2010 health inequalities PSA targets. Working from a spreadsheet of progress indicators developed with the Health Inequalities Unit, augmented by local intelligence from the six SHAs with spearhead areas and their corresponding regional Government Office, the NST has visited 16 of the most challenged areas in its first year.

4.33 The NST uses a very structured, 'deep-dive' approach to appraise each visited area. Interviews with strategic personnel examine the way the districts are set up through partnership, leadership, vision and strategy to deliver effective population-level interventions, front-line services and community engagement. Six parallel workshops examine detail around CVD, diabetes, cancer, smoking cessation, seasonal excess deaths and infant mortality. These workshops use a tailored diagnostic to systematically appraise a range of factors that determine whether optimal population outcomes will be achieved from the main evidence-based interventions. The 'deep-dive' visit results in tailored recommendations, including sharing of key best practice, and a follow-up programme of front-line support packages.

4.34 In consultation with the Health Inequalities Unit, a spreadsheet of data on all spearhead areas has been developed. This is being used to agree which communities currently face the biggest challenge, based mainly on being off trajectory for narrowing the AAACM gap, and on progress overall so far since the baseline year.

4.35 All visits have successfully engaged PCTs at the highest level with the participation of chief executives, professional and executive committees and senior management teams in all cases. Directors of public health and their teams have been central to the visits but balanced by other directorates, particularly commissioning, primary care, finance and provider services. NHS acute trusts have also been engaged and local authority officers and members have played an important part in the process, as have other local strategic partners, particularly the voluntary sector.

4.36 The NST now has considerable experience of what does and does not work on the ground, and that most areas benefit from a clearer understanding of what is needed to deliver the target, together with strong messages about the need for a systematic approach and for action to be deployed on the necessary scale if the health gap is to be narrowed. Gaining wider ownership of the actions required beyond public health is critical. Improving primary care performance is particularly central to delivery.

GOOD PRACTICE – WORKING IN PARTNERSHIP

Bridging the Gap Caused by Alcohol-Related Harm

The North West region has some of the greatest alcohol problems due to high levels of deprivation. In the North West, on average, men living in more deprived areas lose 20 months of life and women lose nine months because of conditions related to alcohol, compared with six months for men and three months for women living in more affluent areas.

Citysafe, Liverpool's Community Safety Partnership, has developed a web of interlinked initiatives to reduce the harmful impact of alcohol. The local partnership has developed a Pub Watch and the Best Bar None scheme to promote good practice in the licensing trade. The Chamber of Commerce, the city council, Merseyside Police and other partners have encouraged city centre pubs and clubs to be part of a radio link, which enables staff to share information about potential problems and to notify the police about incidents quickly. Taxi-marshalling schemes have also been introduced and have had positive effects, reducing the risk of potential flashpoints at the designated taxi ranks.

Citysafe has also funded two schemes as part of its prevention strategy. The first has been to deploy additional handheld metal detectors at pubs and clubs to discourage the carrying of knives and other offensive weapons. The scheme is being extended to include door supervisors. The second scheme promotes the use of polycarbonate glasses in bars and clubs. As part of the promotion, Citysafe is subsidising the difference in price between conventional glasses and the polycarbonate replacements. The scheme builds on the Crystal Clear programme, which aimed to reduce glass-related injuries and assaults. Following joint work involving the city council, Citysafe and the police, a designation order for the city centre was obtained under powers contained in sections 12–14 of the Criminal Justice and Police Act 2001, so as to prevent alcohol consumption in public places.

In a partnership between local accident and emergency (A&E) departments, the police and Liverpool John Moores University, Citysafe has been promoting increased data sharing regarding alcohol-related assaults in the city. The data from A&E departments are helping Citysafe to target hotspot locations and bars. In turn, such activity is beginning to produce a reduction in the number of referrals to A&E departments.

This package of initiatives has helped to reduce assaults, robbery and anti-social behaviour by over 28% in the city centre compared with the previous year. The overall figures represent the lowest in the centre for 10 years.

4.37 The NHS Primary Care Contracting Team is providing support in a selection of spearhead PCTs to identify issues in primary care related to health inequalities and targeted assistance to address them.

4.38 The Improvement and Development Agency (IDeA) for local government is supporting local authorities to work alongside PCTs and lead local action on tackling health inequalities through the Healthy Communities Programme. The main strands of the IDeA Healthy Communities Programme are:

- Healthy Communities peer reviews, where a team of trained peers from health and local government provide feedback to individual local authorities on their work on health inequalities and health improvement using benchmarks developed for this purpose

- leadership academies for elected members who lead on health and social care. Core programmes are delivered nationally and tailored programmes are delivered for individual councils and groups of authorities, and programmes also involve PCT non-executive directors

- Idea.gov.uk/health, which is a popular area on the IDeA Knowledge website for local authorities, health organisations and others, with an emphasis on health inequalities, health improvement and health and wellbeing.

The Improvement Foundation is using healthy community collaborative methodology to improve early presentation for cancer and CVD in poorly performing spearhead areas.

4.39 Promoting local good practice through DH-sponsored awards and other showcased events has shown what can be done. East Lancashire PCT and Burnley Council worked in partnership using an innovative approach to mainstream health inequalities and promote healthier lifestyles among disadvantaged groups. Their work was recognised in the 2007 Health Services Journal (HSJ) Award for reducing health inequalities. Sandwell PCT won the award in 2006 with a physical activity referral scheme. Knowsley Metropolitan Borough Council and Knowsley PCT worked together in a joint programme tackling teenage pregnancy and won the Municipal Journal Award for reducing health inequalities. Fenland District Council's Street Pride scheme to improve the local environment and quality of life won the joint HSJ/Local Government Chronicle Sustainable Communities 2008 health inequalities award.

Key lessons

4.40 The profile of the health inequalities target has been raised since publication of the *Programme for Action*. It has become a priority for the NHS and local government. This should contribute to the successful delivery of targets. The target reviews showed patchy results in translating national priorities into local action. Health inequalities have to compete for attention with other issues and priorities; their complexity and being sufficiently clear about what to do can create uncertainty, and organisational pressures add to these difficulties.

4.41 Important lessons have been learned during the life of the strategy. These lessons include:

- the need for new tools and levers to help clarify the task for local managers and practitioners, such as the health inequalities implementation tool

- the leadership challenge to work in partnership to help achieve the appropriate scale and focus to ensure effective local delivery on health inequalities, such as through the work of the NST

- the need for more and clearer evidence to strengthen confidence about what works, such as through the modelling of the two aspects of the health inequalities target

- the value of learning from others, such as the health inequalities infant mortality implementation plan and the dissemination of good practice.

Chapter 5: Conclusion

5.1 This status report has provided an opportunity to review developments against the strategy set out in the *Programme for Action*. This review can only provide an interim assessment against the wider ambitions of the strategy, namely meeting the 2010 target and achieving a long-term sustainable reduction in health inequalities. As the first national health inequalities strategy, the *Programme for Action* sought to lay the foundations for these ambitions. The true test of the contribution of this strategy will be in the long term. A clearer picture will be delayed by time lags both in the availability of data and in the planning and delivery of services. The *Programme for Action* noted that the impact of this first strategy was unlikely to be visible much before the end of the decade.

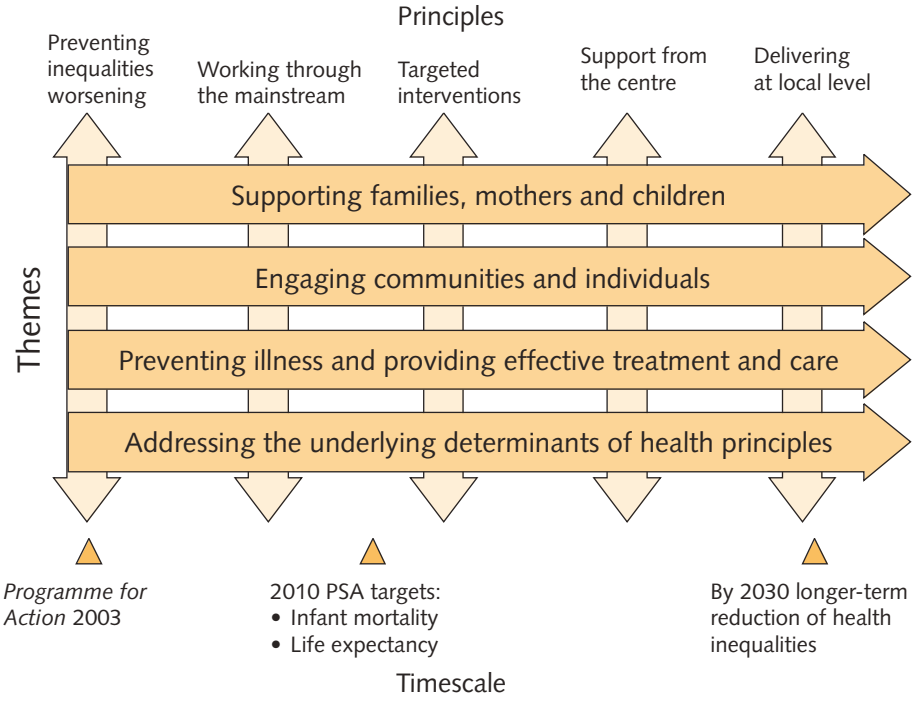
5.2 The key themes and principles of the *Programme for Action* were set against a long-term timescale. These themes were designed to reflect the broad front set out in the Acheson report and endorsed by the Treasury-led cross-cutting review. These themes were developed around supporting families, mothers and children, engaging communities and individuals, preventing illness, providing effective treatment and care, and addressing the underlying social determinants of health.

5.3 The principles underlying the strategy were:

- preventing health inequalities worsening
- working through the mainstream
- targeting specific interventions
- supporting action from the centre and through the regions
- delivering at local level.

5.4 Ultimately, the *Programme for Action* stressed that these principles meant doing things differently. This would require reshaping services, using resources differently and changing the way many services operated. The interaction of these themes and principles against time are set out in Figure 5.1.

Figure 5.1: Health inequalities Programme for Action: Themes and principles



Preventing health inequalities worsening

5.5 Preventing health inequalities worsening was a key goal for the *Programme for Action*, given the long-term trend for a widening of health inequalities between different social groups. This was a considerable challenge as an objective for the strategy. Brigading action across the four themes provided an opportunity to link many different streams of work under a single strategic umbrella. It also offered the chance to maximise the synergy between these activities and promote further action.

5.6 Attempts to stabilise the widening gap have produced some positive results, not least among the social determinants of health arising from the commitments of the 12 government departments that signed up to the strategy. Almost all of these commitments have been delivered. While they have been delivered to meet the objectives of individual departments, the national health inequalities strategy has provided a link across these different objectives that highlights the broader impulse of the government's approach to address poverty and inequality and promote social justice.

5.7 This recognition of health inequalities as an integral part of the plans and objectives of others has been vital in preventing health inequalities widening further. It can be seen in the decision to widen the scope of health targets, such as those related to cancer and cardiovascular disease, and include an explicit health inequalities dimension as part of improving health in these areas. Tackling health inequalities is already implicit in many other targets, including the targets related to several of the 12 headline indicators included in this report. The Wanless report underlined the economic implications of worsening health inequalities in terms of a heavier future cost burden to the NHS and this has given further urgency to the work.

Working through the mainstream

5.8 Addressing health inequalities through the mainstream of service policy and delivery has been – and will continue to be – a double challenge: firstly, through setting the policy and planning agenda of service organisations at national, regional and local level; and secondly, through establishing service delivery that is responsive to need and recognising that, for too long, these services have often been worst in disadvantaged areas. This is a major challenge since work to tackle health inequalities has traditionally operated outside the mainstream, often organised as projects not programmes and seen as related more closely to research rather than policy.

5.9 The partnership with local government has been crucial in beginning to get health inequalities into the mainstream. Many local authorities have worked effectively with primary care trusts (PCTs) and others in Local Strategic Partnerships (LSPs) to identify need and promote local action on health inequalities. Local Area Agreements (LAAs) have been key vehicles for encouraging planning and sponsoring action across local partnerships. Reducing health inequalities has been a key LAA theme. The new LAAs should be completed in June 2008. The new Joint Strategic Needs Assessment (JSNA) will place a duty on local authorities and PCTs to identify current and future local needs as the basis for effective commissioning of services.

5.10 Breaking down barriers to deliver high-quality services to disadvantaged groups and areas is crucial in providing a foundation for improving the health of the next generation and reducing the health gap in the long term. Sure Start local programmes provided high-quality education and health support to children under four and their families in tightly defined areas of disadvantage. These programmes are now being mainstreamed in Sure Start Children's Centres so that many more disadvantaged children and their families will be able to use high-quality services that are available to all.

Targeting specific interventions

5.11 Alongside mainstreaming, there has been an important place for specific initiatives to meet particular needs and reduce health inequalities among disadvantaged and vulnerable groups. Such interventions can also pioneer innovation, tackle specific problems or support those who may have difficulty accessing services.

5.12 Many individual projects and programmes have been directed at meeting such needs and contribute to tackling health inequalities, especially at local level. This is seen in the work of the Beacon councils. These councils have been successful in showing what can be done to meet local needs. Individual national programmes can also address specific needs. Fuel poverty affects many poorer households, particularly vulnerable older people and families with children. The Warm Front programme provides a range of energy efficiency and heating measures for private-sector vulnerable households, helping to improve their comfort in their own homes. The government remains committed to tackling the challenge of fuel poverty by working together with all those who have expertise in the area to enable progress towards the fuel poverty targets.

5.13 There is a risk that an undue emphasis on specific interventions can obscure strategic direction and miss the wider dimensions of health inequalities. It has been important to reaffirm that the needs of individuals and groups experiencing such inequalities have an important place as part of this strategic approach.

Supporting action from the centre and through the regions

5.14 The announcement of a national health inequalities Public Service Agreement (PSA) target flagged the new importance of health inequalities. This was a major policy change and emphasised the need to build work to tackle health inequalities into the wider systems and processes of public services, if the target was to have an impact. It also meant greater clarity about roles and responsibilities – and clarifying who should be doing what.

5.15 Building health inequalities into national planning and performance systems has been a necessary prompt to action at local level. Health inequalities have emerged as a national NHS planning priority in recent years and are now a top six NHS priority, featuring again in the 2008/09 Operating Framework.

5.16 At regional level, regional directors of public health have had a key role in Government Offices in bringing health inequalities into play across a wide range of different interests, covering many of the underlying social determinants of health. NHS changes have also strengthened the links with delivery of NHS services.

5.17 Identifying health inequalities as a priority for action, while necessary, has not always been sufficient for prompting effective local action. This was evident in the follow-up to the publication of the 2005 Status Report which reported a further widening of the gap against the target. A review process was launched with a view to focusing on key interventions and sharpening local delivery. This process of audit and review showed a responsiveness that underlined the importance of the health inequalities target and confirmed with clarity what was needed – that local action was both necessary and expected.

5.18 Sharpening local delivery has been assisted by the development of new levers and tools, in particular the health inequalities intervention tool. This tool breaks new ground in understanding the implications of the target for action at local level. This is in addition to the local basket of indicators and the health poverty index. The health inequalities National Support Team (NST) has had a key role in beginning to work with local authorities, PCTs and other organisations to promote and encourage the adoption of good practice in different local contexts.

Delivering at local level

5.19 Differences in the way services are delivered and improvements in their range and scope will be experienced first at local level. Good quality services are crucial in improving the health and narrowing the gap of disadvantaged population, as shown by the Sure Start experience.

5.20 The increased investment in NHS services has been significant. Much of it has been directed towards improving access to, and the quality of, NHS services. There have been improvements in the way in which many people in disadvantaged areas receive NHS services, for example through improvements to the physical state of GP surgeries and the development of new primary care centres, especially in inner cities and urban areas.

5.21 Improving primary care in many disadvantaged areas remains a continuing challenge – not least in terms of increasing the number of primary care professionals. Some areas have acute problems and this has been highlighted in Lord Darzi's promise to create 100 new GPs surgeries in under-doctored areas.

5.22 While there are signs that smoking cessation programmes in disadvantaged groups have been more effective than elsewhere, the evidence also suggests that, despite this substantial achievement, it is not enough on its own to meet government smoking targets or substantially contribute to the health inequalities target. This is a key local challenge given the significant gap that remains in smoking prevalence between manual and non-manual groups.

5.23 The NHS is not the only vehicle for delivering improvements in access and quality of local services which will reduce health inequalities. The National Strategy for Neighbourhood Renewal has worked in deprived areas to tackle health, crime, education, worklessness and housing supported by the £3 billion Neighbourhood Renewal Fund. The New Deal for Communities is a regeneration programme for 39 of some of the most deprived communities in the country. While this programme has overseen some slight short-term improvements in health, most initiatives are focused on changing habits and improving access which will bear fruit in the long term, but there have also been more significant changes in physical and environmental outcomes of the programme, most notably through housing and environmental improvements.

5.24 Work is a key factor for health, and unemployment and worklessness contribute to the widening of the health gap. The national minimum wage has provided extra protection for low-paid workers. For the unemployed, Jobcentre Plus has sought to upgrade the quality of local services for unemployed people seeking work. The Skills for Life programme has sought to raise basic adult skills in language, literacy and numeracy to improve the prospects for work, while the Pathways to Work programme focused on rehabilitation as a way of reducing worklessness and improving employability among disadvantaged groups. The Working Neighbourhoods Fund has committed to give £1.5 billion to deprived areas over the next three years.

5.25 New employment opportunities in disadvantaged areas have been created through the Regional Development Agencies and programmes like the Phoenix Development Fund and Good Corporate Citizen. These and other activities have sought to promote economic regeneration by creating jobs in new enterprises in deprived areas. Issues remain, however, about the quality and security of many jobs.

5.26 Effective action has been undertaken in reducing accidental injuries, especially among children and young people in disadvantaged areas, through a combination of environmental improvement, public education campaigns and local projects to reduce road casualties. Greater improvements have been shown in Neighbourhood Renewal areas than in the rest of the country.

5.27 The economic and social benefits of greater equality seem to go hand in hand. The persistence of income and wealth inequalities with a significant gap between rich and poor remains a barrier to tackling health inequalities, despite efforts to improve the position of disadvantaged groups.

Conclusion

5.28 The *Programme for Action* has been ambitious in seeking to lay the foundation for tackling health inequalities on a broad front. It acknowledged the difficulties given the persistence and complexity of health inequalities. It was clear that effective action meant long-term commitment and continuing high-level support.

5.29 This final report against the strategy set out in the *Programme for Action* shows that a start has been made on this long road. Considerable activity has been generated, much of it focused on disadvantaged groups and areas with the aim of improving the health of disadvantaged people faster than other groups. Much of this activity has also taken place outside the NHS, particularly in local government. Continuing this effort will be crucial if the causes of health inequalities are to be addressed as well as the symptoms.

5.30 Some useful results have been achieved. The data in this report show that, while meeting the target remains a challenge, many of the fundamentals offer some encouragement for long-term change. This is the message from the 12 headline indicators and the audit of departmental commitments. England is recognised as an international leader for its systematic approach in tackling health inequalities, and it's work to improve and strengthen its response to this challenge.

5.31 Sustaining and developing this 'broad front' approach will be crucial if these early results are to be translated into a long-term, sustainable reduction in health inequalities. Constant vigilance will be required to ensure that action is focused appropriately and helps to match needs and resources. Further efforts will be required to ensure that action is joined up within and across local, regional and central government and other partners. Health and social policies will also need to be tested for potentially perverse effects that will improve health but end up widening the health gap.

5.32 This report shows that the commitment to tackle health inequalities has grown steadily in the years since the publication of the *Programme for Action*. This support for tackling health inequalities is set to strengthen further with the Secretary of State for Health's commitment to refresh the strategy later in 2008.

Glossary

AAACM	All-age, all-cause mortality
APHO	Association of Public Health Observatories
BERR	Department for Business, Enterprise and Regulatory Reform
BME	Black and minority ethnic
CAMHS	Children and adolescent mental health services
CHD	Coronary heart disease
CLG	Department for Communities and Local Government
CVD	Cardiovascular disease
DCSF	Department for Children, Schools and Families
DCMS	Department for Culture, Media and Sport
Defra	Department for Environment, Food and Rural Affairs
DfT	Department for Transport
DH	Department of Health
DIUS	Department for Innovation, Universities and Skills
DPH	Directors of public health
DWP	Department for Work and Pensions
FNP	Family Nurse Partnership
fte	Full-Time Equivalent
GO	Government Office
HIA	Health Impact Assessment
HMT	Her Majesty's Treasury
HO	Home Office
IDeA	Improvement and Development Agency
IMR	Infant mortality rate
JSNA	Joint Strategic Needs Assessment
LA	Local authority
LAA	Local Area Agreement
LAD	Local authority district
LDP	Local Delivery Plan
LSP	Local Strategic Partnership
NDC	New Deal for Communities
NHS	National Health Service
NS-SEC	National Statistics Socioeconomic Classification
NRF	Neighbourhood Renewal Fund
NST	National Support Team
ONS	Office for National Statistics
PCT	Primary care trust
PSA	Public Service Agreement
R&M	Routine and manual (socioeconomic) group
RSL	Registered social landlord
SHA	Strategic health authority
SRG	Scientific reference group on health inequalities
WHO	World Health Organization

Annex 1: The scientific reference group on Health Inequalities

The group has overseen the development of this report and guided its judgements and conclusions. The members of the group are:

Professor Sir Michael Marmot (Chair)
Director of the International Institute for Society and Health, University College London

Professor Brian Ferguson
Director, Yorkshire and Humber Public Health Observatory, University of York

Professor Hilary Graham
Professor of Health Services, University of York

Dr Peter Goldblatt
Chief Medical Statistician, Office for National Statistics

Dr Bobbie Jacobson
Director, London Health Observatory

Professor Paul Johnstone
Regional Director of Public Health, Yorkshire and the Humber

Professor Ken Judge
Head of School for Health, University of Bath

Professor Mike Kelly
Director of the Centre for Public Health Excellence, National Institute for Health and Clinical Excellence

Professor Catherine Law
Professor of Public Health and Epidemiology, University College London Institute of Child Health

Dr Veena Raleigh
Lead, Methods and Research, Healthcare Commission

Annex 2: List of spearhead areas

Barking and Dagenham
Barnsley
Barrow-in-Furness
Birmingham*
Blackburn with Darwen*
Blackpool
Blyth Valley
Bolsover
Bolton*
Bradford*
Burnley
Bury
Carlisle
Chester-le-Street
Corby
Coventry*
Derwentside
Doncaster*
Easington
Gateshead
Greenwich*
Hackney*
Halton
Hammersmith and Fulham
Haringey*
Hartlepool
Hyndburn
Islington
Kingston upon Hull, City of*
Knowsley
Lambeth*
Leicester*
Lewisham
Lincoln
Liverpool*
Manchester*
Middlesbrough
Newcastle upon Tyne
Newham*
North East Lincolnshire

North Tyneside
Nottingham*
Nuneaton and Bedworth
Oldham*
Pendle
Preston*
Redcar and Cleveland
Rochdale
Rossendale
Rotherham*
Salford
Sandwell*
Sedgefield
South Tyneside
Southwark*
St Helens
Stockton-on-Tees
Stoke-on-Trent*
Sunderland*
Tameside
Tamworth
Tower Hamlets*
Wakefield*
Walsall*
Wansbeck
Warrington
Wear Valley
Wigan
Wirral
Wolverhampton*

* Denotes part of the 43 local authority areas with the highest number of infant deaths among the target group. The remaining areas in the group of 43 are: Brent, Bristol, Calderdale, Croydon, Derby, Dudley, Ealing, East Riding of Yorkshire, Kirklees, Leeds, Luton, Medway Towns, Milton Keynes, Northampton, Portsmouth and Sheffield.

Annex 3: Spearhead Group Local Authority Performance Against Contribution to National Life Expectancy Target for Males and Females, 2004–06/2003–05/ 2002–04 (three-year rolling average)

Spearhead local authority	2004–06 status				2003–05 status (revised data)				2002–04 status (revised data)			
	On track both	On track male	On track female	Off track both	On track both	On track male	On track female	Off track both	On track both	On track male	On track female	Off track both
Hackney	●				●				●			
Hammersmith and Fulham	●				●				●			
Haringey	●						●				●	
Southwark	●				●				●			
Tower Hamlets	●				●				●			
Derwentside	●				●				●			
Hyndburn	●				●				●			
Blyth Valley	●						●				●	
Barking and Dagenham		●						●				●
Lambeth		●				●			●			
Lewisham		●				●				●		
Newham		●				●				●		
Manchester		●						●		●		
Knowsley		●				●				●		
Redcar and Cleveland		●					●				●	
Sedgefield		●				●				●		
Wear Valley		●				●				●		
Burnley		●				●				●		
Wansbeck		●				●				●		
Tamworth		●				●				●		
Greenwich			●					●			●	
St Helens			●			●			●			
Doncaster			●				●				●	
Gateshead			●				●				●	
Newcastle upon Tyne			●				●				●	
Coventry			●				●		●			
Warrington			●		●				●			
Carlisle			●				●		●			
Easington			●					●				●
Islington				●		●						●
Bolton				●				●				●
Bury				●			●				●	
Oldham				●				●				●
Rochdale				●				●			●	
Salford				●				●				●
Tameside				●	●						●	●
Wigan				●				●				●
Liverpool				●				●				●

Spearhead local authority	2004–06 status				2003–05 status (revised data)				2002–04 status (revised data)			
	On track both	On track male	On track female	Off track both	On track both	On track male	On track female	Off track both	On track both	On track male	On track female	Off track both
Wirral				●		●				●		
Barnsley				●				●			●	
Rotherham				●				●				●
North Tyneside				●			●					●
South Tyneside				●				●				●
Sunderland				●				●				●
Birmingham				●			●				●	
Sandwell				●				●				●
Walsall				●			●			●		
Wolverhampton				●				●			●	
Bradford				●				●				●
Wakefield				●				●				●
Hartlepool				●				●				●
Middlesbrough				●				●				●
Stockton-on-Tees				●			●		●			
Halton				●		●				●		
Blackburn with Darwen				●		●				●		
Blackpool				●				●				●
Kingston upon Hull, City of				●				●				●
North East Lincolnshire				●				●				●
Leicester				●				●				●
Nottingham				●				●				●
Stoke-on-Trent				●				●				●
Barrow-in-Furness				●			●				●	
Bolsover				●				●				●
Chester-le-Street				●		●				●		
Pendle				●				●				●
Preston				●				●		●		
Rossendale				●				●			●	
Lincoln				●		●				●		
Corby				●			●			●		
Nuneaton and Bedworth				●			●		●			

Note: revised population estimates. In 2007, the Office for National Statistics published revised mid-year population estimates for England and Wales at local authority level for all years between 2002 and 2005. This is due to improvements made to the methodology used to produce the mid-year population estimates. The changes to population estimates have had an effect on the on/off track analysis. The table above shows the spearhead on/off track analysis according to the revised population estimates.

Annex 4: Absolute and relative inequalities

This report focuses on monitoring inequalities in terms of the **gap** between disadvantaged groups and a chosen reference group (the least disadvantaged group or the population as a whole). The gap in performance on an indicator between a disadvantaged group and the reference group can be measured in **absolute** or **relative** terms. Both the absolute and relative gaps are important and relevant measures of inequality, and in this report we have used both measures to assess progress against the headline indicators.

The relative gap is the ratio of the indicator value in the disadvantaged group to the reference group (an alternative measure of the relative gap is the percentage difference between the two groups). Taking inequalities in health outcomes as an example, the relative gap measures how unequal the health experience between groups is, i.e. how much more likely someone from a disadvantaged group is to experience poor health (for example death from cancer) than, say, the national average.

The absolute gap is the difference between the indicator values for the disadvantaged group and the reference group. The absolute gap measures the impact of the unequal health experience in absolute terms, for example how many more cancer deaths (per 100,000 population) occur in the disadvantaged group than the national average as a result of the higher risk in the disadvantaged group.

It is important to consider both absolute and relative measures and to interpret these carefully when assessing the extent of inequality. For example, a large social class gradient in a rare cause of death may be less important in public health terms than a smaller social class gradient in a common cause of death (for which absolute differences between social classes, and so the overall impact of the inequality, are higher).

It is also important to assess trends in both absolute and relative measures of inequality when interpreting changes over time. For example, where indicator values are decreasing in the reference group, it is possible for a narrowing in the absolute gap between disadvantaged groups and the reference group to be accompanied by a static or increasing relative gap. Similarly, where indicator values are increasing in the reference group, it is possible for a narrowing in the relative gap to be accompanied by a static or increasing absolute gap.

For this report, we have presented information in relation to the headline indicators using both absolute and relative measures of inequality. We have used the indicator ratio (rather than the percentage difference) to measure relative inequality.

Figure A4.1: Absolute and relative gap measures: formulae, interpretation and examples

Measure	Indicator difference	Indicator ratio	Percentage difference
Absolute or relative?	Absolute	Relative	Relative
Description	Difference in performance between the disadvantaged and reference groups	Performance in the disadvantaged group as a proportion of performance in the reference group	Difference in performance between the disadvantaged and reference groups as a proportion (measured as a percentage) of performance in the reference group
Formula	$R_A - R_B$	R_A / R_B	$[(R_A - R_B) / R_B] \times 100$
R_A = indicator value for disadvantaged group (group A) R_B = indicator value for reference group (group B)			
Interpretation:			
Values	Greater than 0 if poorer performance corresponds to a higher indicator value (as for mortality rates) Less than 0 if poorer performance corresponds to a lower indicator value (as for educational attainment)	Greater than 1 if poorer performance corresponds to a higher indicator value (as for mortality rates) Less than 1 if poorer performance corresponds to a lower indicator value (as for educational attainment)	Greater than 0 if poorer performance corresponds to a higher indicator value (as for mortality rates) Less than 0 if poorer performance corresponds to a lower indicator value (as for educational attainment)
No inequality	Indicator difference = 0	Indicator ratio = 1	Percentage difference = 0
Size of inequality	Greater distance from 0 (positive or negative) = larger inequality	Greater distance from 1 (above or below 1) = larger inequality	Greater distance from 0 (positive or negative) = larger inequality
Examples:			
1) Suppose the death rate is 120 deaths per 100,000 population in the lowest social class, and 80 deaths per 100,000 in the highest social class			
	The death rate difference is 40 deaths per 100,000 i.e. the death rate in the lowest social class is 40 deaths per 100,000 population greater than the death rate in the highest social class	The death rate ratio is 1.5 i.e. the death rate in the lowest social class is 1.5 times the death rate in the highest social class	The death rate percentage difference is 50% i.e. the death rate in the lowest social class is 50% higher than the death rate in the highest social class
2) Suppose the proportion of pupils achieving five GCSEs is 30% in the lowest social class, and 50% in the highest social class			
	The GCSE attainment difference is –20 percentage points i.e. GCSE attainment in the lowest social class is 20 percentage points lower than in the highest social class	The GCSE attainment ratio is 0.6 i.e. GCSE attainment in the lowest social class is 0.6 times lower than attainment in the highest social class	The GCSE attainment percentage difference is –40% i.e. GCSE attainment in the lowest social class is 40% lower than in the highest social class

Relationship between absolute and relative measures

The two relative gap measures (indicator ratio and percentage difference) are closely related. Since $R_A / R_B - 1 = (R_A - R_B) / R_B$, then

Percentage difference = (Indicator ratio – 1) x 100

For example, if the indicator ratio between groups A and B is 1.3, the percentage difference is 30% (the value for group A is 30% higher than that for group B). If the indicator ratio is 0.7, the percentage difference is –30% (the value for group A is 30% lower than that for group B).

The relative gap measures depend on the absolute gap (indicator difference) divided by the indicator value in the reference group (group B):

Percentage difference = 100 x indicator difference / R_B

Indicator ratio = 1 + indicator difference / R_B

One consequence of this is that a large indicator difference between two groups can occur with a small indicator ratio between the same groups, if the reference group indicator value is large. Similarly, a small indicator difference can occur with a large indicator ratio, if the reference group indicator value is small. So there may be a large inequality measured in absolute terms but a small inequality measured in relative terms, and vice versa.

Another consequence is that if the indicator value for the reference group is decreasing, it is possible for the absolute inequality to narrow over time while the relative inequality remains the same or increases over the same period. Similarly, if the indicator value for the reference group is increasing, it is possible for the relative inequality to narrow over time while the absolute inequality remains the same or increases over the same period (see Figures A4.2 and A4.3 overleaf).

Figure A4.2: Trajectories for maintaining constant absolute and relative inequality between two groups, A and B, when reference group B trajectory is decreasing over time

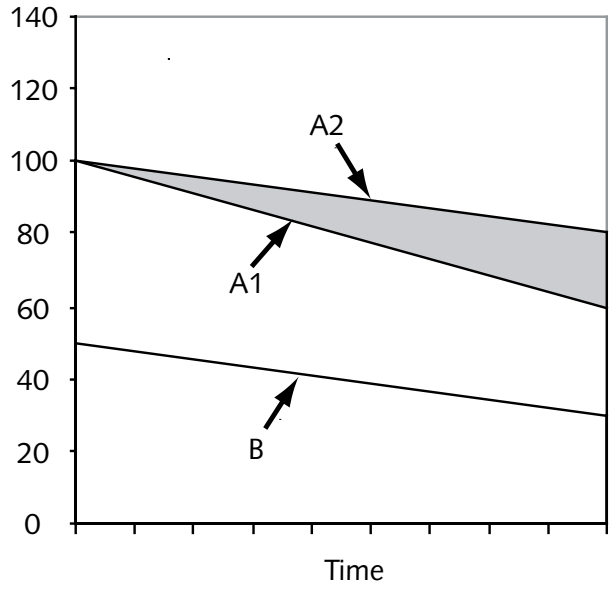
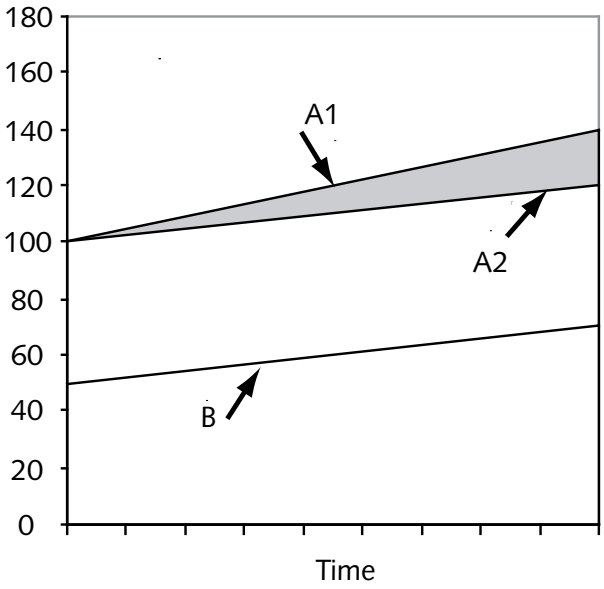


Figure A4.3: Trajectories for maintaining constant absolute and relative inequality between two groups, A and B, when reference group B trajectory is increasing over time



KEY:
B = Trajectory of reference group B
A1 = Trajectory that group A must follow to maintain constant relative inequality with group B
A2 = Trajectory that group A must follow to maintain constant absolute inequality with group B

Figure A4.2: If group A follows trajectory within shaded area, absolute inequality is narrowing but relative inequality is widening
Figure A4.3: If group A follows trajectory within shaded area, relative inequality is narrowing but absolute inequality is widening

Annex 5: Changes in definitions of social class

Old Social Class and new National Statistics Socioeconomic Classification

Box: A5.1

Registrar General's Social Class (based on occupation)

These are valid up to and including 2000.

Class description and examples of occupations:
Non-manual
I – Professional: doctors, chartered accountants, professionally qualified engineers
II – Managerial and technical/intermediate: managers, school teachers, journalists
IIIN – Skilled non-manual: clerks, cashiers, retail staff
Manual
IIIM – Skilled manual: supervisors of manual workers, plumbers, electricians, goods vehicle drivers
IV – Partly skilled: warehousemen, security guards, machine tool operators, care assistants, waiters and waitresses
V – Unskilled: labourers, cleaners and messengers

The Registrar General's Social Class (RGSC) was the principal classification of socioeconomic status used in the UK since its first appearance in the Registrar General's Annual Report for 1911. Analysis by RGSC has consistently shown social gradients in health, and particularly in mortality at working ages, infant mortality and birthweight. From 2001, RGSC was replaced by the new National Statistics Socio-Economic Classification (NS-SEC) in all official statistics. NS-SEC also replaces Socio-Economic Group (SEG) which has also been used in official statistics.

These socioeconomic classifications are based on occupation, in combination with employment status and, in some circumstances, size of workplace.

There is no direct mapping between the old and new classifications.

Figure A5.1 illustrates the construction of the various analytical class breakdowns of the new NS-SEC. The three-class version is the one used to define the Department of Health Public Service Agreement target on infant mortality.

When NS-SEC was introduced, the target was reformulated in terms of routine and manual occupations compared with the national average.

Figure A5.1: NS-SEC analytical classes

Operational categories	Analytical classes			
	Nine-class version	Eight-class version	Five-class version	Three-class version
1 Employers in large establishments	1.1 Large employers and higher managerial occupations	1 Higher managerial and professional occupations	1 Managerial and professional occupations	1 Managerial and professional occupations
2 Higher managerial occupations				
3 Higher professional occupations	1.2 Higher professional occupations			
4 Lower professional and higher technical occupations	2 Lower managerial and professional occupations	2 Lower managerial and professional occupations		
5 Lower managerial occupations				
6 Higher supervisory occupations				
7 Intermediate occupations	3 Intermediate occupations	3 Intermediate occupations	2 Intermediate occupations	2 Intermediate occupations
8 Employers in small establishments	4 Small employers and own-account workers	4 Small employers and own-account workers	3 Small employers and own-account workers	
9 Own-account workers				
10 Lower supervisory occupations	5 Lower supervisory and technical occupations	5 Lower supervisory and technical occupations	4 Lower supervisory and technical occupations	3 Routine and manual occupations
11 Lower technical occupations				
12 Semi-routine occupations	6 Semi-routine occupations	6 Semi-routine occupations	5 Semi-routine and routine occupations	
13 Routine occupations	7 Routine occupations	7 Routine occupations		
14 Never worked and long-term unemployed	8 Never worked and long-term unemployed	8 Never worked and long-term unemployed	Never worked and long-term unemployed	Never worked and long-term unemployed

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