



Tackling Health Inequalities: 10 Years On

*A review of developments in
tackling health inequalities
in England over the last 10 years*

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Tackling Health Inequalities: 10 Years On

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Foreword by Professor Sir Michael Marmot



Inequalities in health arise because of social inequalities in society, not simply because of inequalities in healthcare. Lack of access to high-quality healthcare can contribute to health inequalities, and universal access is necessary to deal with problems of illness when they arise. But – and it is an important but – if the causes of health inequalities are social, economic, cultural and political, then so should be the solutions.

This was the perspective taken by the Acheson report in 1998, and by the WHO Commission on Social Determinants of Health (CSDH) in setting out its conceptual framework. Acheson called for action across the whole of society in order to address health inequalities. The CSDH, in addition to recommending action across all sectors of society, called for monitoring of both health inequalities and the social determinants of health.

Responses to these two calls come together in this document. It answers two linked questions: what has happened in the 10 years since publication of the Acheson report, and, given our understanding of the social determinants of health, what do these developments look like in England?

Such monitoring is of vital importance. It provides the basis of rational policy-making and demonstrates whether it is making a difference. There will be interest in this in the UK among all who are concerned with health inequalities. It is likely that there will also be wider interest. By reviewing government policies relevant to health inequalities across the board, and bringing together data from a wide array of disparate sources, this report shows what can be done in monitoring health inequalities and their social determinants.

The document makes clear that the health of the worst off in England has improved over the last 10 years – a most important societal achievement. But, with comparable improvements in average health, the gap between the worst off and the average has not narrowed. Although much has improved socially and economically, the data presented here lay out persistent inequalities in income, educational achievement, literacy, child poverty, unemployment, local areas, anti-social behaviour and crime. Even with total political commitment to improvement across these important domains, these inequalities are deep-seated in society and improvements inevitably take time.

By setting targets for reduction in health inequalities, the Government signalled a commitment to this task that is greatly welcomed – as is the commitment to a national strategy to implement policies to achieve those targets, and the invitation to an independent group, the Scientific Reference Group on Health Inequalities, to oversee the monitoring of what has happened. It is a model that is of wide interest, nationally and internationally.

I am very grateful to Department of Health colleagues who compiled this report, and to the members of the Scientific Reference Group on Health Inequalities who brought their considerable experience, insight and energy to guiding the process of developing this report.

A handwritten signature in black ink that reads "Michael Marmot". The signature is written in a cursive, flowing style.

Professor Sir Michael Marmot
Chair, Scientific Reference Group on Health Inequalities

Executive summary

1. This document, *Tackling Health Inequalities: 10 Years On – A review of developments in tackling health inequalities in England over the last 10 years*, examines the changes in policies, determinants and outcomes that have shaped health inequalities in England over the last 10 years and sets out the key lessons and challenges. It provides the context and background for the recently announced post-2010 strategic review of health inequalities commissioned to look forward to 2020 and beyond.
2. The message from the last 10 years in addressing health inequalities is: much achieved; more to do.
3. This document takes stock of developments in health inequalities from the publication of the Acheson inquiry report in November 1998 to November 2008 when the post-2010 strategic review was announced.
4. The Acheson report reviewed the evidence on health inequalities and noted that: “there is convincing evidence that, provided an appropriate agenda of policies can be defined and given priority, many of these inequalities are remediable.”¹

The evidence base in the report has provided a cornerstone for policy development over the last 10 years informing action on the national target and the cross-government strategy, the Programme for Action.

5. The report focused on socio-economic inequalities and showed a widening health gap between different social groups. It made 39 recommendations across a broad policy front and around four themes:
 - the wider, social determinants of health
 - issues around the life course
 - the different dimensions of inequality (e.g. gender, ethnicity)
 - the role of the NHS.

The report gave a high priority to mothers, children and families.

6. Developments over the last 10 years are summarised in Chapter 1. In particular, there have been significant improvements in the health of the population over the last 10 years, an improvement almost wholly shared by disadvantaged groups and areas, as measured by life expectancy and infant mortality.²
 - Average life expectancy for all groups in England has increased significantly – for males by an extra 3.1 years and for females by an extra 2.1 years between 1995–97 and 2005–07.
 - For disadvantaged areas (the spearhead group of 70 local authority areas with the worst health and deprivation indicators) there has been an increase in life expectancy of only very slightly less than for the whole population – 2.9 years for men and 1.9 for females.
 - Infant mortality rates have fallen to an historic low level over the last 10 years – having fallen from 5.6 infant deaths per 1,000 live births in 1995–97 to 4.7 per 1,000 in 2005–07 for all

¹Independent Inquiry into Inequalities in Health (Acheson Inquiry) (1998) *Report of the Independent Inquiry into Inequalities in Health*.

²Department of Health (2008) *Tackling Health Inequalities: 2007 Status Report on the Programme for Action*.

those in England with a valid socio-economic group, with rates in the routine and manual (target) group having fallen from 6.3 to 5.4 per 1,000 live births over the same period.³

Health inequalities between different groups and areas and the whole population, however, persist in both of these areas.

7. The lessons and challenges emerging from the experience of the last 10 years provide the starting point for the strategic review (Chapter 2). The document notes that while there has been a favourable public policy context for tackling health inequalities, the wider context has been more challenging. Developments in policy design and implementation have improved delivery on health inequalities, notably since the adoption of the national health inequalities strategy in 2003.⁴ These developments have included:
 - better cross-government working and partnership, including with the NHS
 - more sensitive levers, systems and processes to foster this working
 - health inequalities messages that have become embedded in other targets and the planning of mainstream services
 - a process of monitoring, audit and review, which has improved focus of action on the targets.
8. This review records the policy responses to the Acheson report from government, based on contributions from the Department of Health and other government departments (Chapter 3). It takes account of key developments promoting action on health inequalities across government, including the announcement of the national target, the cross-cutting review on health inequalities, the development of a national strategy and, most recently, the publication of *Progress and Next Steps*.⁵
9. This record of policy responses is supported by an extensive survey of data developments over this period (Chapter 4). This final section presents a long-term perspective across a wider range of indicators, well beyond that of the year-on-year view of the annual status reports and reflecting the work of the World Health Organization Commission on Social Determinants of Health. It analyses the contribution of different social determinants to the overall burden of health inequalities to inform the strategic review. This framework covers four areas:
 - socio-economic political context
 - social stratification
 - differential exposures, vulnerabilities and consequences (e.g. including health-related behaviours)
 - differential outcomes in health
10. The analysis in this document highlights that progress against the social determinants of health will be crucial to a long-term, sustainable reduction in health inequalities. This will require a sustainable, systematic approach with a rigorous focus on reducing health inequalities across all areas of government. The experience of the 10 years between November 1998 and November 2008 set out in this review shows the development of evidence-based, practical and effective policy design and delivery systems. Building on these achievements through further policy development, monitoring and evaluation offers the prospect of further improvements in the health of disadvantaged groups and areas, and a long-term narrowing of the gap.

³Department of Health (2008) *Tackling Health Inequalities: 2005–07 Policy and Data Update for the 2010 National Target*.

⁴Department of Health (2003) *Tackling Health Inequalities: A Programme for Action*.

⁵Department of Health (2008) *Health Inequalities: Progress and Next Steps*.

Chapter 1: Introduction – Developments over the last 10 years

1. Meeting the 2010 health inequalities target on infant mortality and life expectancy is at the core of the health inequalities agenda. *Health Inequalities: Progress and Next Steps* (2008) started looking at how this agenda might develop beyond 2010. This document, *Tackling Health Inequalities: 10 Years On – A review of developments*, contributes to this process by reviewing developments between 1998 and 2008 through a framework of key data indicators. It also focuses on lessons and challenges over this period.
2. In detailing the policy response to the Acheson report⁶ and monitoring data on developments, it provides a close-up view of the action for participants and interested players in the post-2010 strategic review of health inequalities announced by the Secretary of State on 6 November 2008, as well as providing a reference point for others. It takes the long view, going beyond the year-on-year comparisons with the target and headline indicators in the series of status reports.⁷ It offers a comprehensive data analysis covering a 10-year period, within a framework developed by the World Health Organization (WHO) Commission on the Social Determinants of Health.⁸ In summary, this document reviews the achievements, lessons and challenges of the last 10 years and it:
 - highlights the changes in the policies, determinants and outcomes that have shaped health inequalities in England over the past 10 years
 - provides context and learning from the last 10 years for the post-2010 strategic review
 - shares more widely the experience of England in tackling health inequalities in the light of the WHO Commission report.

The Acheson report

3. The report of the Acheson inquiry into inequalities in health was published 10 years ago. It has been a cornerstone for action on health inequalities ever since.
4. This independent scientific review considered developments over the previous 20 years and identified possible policy developments to address health inequalities. The report presented data showing a widening gap between different social groups: “in the early 1970s, the mortality rate among men of working age was almost twice as high for those in social class V (unskilled) as for those in social class I (professional). By the earlier 1990s, it was almost three times higher.” This widening health gap between different social groups was echoed in the impact that the wider social determinants had on people’s health. It meant that action to address the widening gap was needed ‘upstream’ as well as ‘downstream’, in other words from outside the NHS as well as within it.

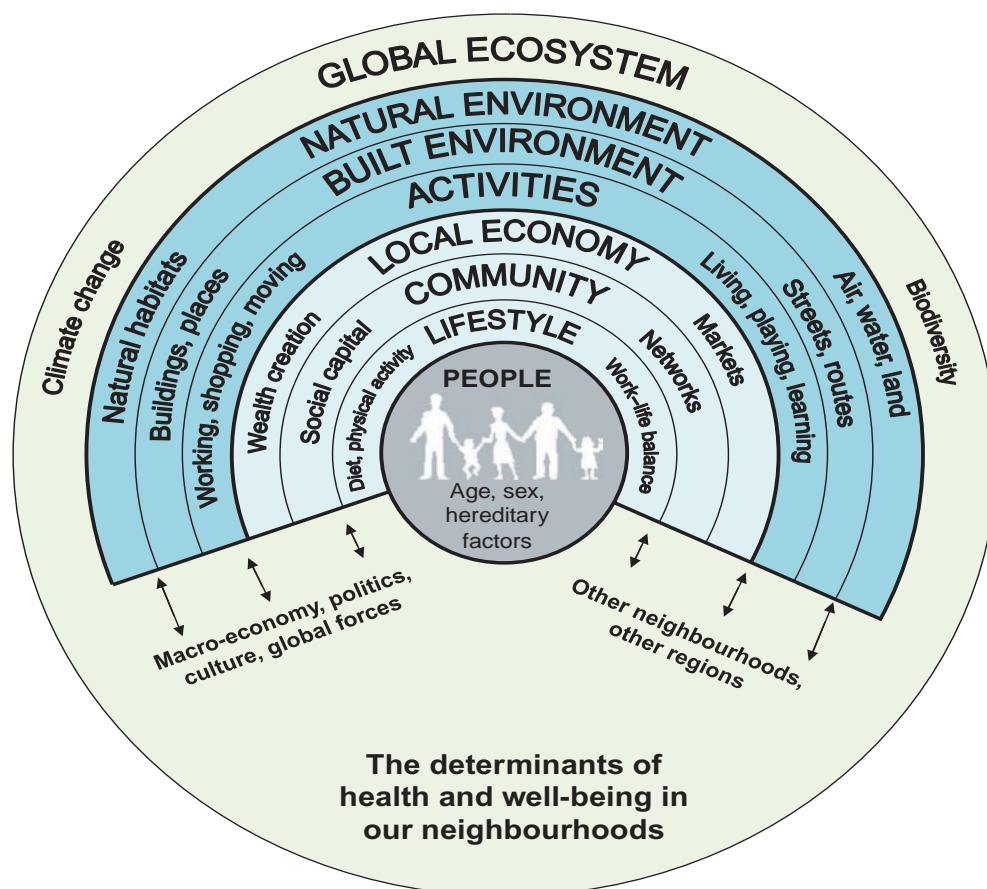
⁶Independent Inquiry into Inequalities in Health (Acheson Inquiry) (1998) *Report of the Independent Inquiry into Inequalities in Health*.

⁷See Department of Health (2008) *Tackling Health Inequalities: 2007 Status Report on the Programme for Action*. The Scientific Reference Group on Health Inequalities (chaired by Professor Sir Michael Marmot) oversaw the development of this document. The material to support it came from a wide range of contributors from within the Department of Health and across other government departments.

⁸WHO (2008) *Closing the Gap in a Generation*.

5. The report also noted that, while social determinants affect people’s health across their lives, the early years are a particularly important stage of life, where poor socio-economic circumstances have lasting effects. Consequently, it gave priority to policies and interventions with the potential to reduce inequalities in access to the determinants of good health among parents, particularly present and future mothers, and children.
6. It made 39 main recommendations that covered:
 - the social determinants of health, such as poverty and income, education, employment, environment and housing
 - the life course, including lifestyle factors such as smoking, nutrition and alcohol consumption
 - other dimensions of health inequalities beyond socio-economic status, namely ethnicity, gender and age
 - measures to improve the effectiveness of the NHS’s systems of care, not least in terms of resources and access to services.
7. The report acknowledged that tackling health inequalities was complex and a long-term challenge, requiring action across a broad front to address the ‘layers of influence’ on health, particularly in the early years of life. The relationship between these layers is shown below in Figure 1 (an updated version of the Dahlgren and Whitehead diagram that appeared in the Acheson report).

Figure 1: The main determinants of health



Source: Barton and Grant (2006) adaptation of Dahlgren and Whitehead (1991) from UN Economic Commission for Europe (2007) *Resource Manual to Support Application of the Protocol on Strategic Environment Assessment*.

Developments over the last 10 years

8. A national health inequalities target was set in 2001 to provide a focus for short- and medium-term action. The aim of the target was to reduce the inequalities in health outcomes in infant mortality and life expectancy by 2010. Updated in 2004, it was supported by two more detailed objectives:
- 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.⁹*
9. The national health inequalities strategy, the Programme for Action,¹⁰ was built on the ‘broad front’ set out in Acheson. It emphasised the crucial importance of working across government (at local, regional and national levels) and in partnership both with other service providers and with local communities. The Programme for Action had four themes:
- supporting families, mothers and children – reflecting the high priority given to them in the Acheson report
 - engaging communities and individuals – strengthening capacity to tackle local problems and pools of deprivation, alongside national programmes to address the needs of local communities and socially excluded groups
 - preventing illness and providing effective treatment and care – by means of tobacco policies, improvements in primary care and tackling the ‘big killers’ coronary heart disease (CHD) and cancer
 - addressing the underlying social determinants of health – emphasising the need for concerted action across government at national and local levels up to and beyond the 2010 target date.
10. This included a wider range of activities such as:
- improving employment opportunities and living conditions for disadvantaged groups
 - tackling poverty, particularly child poverty
 - reducing smoking prevalence and promoting access to a healthy diet in poorer communities
 - improving access to, and use of, health services among those who have traditionally been underserved.
11. Some factors, such as inequalities in access to transport, cut across the layers of influence by affecting people’s ability to get to services required (such as supermarkets), engage in physical activity or sustain social networks. It was recognition of the different roles played by the wider social determinants of health that emphasised the need for a cross-government response to the challenge of health inequalities.

⁹Department of Health (2008) *Tackling Health Inequalities: 2007 Status Report on the Programme for Action*.

¹⁰Department of Health (2003) *Tackling Health Inequalities: A Programme for Action*.

12. The *Programme for Action* had twin aims: to deliver the 2010 target and support a long-term sustainable reduction in health inequalities. Developments were to be reported annually in a published status report, throughout the lifetime of the strategy. These developments were monitored against the components of the target: 12 cross-government headline indicators that looked across the NHS to the wider determinants of health (reflecting Acheson's proposal for action on a broad front), and 82 departmental commitments.
13. Successive status reports show health improvements in real terms across all social groups, against a range of indicators including life expectancy, infant mortality, cardiovascular disease and cancer, and reported on developments against the cross-departmental commitments.
14. There have been significant, real improvements in health over the last 10 years. Infant mortality is at an historic low level – a major achievement – with a rate of 4.7 infant deaths per 1,000 live births in 2005–07 for all those in England with a valid socio-economic group compared to 5.6 per 1,000 in 1995–97. This improvement has affected all social groups. Male life expectancy for those living in disadvantaged spearhead areas has increased by almost three years over the last 10 years, and for females by almost two years, only just short of the improved life expectancy rates for the whole population. For male life expectancy, the gap has widened by 4 per cent in 2005–07 since 1995–97, and by 11 percentage points for females.¹¹ Measured against the target baselines in relative terms, the infant mortality gap has widened from 13 per cent in 1997–99 to 19 per cent in 2002–04 and fallen to 16 per cent in 2005–07.
15. In addition, there has been long-term progress in reducing child poverty and narrowing inequalities in housing standards, educational attainment and uptake of flu vaccinations. Cancer and circulatory (heart) disease mortality have fallen sharply in real terms and child road-accident casualties and teenage conceptions also show a narrowing of health inequalities in absolute terms (but not in relative terms); other areas show a general reduction in prevalence but no narrowing of the gap between social groups. Almost all the 82 departmental commitments set out in the *Programme for Action* and due for delivery by the end of 2006 are reported as wholly or substantially achieved.¹²

The role of the NHS

16. The NHS has a key part to play in meeting the target, especially the life expectancy element, and over recent years health inequalities have increasingly featured as an NHS priority. This has been evident in their incorporation into other Public Service Agreement health targets, and the findings of the Wanless report noted the association between lower socio-economic status and poor health outcomes, and the cost consequences for the NHS.¹³ Wider government action on poverty and disadvantage has also contributed both to the target – as shown in the health inequalities infant mortality review exercise – and to the long-term sustainable reduction in health inequalities.
17. The contribution of the NHS to the 2010 target was recognised in the Treasury-led cross cutting review.¹⁴ This review considered the implications of the Acheson report for departments across government and the NHS. It identified NHS interventions as more likely than other interventions to help deliver the short-term target through reducing smoking in manual groups and preventing and managing other risk factors for coronary heart disease and cancer, but it

¹¹ Department of Health (2008) *Tackling Health Inequalities: 2005–07 Policy and Data Update for the 2010 National Target*.

¹² Department of Health (2008) *Tackling Health Inequalities: 2007 Status Report on the Programme for Action*.

¹³ Wanless, Derek (2004) *Securing Good Health for the Population*, Final Report.

¹⁴ HM Treasury/Department of Health (2002) *Tackling Health Inequalities: A Summary of the Cross Cutting Review*.

recognised that the social determinants were crucial for a long-term sustainable reduction in health inequalities.

Lessons and challenges

18. The lessons and challenges of the health inequalities agenda over the last 10 years are the focus of Chapter 2. The favourable context for public policy, including on health inequalities, has had to contend with a less favourable economic and social context in terms of widening the gap. Chapter 2 highlights the opportunities to improve the health of disadvantaged groups and areas through an approach promoting access to high-quality services for these groups. The recent change in economic conditions is likely to intensify the policy challenge up to 2010.
19. The importance of policy design within the overall strategic framework set by the Programme for Action is also emphasised. Joined-up government at local, regional and national levels is a key part of this work. A necessary objective has been substantially achieved by moving health inequalities from a peripheral concern characterised by small-scale, uncoordinated project work to a place in the mainstream as an established policy priority, forming part of the planning and performance systems of health services and local government.
20. Policy delivery has been a key test for the health inequalities strategy. It continues to pose a significant challenge as thinking moves into the post-2010 period. Considerable attention has been directed to improving local coordination, particularly in terms of engaging local authorities as leaders and champions for this work. The focus provided by the formation spearhead group for the life expectancy element of the target in 2004 has since gone hand-in-hand with the development of practical tools and the support needed to narrow the gap and meet the target.
21. This has included making clear the action needed to tackle health inequalities at the local level. A process of monitoring (through the status reports), audit and review has filled in some of the detail in the national strategy, clarifying the interventions and actions needed to drive down health inequalities, particularly in the spearhead areas. The recently developed public health national support teams NSTs have had a key role in developing the partnerships and focus needed in these areas.

The policy response

22. The policy response to the Acheson report is set out in Chapter 3 across the 13 themes identified in the report, on the basis of responses contributed by policy-makers in government. The box on page 11 summarises some of the key policy developments.
23. The outline of some of the most important policy developments was beginning to take shape by the time the Acheson report was published. Important structural changes in the way government was organised and conducted its business were already under way, and have changed the context in which policy has operated over the last 10 years.

The indicator framework

24. Action on the social determinants of health is at the heart of the WHO Commission report *Closing the Gap in a Generation*. Established in 2005, the WHO Commission on the Social Determinants of Health explored the options for promoting health equity through policies to address these determinants within and across countries. Underpinning the Commission was a recognition that, while access to high-quality healthcare is vital, the fundamental determinants

of people's health lie in the social conditions in which they live and work. This is a message attuned to the Acheson report and its emphasis on action across a broad front. Effective action to tackle inequalities in health must address the underlying social conditions that leave disadvantaged groups more likely to engage in health-compromising behaviours and more vulnerable to poor health.¹⁵

25. As part of its work, the Commission developed a conceptual framework of indicators to help analyse the contribution of different social determinants to the overall burden of health inequalities in any one country. The WHO Commission proposed that this framework be used to guide the development of a set of indicators to monitor the social determinants of health and health inequalities. Chapter 4 uses an initial version of this framework and applies it to data from England and the UK. The indicator set is structured around four themes:
 - the social, economic and political context, e.g. social policies, the economic and labour systems
 - social stratification, e.g. economic status, education
 - differential exposures, vulnerabilities and consequences, e.g. material circumstances, health-related behaviours
 - differential outcomes in health, e.g. in mortality, morbidity.
26. The framework contains 39 representative indicators covering all four sub-themes. The indicators have been selected to be consistent with existing departmental targets and indicators – including the national headline indicators used to support the Programme for Action. This helps ensure, where possible, a read-across to national activity against a 10-year trend. The box below sets out some examples of these developments against selected Acheson recommendations.

¹⁵ Irwin, A, Valentine, N, Brown, C, et al. (2006) The Commission on the Social Determinants of Health: Tackling the social roots of health inequalities. *PLoS Medicine*, vol.4, no.6, e106, doi:10.1371/journal.pmed0030106: 0001–0003.

Some developments over the last 10 years

Employment

Acheson emphasised the fundamental role that employment plays – it is the glue that keeps society together. Work is important to life and health, and levelling up the opportunities for rewarding employment is important for reducing health inequalities. Unemployment is a major risk to health for working people and their families.

What the data shows

The number of jobs for both men and women has significantly increased over the last 15 years.

The UK unemployment rate was 25 per cent lower in 2007 than in 1997. Unemployment rates have fallen for all educational groups over the last 10 years, including those with low levels of educational qualifications. More recently this trend has gone into reverse.

Housing conditions

Acheson pointed to the link between poor quality housing and poor health and recommended policies to improve the quality of housing.

What the data shows

The proportion of households living in non-decent homes fell from 44 per cent in 1996 to 26 per cent in 2006. The decrease was greater for social tenant households than for non-vulnerable private households: the proportion of social tenant households in non-decent homes fell by nearly half from 52 per cent in 1996 to 28 per cent in 2006.

Educational achievement

Acheson noted that those with low levels of educational attainment have poor adult health. Educational attainment provides additional opportunities for income and employment with improved consequences for health.

What the data shows

The percentage of 16-year-olds who achieve 5 or more A*–C passes at GCSE continues to rise – from 45.1 per cent in 1996/97 to 60.8 per cent in 2006/07.

Crime

Acheson showed how crime and fear of crime can profoundly affect the quality of people's lives. There is a link too between income inequality, social cohesion and crime.

What the data shows

Long-term trends show that crime – as recorded by the British Crime Survey (BCS) – rose steadily from 1981 through to the early 1990s, peaking in 1995. A substantial fall then occurred until 2004/05, when BCS crime levels stabilised until a further decline in 2007/08. BCS crime is now at the lowest ever level since the first results in 1981.

Child poverty

Acheson observed that poverty falls disproportionately on children and recommended measures to address poverty and increase the incomes of mothers and children.

What the data shows

Taking 60 per cent of median income in 1998/99 as the definition of poverty, the proportion of children living in poverty fell from 26 per cent in 1998/99 to 22 per cent in 2006/07, representing a reduction of 600,000 children before housing costs are deducted.

27. The indicators presented in this document need to be considered alongside the headline indicators that were reviewed in the 2007 status report. The headline indicators explicitly address the gradient between the most and least advantaged sections of the population. Taken together, these two closely related sets of indicators combine to provide a rich source of information on recent trends in health inequalities in England and the UK.

Chapter 2: Some lessons and challenges

1. The progress on health inequalities over the last 10 years can be summed up as: much achieved; more to do. The experience against the target makes this clear – there have been improvements in terms of lower rates of infant mortality and longer life expectancy for all groups and areas, but the gap between disadvantaged groups and areas and the rest of the population has remained. The current data (for 2005–07) shows that the gap is no narrower than when the targets were first set.
2. Health inequalities are persistent, stubborn and difficult to change. An effective response needs to be on a sufficient scale if it is to have an impact. The national strategy (the Programme for Action) focused on the health of the poorest third of the population, not just the most disadvantaged and socially excluded. It also made it clear that no single action could narrow the health gap but that concerted action was required across government in a combination of effectively designed and implemented policies, using the available levers, systems and processes to ensure effective delivery of those policies on the ground.
3. This chapter reviews some of the key lessons and challenges from the last 10 years.

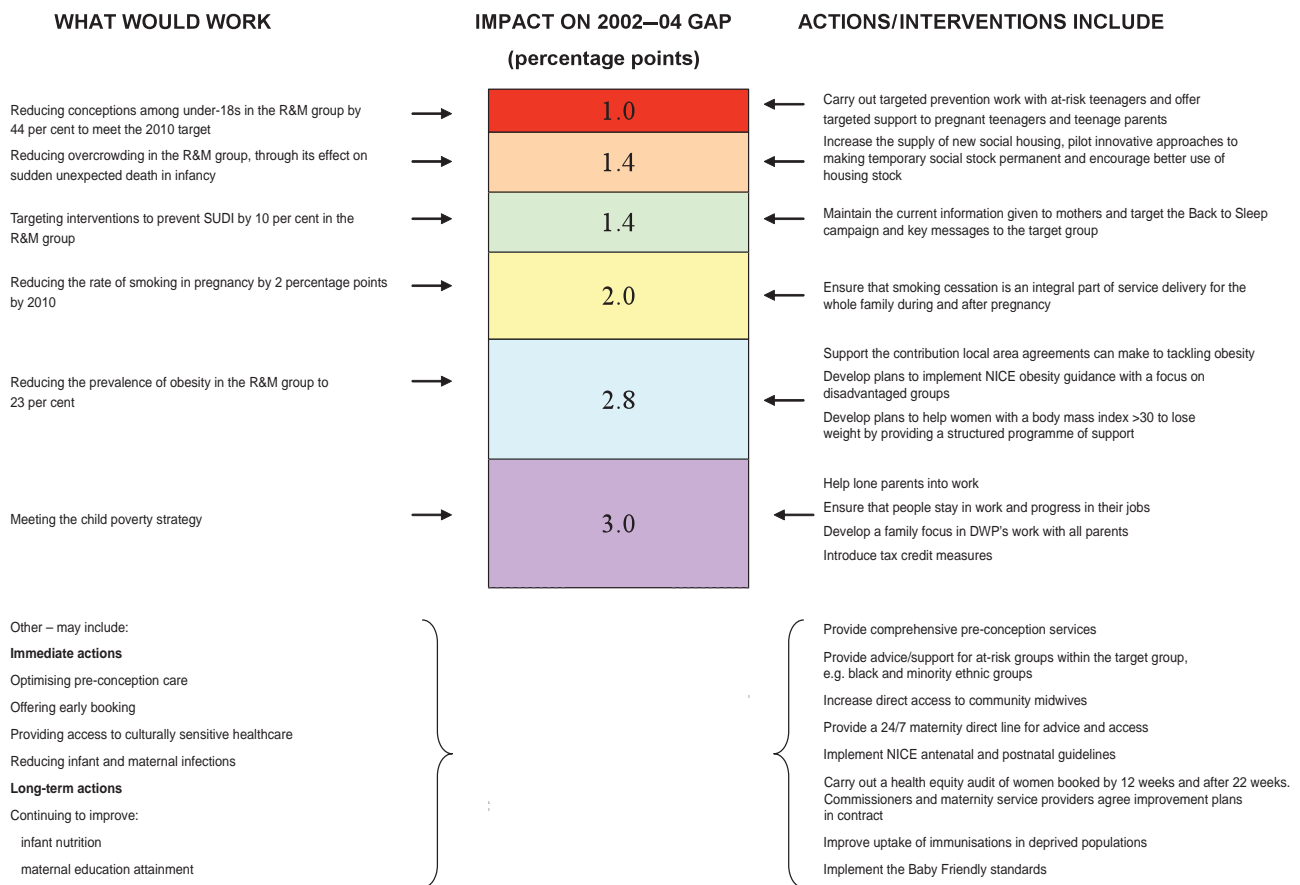
A new context for public policy

4. The continuing efforts to tackle health inequalities reflect their place as part of a much broader coalition to promote social justice. Reducing poverty, addressing inequality and tackling disadvantage are central themes of this agenda. It has also provided a more favourable context in which to act on health and social policy. Context is all-important and where individual policies and programmes operate in a more favourable environment, each single development contributes to success across the whole policy area.
5. The impact of national programmes such as Sure Start, the child poverty strategy and neighbourhood renewal on the social determinants of health was flagged in the 2007 status report. This association between these social determinants and health inequalities was made explicit in the work of the health inequalities infant mortality review; this work showed that reducing child poverty, improving housing and reducing overcrowding had a direct impact on the infant mortality aspect of the health inequalities target.¹⁶

¹⁶ Department of Health (2007) *Implementation Plan for Reducing Health Inequalities in Infant Mortality*.

Figure 2: Key interventions and their contribution to the health inequalities infant mortality target

The target is: *starting with children under one year, by 2010 to reduce by at least 10 per cent the gap in mortality between routine and manual (R&M) groups and the population as a whole.*



- A favourable context improves the likelihood of success for health and social policies on issues and this has been the experience of the Nordic countries. Public policy has been framed against a commitment to universalist policies based on equality of rights and entitlements, and low levels of social exclusion.¹⁷
- In England and the UK as a whole, building a context for effective public action has co-existed with other influences, notably the impact of the market and the private sector. The effect has been paradoxical. On the one hand, standards have improved in health (and other public service areas) for people in disadvantaged groups and areas, partly because of effective public policy initiatives; but narrowing the gap between these groups and areas and the whole population has proved more difficult. This is seen in the widening of income inequalities, which underpin inequality more generally – Figure A.11 in Chapter 4 shows a widening of income inequalities between 2004/05 and 2006/07 against the Gini co-efficient.
- A consequence of this context has been to sustain the importance of health inequalities as a strategic policy objective beyond the life of a single policy programme. It also owes something to the legacy of the stillborn Black report (1980) on health inequalities.¹⁸ The fate of this report was part of the impetus behind the decision to establish the Acheson inquiry.

¹⁷ WHO (2008) *Closing the gap in a generation*. Page 33.

¹⁸ Department of Health and Social Security (1980) *Report of the Working Group on Inequalities in Health* (the Black report).

9. Equally, a strong context for public policy action does not always mean that policies which might support a reduction of health inequalities end up narrowing the gap. Sometimes they could have the opposite effect, as the Acheson report noted.
10. The drive for health improvement can produce an ‘inverse care law’ effect where the benefits of such programmes accrue to the more advantaged groups who have awareness and knowledge of how to use the system. In addition, the reach of public services can be weaker in disadvantaged areas and less able to counteract this effect. The result is that overall improvements in health can mask continuing inequalities. While improving the health of the population has been a priority, the potential for mixed messages and differential health outcomes is clear.
11. Such an adverse and unintended impact is not limited to action in the health field. Effective action all on health inequalities requires action across all the social determinants of health. All policies in these areas, whether on education and employment, transport or the environment, have the potential unintentionally to widen the health gap.

New approaches and structural change

12. New programmes like the Family Nurse Partnership – and existing programmes like Sure Start – are working to counteract this effect by operating a form of ‘progressive universalism’. This approach delivers high-quality services to disadvantaged groups and offers opportunities for the health of disadvantaged people to improve faster than that of the rest of the population. This approach is one of the keys to reducing health inequalities between social groups.
13. Wider, structural changes also influence the public policy context, through their impact on the implementation of policy. NHS reorganisation over the past decade has strengthened the ability of the NHS to deliver effective services and improve population health. A corollary has been, however, a short-term impact on existing structures that has sometimes resulted in disrupted priorities and networks. New, cross-cutting issues such as health inequalities, which have only recently emerged as priorities, have been more vulnerable to a loss of momentum from these changes.
14. This context has provided the background for policy design and implementation. Timing has been a key factor. Coordinated action – even where agreed – is difficult across such a complex field. Change was not expected to be seen either easily or quickly – the timeframe of the Programme for Action runs until 2030. The data time lag may also obscure the current picture – the latest data for 2009 refers to 2005–07 – which also means that news of health inequalities policy runs some way behind the policy’s impact on the ground.
15. The greater impetus to concerted action through partnership, including through local, regional and national government, has been key to generalising the wider health inequalities agenda. A national strategy that 12 government departments signed up to was a significant achievement: it provided – among other things – a basis for learning about barriers, shortcomings and other factors related to turning policy into action.

Policy design

16. The distinction between policy design and implementation can be a fine one. Effective policy needs to build in mechanisms to help navigate barriers to implementation if it is to work on the ground. Individuals and local organisations need to be clear about what the strategy asks of them. This means building in joined-up action, nationally and locally, vertically and horizontally. It means challenging the structural barriers in the organisation of policy and service delivery ('silo working') to promote a cross-cutting approach.¹⁹ For health inequalities, these barriers include a lack of effective mechanisms to promote practical joint working between interested organisations, most obviously in the links between local authorities and the NHS at local level (now mainly primary care trusts (PCTs)).
17. New mechanisms have been developed to promote effective cooperation, joint funding and shared objectives at local level. Even within the NHS, recognition that health inequalities were relevant to PCTs, even those in disadvantaged areas, was not axiomatic. The focus on the individual patient – though crucial – has sometimes failed to connect the health of an individual and their social circumstances.
18. At the beginning of the 10-year period, the area of health inequalities was seen as a public health issue, peripheral to key services concerns and with a focus on analysis rather than action. These perceptions were challenged by the publication of the Wanless report (2004). This report highlighted the vital importance of health inequalities and public health to the future viability of the NHS.²⁰ The growing importance of health inequalities was reflected in its inclusion into clinical Public Service Agreements (PSAs) on cancer and coronary heart disease, and in the *Choosing Health* (2004) White Paper.²¹ Public health also became more influential on the ground, not least through joint local authority/PCT appointments of directors of public health and the new joint role of regional directors of public health within both the Government regional office and the strategic health authority (SHA).

Performance and targets

19. Similarly, although health inequalities have been the subject of a PSA target since 2002, it took time for the issue to be embedded in the policy and planning frameworks of the NHS. Public health and health inequalities were included in the 2004 planning guidance,²² but the decisive development was the inclusion of health inequalities as a top-six NHS priority in 2006. Health inequalities had become a performance issue for the local NHS, subject to scrutiny. This has helped health inequalities become part of the everyday language of the health service.
20. A related issue has been the way in which the policy aims around health inequalities were expressed: to meet the 2010 target and to contribute to a long-term sustainable reduction in health inequalities. These aims and the relationship between them have shaped policy design since 2003.
21. Given the Government's emphasis on targets and the approach of 2010, attention has tended to focus on the first of these aims. The target has the advantage of being clear, measurable and based on sound data, but it has been seen as narrow – particularly in terms of capturing the impact of the social determinants of health. This issue was acknowledged in *Health Inequalities:*

¹⁹ Department of Health (1980) HM Government (1999) *Modernising Government*.

²⁰ Wanless, Derek (2004) *Securing Good Health for the Whole Population*.

²¹ Department of Health (2004) *Choosing Health: Making Healthy Choices Easier*.

²² Department of Health (2004) *National Standards, Local Action*.

Progress and Next Steps, with a promise to look at the issue of metrics and objectives against the background of the wider, social determinants of health.

22. The challenge for a health inequalities target is to encapsulate the complexity of the issue in a simple, meaningful formula. The current high-level target provides clarity and simplicity around what to measure but it cannot capture all the elements of health inequalities, even within the areas covered by the target.
23. The formulation of the infant mortality aspect of the target highlights this challenge. As a socio-economic target, it followed the Acheson approach and gives a picture of inequalities based on the spread of infant deaths in married or jointly registered households. However, it excludes other disadvantaged groups including sole registrations (where the birth is usually registered by the mother alone) and other groups (unemployed, students and never worked). While an appropriate definition for a socio-economic target reflecting the practicalities of data collection, the target does not provide a full picture given that both these groups suffered higher rates of infant mortality than the ‘routine and manual’ (R&M) group, the focus of the target. Table 1 sets the different rates between social groups below. In practice – and for measurement purposes – infant mortality in all disadvantaged groups is addressed through the target. The implementation plan reiterated the commitment to improve rates among these disadvantaged groups alongside the R&M group.²³

Table 1: Infant mortality rates 2005–07, by social group

England all with social class	4.7 infant deaths per 1,000 live births
R&M group	5.4 infant deaths per 1,000 live births
Sole registrations	6.5 infant deaths per 1,000 live births
Other	8.6 infant deaths per 1,000 live births

24. To help develop a fuller picture of what was happening on health inequalities the Programme for Action adopted 12 cross-government headline indicators to set alongside developments against the target. These two elements provided the core of successive status reports published by the Department of Health and overseen by the health inequalities scientific reference group.

Implementation issues

25. A second main area of learning, after policy design, has been around policy implementation and delivery. The strategy made it clear that a step change was needed in the way that programmes dealing with health inequalities were delivered, if the target was to be met and longer-term objectives secured. Delivering the national strategy over the last five years has yielded some valuable lessons and created some sharp challenges.
26. There were good examples of health inequalities projects around the country before publication of the strategy, which emphasised the need to share learning and transfer good practice more widely across the country. But even if a project was capable of making a difference, its size and scope was generally insufficient to have a widespread impact on the problems faced by disadvantaged groups and areas. Many projects were delivered piecemeal, in ‘penny packets’ even at a local level, reflecting the lack of secure funding and organisation.

²³ Department of Health (2008) *Implementation Plan for Reducing Health Inequalities in Infant Mortality*. Page 9.

27. Responses to an early consultation asked “for a sustained and long-term approach, rather than one based on short-term, time-limited projects and initiatives”.²⁴ Despite the clarity of the target, getting it right on the ground was seen as vital but difficult, not least because of the risk of overlapping programme and initiatives. Health Action Zones (HAZs) were an early attempt to bring some of these programmes together. It was clear, however, that a scaled-up and more systematic approach was needed if health inequalities programmes were to be delivered effectively at local level.
28. Addressing this issue has required action on a number of fronts, including:
 - developing better coordination between key local players, notably local government and through local strategic partnerships (LSPs)
 - mainstreaming the health inequalities message through key services and programmes
 - providing a focus for action through spearhead areas
 - developing a range of support tools and mechanisms.
29. The partnership with local government has been crucial to progress on health inequalities. Local government has provided necessary leadership as well as staff, resources and expertise. Its engagement with the health inequalities agenda has meant that local areas have been able to act on the causes of health inequalities as well as the results through the NHS.

Local partnerships

30. Fostering of better local coordination has developed, through local authorities, health organisations and other voluntary and statutory agencies. This has included specific cooperation on individual programmes, such as between local education authorities and PCTs on the healthy schools programme work, and a more generic approach through LSPs. These partnerships are led by local authorities and bring together the NHS and other bodies in the public, private, business, community and voluntary sectors to improve outcomes for local people. They are characterised by partnership and flexibility with a local focus, such as Bradford’s ground-breaking work on infant mortality, the Birmingham Health and Wellbeing Partnership or the promotion of joint community action in Nottingham.
31. The success of LSPs and similar arrangements has depended on local leadership. New mechanisms have been introduced to generalise this approach, notably through Local Area Agreements (LAAs). LAAs line up with PCT plans, including on health inequalities, in what is a vital development.

Mainstreaming

32. Mainstreaming is about embedding action on health inequalities in the NHS and across other services. This approach is at the heart of the Programme for Action – a crucial departure from the ‘small project’ culture. It also offered the prospect of the necessary step change in improving the health of people in disadvantaged groups and areas. Health is a domain of several major national programmes that focus on disadvantaged areas, and its importance has been increasingly recognised in other areas. The penetration of health inequalities into the planning and performance regimes of the NHS and local government has also been crucial in establishing the issue as part of everyday business.

²⁴ Department of Health (2001) *Tackling Health Inequalities: the results of the consultation exercise*. Page 9.

An area-based approach

33. Health inequalities exist everywhere, but they are more evident in some areas than others. The decision to focus on disadvantaged areas with the greatest needs marked a stronger emphasis on the target and it resolved any confusion about whether the target was real or aspirational.
34. A spearhead group of 70 local authority areas with the worst health and deprivation indicators (covering 28 per cent of the population) was identified as the focus of the life expectancy element of the target at the end of 2004. These areas were primarily in the North, the West Midlands and parts of London. The spearheads have provided a focal point for the early rollout of programmes from *Choosing Health*²⁵ and other initiatives. Developments in individual spearhead areas have been closely monitored.
35. The infant mortality aspect of the target adopted a similar area approach to address the high number of infant deaths in a small number of areas. Forty-three local authority areas with the highest number of infant deaths in the target group were identified as the key to delivering this part of the target. Many of these areas overlap with the spearhead group, but also include areas in other regions outside the group.
36. Lower life expectancy – together with the prevalence of health problems such as smoking and obesity – affects disadvantaged groups in all areas. Together with the stronger emphasis on setting local priorities to match local needs, greater attention will be paid to health inequalities in areas outside the spearhead areas as trailed in *Health Inequalities: Progress and Next Steps*. It will help move beyond the 2010 target towards a longer-term, more sustainable reduction in health inequalities across the country.
37. Knowing how to tackle health inequalities locally is crucial in prompting action that will narrow the gap and meet the target. It has been easier to analyse the causes of inequalities than to reduce them. The Acheson report provided a firm analytical base for the cross-cutting review and the Programme for Action. Switching from analysis to action has been hampered by a lack of evidence about effective interventions.
38. Efforts have been made to fill this lack of knowledge about what works and to develop a range of tools and other mechanisms to promote action. Activity has gathered pace as it has become clearer what to do and how to do it.
39. The first requirement has been to understand the nature and extent of health inequalities at local level. Understanding local need through health equity audits was highlighted in the Programme for Action. This tool has shown how to use local data to establish health need against service provision, and provides the basis for local priority setting. Related developments such as the health poverty index, the local basket of indicators and, more recently, the national²⁶ and community health profiles²⁷ have provided other sources of local evidence and the means to monitor progress.

Tools and mechanisms

40. Expert help and the sharing of good practice have become systematised through the work of such bodies as the Improvement and Development Agency (IDeA), which works with local government to improve the capacity of local authorities to reduce health inequalities, and the

²⁵ Department of Health (2004) *Choosing Health: Making Healthy Choices Easier*.

²⁶ Department of Health (2007) *Health Profile of England 2007*.

²⁷ See: www.apho.org.uk/default.aspx?ON=P_HEALTH_PROFILES.

Improvement Foundation, which uses healthy community collaborative methods to raise heart disease and cancer issues in the most disadvantaged communities. Effective action on health inequalities by local authorities has also been recognised by the Beacon Council scheme.

41. The formal monitoring of the target and the 12 cross-government headline indicators created an opportunity to monitor, audit and review progress, particularly with a view to sharpening local delivery. This approach was deployed following a reported widening of the gap in 2005. The review of the infant mortality aspect of the target explored the realities on the ground. In many areas there was:
 - no recognition of the target or the widening gap
 - a range of services that were not fully delivering to the target group
 - lack of leadership and systems to support delivery
 - lack of knowledge and understanding of the target
 - poor handling and use of data, and gaps in the evidence base.²⁸
42. Urgent action has been taken to strengthen the connection between strategic plans and the realities on the ground. The health inequalities intervention tools, developed jointly by the Department of Health and the Association of Public Health Observatories, provided a mechanism for PCTs and local authorities to identify the extent of their local gap, and to quantify the impact on that gap of key interventions on issues such as smoking and heart disease.²⁹
43. A health inequalities national support team (NST), focusing on the life expectancy element of the target, was established to promote effective collaboration and action at local level in the spearhead areas. The infant mortality implementation plan prescribed the actions needed to translate the findings of the review into action at local level, illustrated by examples of good practice. A health inequalities infant mortality NST has also been established to promote local collaboration and action across the implementation plan recommendations to tackle the infant mortality gap and improve maternal and infant health.
44. A range of other developments supports this work, from closer links between the PSA target and objectives at national level to new developments, such as social marketing health trainers and the promotion of health literacy to engage with disadvantaged groups. Other initiatives have had encouraging results (such as promoting outreach and the role of community volunteers), though not all of this work has been applied systematically across the country or within spearhead areas.

Lessons and future challenges

45. Over the last 10 years, there has been much progress in the understanding of health inequalities, in developing a strategic vision, in policy design, and in delivering programmes that will help narrow the gap and meet the target. Health inequalities are now part of the language of the NHS and local government. The staying power of health inequalities as a priority means that the issue has become more embedded in the consciousness and processes of these and other organisations.

²⁸ Department of Health (2007) *Review of the Health Inequalities Infant Mortality PSA Target*. Page 21.

²⁹ See: www.lho.org.uk/HEALTH_INEQUALITIES/Health_Inequalities_Tool.aspx.

46. This process, however, has taken time. Much of it has been concerned with the process of policy development and implementation, of learning lessons, and of constant iteration and renewal. The impact of many of these changes is only now beginning to be realised. The data that testifies to progress against the health inequalities target and the headline indicators runs some way behind developments on the ground, with the result that these developments are not yet fully reflected in the data. This was why the Programme for Action observed that the impact of these programmes was most likely to be visible only towards the end of the decade. Whether this – and subsequent – action has been sufficient to narrow the gap and meet the target will only become clear after 2010.
47. Whatever the final verdict against the target, England (along with the rest of UK) has an important international leadership role in tackling health inequalities. Notwithstanding the challenges that have had to be faced, the Government has shown leadership through its approach of reviewing the evidence, setting targets, developing a comprehensive strategy across government and monitoring progress, and in its persistence in sticking with this difficult and complex agenda.
48. These lessons will help to shape a new post-2010 agenda – and contribute to the work of the strategic review. This review – chaired by Professor Sir Michael Marmot – will draw on the experience, lessons and challenges of the last 10 years and, more recently, on the findings of the *Closing the Gap* report of the WHO Commission.
49. The strategic review will also have to take account of new challenges in the wake of more difficult economic conditions, particularly through its impact on unemployment, together with environmental challenges like climate change. These factors will put pressure on principles of social justice that will need to be asserted even more strongly against this background.

Chapter 3: The Acheson inquiry – a policy response

1. The Independent Inquiry into the Inequalities of Health (Acheson inquiry) was commissioned because of a concern that, while the 20 years prior to 1997 had seen a marked increase in prosperity and substantial reductions in mortality in the country as a whole, the health gap between those at the top and bottom of the social scale had widened.
2. Sir Donald Acheson, a former Chief Medical Officer, chaired the inquiry; he was invited to review the evidence on health inequalities in England from the mid-1970s and identify areas for policy development likely to reduce these inequalities, drawing on scientific and expert evidence. The inquiry reported in November 1998.
3. This chapter summarises the recommendations for areas of policy development in the report, and it looks at the detail of the policy response against the themes identified in the related policy responses across government over the last 10 years. It should be read in conjunction with the data tables in Chapter 4, which show developments across a wide range of social, economic and health-related factors.
4. It is not a complete or exhaustive assessment of all policies aimed, directly or indirectly, at tackling health inequalities over the last 10 years. Policy-makers from different departments were invited to provide summary responses and asked to assess the influence of the Acheson report. They also provided details of actions that contributed to the wider health inequalities agenda; some of these actions were carried forward in the national health inequalities strategy (the Programme for Action, 2003). Their contributions are intended to give a sense of the issues raised by the report and taken forward across government; some of these issues remain relevant to any approach to tackling health inequalities.
5. Tackling health inequalities has been an integral part of the Government's drive for social justice. As in other areas of policy such as education, employment, poverty and housing, the Government has sought to tackle persistent disadvantage and to widen opportunities for poorer groups, particularly children, to achieve the life chances and living standards enjoyed by the majority of the population. The policy responses discussed in this chapter include both those developed specifically in response to the Acheson inquiry and those that form part of the government's wider policy agenda.
6. The priorities, themes and issues – as well as the structures of government – have changed considerably over the 10 years since the Acheson inquiry reported. For example, collaboration across government has strengthened at local, regional and national level. Today, Local Area Agreements (LAAs) provide a formal framework for local government and the NHS to work together in pursuit of common objectives. New regional structures through Government Offices offer new ways of looking at the impact of the social determinants on health, and the siting of regional directors of public health across Government Offices and strategic health authorities strengthen these links.

7. Nationally, government investment is now funded through three-year spending reviews. Cross-cutting issues that promote a government-wide approach on issues such as health inequalities are considered across government, as part of the spending review priorities set out in national Public Service Agreement (PSA) targets. There have been changes too in the machinery of government, promoting joint working and new responsibilities, such as the appointment of a Minister for Children, a significant policy response to the importance of early life, with implications for health inequalities.
8. Equally, the state of knowledge has advanced. The impact of interventions is better understood compared with 10 years ago, and at least involves asking some of the right questions. The public health evaluations of NICE and other bodies have strengthened the evidence base. The WHO Commission report, *Closing the Gap in a Generation*,³⁰ has explored the impact of the social determinants on a global basis, with lessons for England and the rest of the UK. Evaluation of government programmes has gradually improved understanding of what works, and these lessons have started to shape future action. There have also been substantial changes in NHS structures and systems and in the regulatory framework since 1998, though health inequalities and the difficulties in diminishing their impact remain.
9. This chapter has been developed against these changing circumstances. Many areas identified by Acheson for development remain highly relevant and are continuing to shape government priorities. Other areas have become part of the wider business of government, or have helped set the wider context for action and change.

The Acheson report

10. The inquiry adopted a socio-economic approach to health inequalities. It made 39 recommendations to underpin “action on a broad front”. These recommendations reflected the many different factors that fostered and influenced the development of health inequalities, both upstream and downstream. These factors were developed into themes around the wider determinants of health, across the life course and the other dimensions of inequality. The potential contribution of the NHS was also assessed for its impact on health inequalities and on action to address them.
11. The report was in two parts. The first part of the report reviewed the data between the mid-1970s and mid-1990s. Ten years on, there have been real improvements in health over this period. Life expectancy has increased for all groups over this period and infant mortality rates are at an historic low level. This is shown in Table 2. Death rates from cancer and coronary heart disease have fallen sharply, particularly in disadvantaged areas. As two tangible indicators of commitment to improving health – and the conditions that give rise to it – there have been substantial spending increases on the NHS, increasing the share of GDP devoted to health from 6.6 per cent in 1997 to 8.4 per cent in 2006 – close to the EU average (Figure A.8 in Chapter 4) – and striking reductions in child poverty.

³⁰ WHO (2008) *Closing the Gap in a Generation*.

Table 2: Improvements in health over the last 10 years

	1995–97	2005–07	Difference over 10 years
Life expectancy: males (years)			
England	74.6	77.7	+3.1
Spearhead areas	72.7	75.6	+2.9
Absolute gap	1.9	2.1	
Life expectancy: females (years)			
England	79.7	81.8	+2.1
Spearhead areas	78.3	80.2	+1.9
Absolute gap	1.4	1.6	
Infant mortality (per 1,000 live births)			
England	5.8	4.7	-1.1
Routine and manual groups	6.6	5.4	-1.2
Absolute gap	0.8	0.7	

Note: The spearhead group comprises the 70 local authority areas with the worst health and deprivation indicators. This is the basis for the life expectancy targets. The routine and manual group covers groups 5–7 in the ONS NS-SEC socio-economic classifications. This is the basis of the infant mortality target.

Source: based on Department of Health (2008) *Tackling Health Inequalities: 2005–07 Policy and Data Update for the 2010 National Target*. Absolute gap and difference over 10 years based on rounded figures.

12. The second part of the report systematically identified potential areas for development by reviewing the extent of the inequalities and the supporting evidence, and assessing the benefit of action in each area. It did not quantify the costs of its recommendations, but took general account of the Government's overall financial strategy as set out in its terms of reference. It also recognised that the setting of health inequalities targets was an important area for policy development. Its aim was to explore:

*“areas for policy development which we have identified from the available evidence, [and which] comprise an effective agenda. Its components are congruent and mutually reinforcing... a sound basis for policy development well into the next millennium”.*³¹
13. These potential areas covered the wider, social determinants of health such as education and employment; the life course as it affected, for example, mothers, children and families; the wider dimensions of inequality, notably ethnicity and gender; and the role of the NHS.
14. The inquiry report was clear that such a range of activity was crucial if a general improvement in health and a greater impact on the health of the less well-off was to be achieved. The report also warned against the unintended consequences of policies that are designed to improve health but, because of a failure to recognise their implications, end up widening inequalities.
15. Some of the report's recommendations were of a general nature; others were more prescriptive and detailed. Many were cross-referenced and included sub-clauses. The result was that some recommendations became part of a wider government drive for new policies addressing social justice and tackling poverty and disadvantage. These developments were assisted by the development of new mechanisms, such as the introduction of the PSA target framework that was intended to drive forward the Government's top priorities and ambitions for delivery

³¹ Independent Inquiry into Inequalities in Health (Acheson inquiry) (1998). *Report of the Independent Inquiry into Inequalities in Health*. Page v.

(2004 SR p1³²). It was nearly three years after the publication of the report that the first national health inequalities targets on life expectancy and infant mortality were set; a crucial factor in driving and sustaining health inequalities as a policy priority.

Longer-term influence

16. Wider economic and social trends have made the task identified by Acheson even more challenging. A successful and growing economy over the last 10 years has widened some economic inequalities and put pressure on social mobility, even while the situation of much of the population has improved. Another key issue for a government committed to social justice has been to ensure that the reality on the ground matches the aspirations of policy-makers. Changes and improvements need to be delivered systematically and on an appropriate scale if they are to have the desired effect.
17. This assessment, *10 Years On*, of the potential areas for development identified by Acheson has shown three main patterns:
 - many of the proposals advocated by the inquiry have been translated into policy directly (though not necessarily just because of Acheson)
 - others have been influential in shaping policy development in particular areas
 - a third group have contributed more widely to developing an ethos of social justice hostile to poverty and inequality, which has shaped the last 10 years.
18. The Acheson report provided a cornerstone for all subsequent work on health inequalities. It informed the Treasury-led cross-cutting review, underpinned the national health inequalities strategy (the Programme for Action (2003)) and resonates in the latest document *Health Inequalities: Progress and Next Steps* (2008), which maps out territory beyond 2010. Its commitment to action on a broad front and its use of data and evidence confirm its continuing relevance.
19. The status reports on the Programme for Action have documented both the significant improvements in the health of all groups in the population, including disadvantaged groups and those in disadvantaged areas, and the persistence of the health gap. Narrowing the gap on a rising tide of improvement remains a challenge, although current economic concerns may present a greater challenge. It remains as true now as it was at the time of the Acheson inquiry that action on a broad front is the key to improving the health of the worst-off in society and narrowing the health gap.
20. The next section considers each of the main areas identified for development by the Acheson report and sets out a brief policy response to each, in some cases looking forward with plans beyond 2008/09. The four areas are:
 - wider social determinants (poverty, education, employment...)
 - the life course (families, mothers and children...)
 - other dimensions of inequality (ethnicity and gender)
 - the role of the NHS.

³² HM Treasury (2004) *2004 Spending Review: Public Service Agreements*.

The areas identified by Acheson for development

RAISING THE PROFILE OF HEALTH INEQUALITIES, INCLUDING BY IMPACT ASSESSMENT AND DATA MONITORING

21. Acheson recognised that a well intended policy that improved average health might have no effect on health inequalities; in fact it might widen them by having a greater impact on the better-off. The report cited examples of policies that did this, including measures designed to prevent illness by promoting immunisation, cervical screening, smoking cessation and breastfeeding. The unintended consequences of such policies in widening the health gap highlighted the need for clarity in developing policy, and giving due regard to health inequalities alongside other action to tackle poverty and disadvantage. Raising the profile of health inequalities, it said, could also be supported by action on:
- **monitoring health inequalities** – the report stressed the need for authoritative statistics on health inequalities at regular intervals to help monitor the effects of future policies and to set and support targets
 - **assessing impact** – the report emphasised the need to pay extra attention to the health of the less well-off through the policy process and through cross-government coordination
 - **improving data capacity** – the report highlighted the limitations and inconsistencies of data and the need for strengthening and improving data and data monitoring.

Policy response

22. One of the key developments since Acheson reported was the establishment of a national health inequalities target, first announced in the NHS Plan (2000),³³ subsequently linked to the PSA process and extended (and linked) to other areas such as coronary heart disease (see Figures A.32a and b in Chapter 4) and cancer. This raised the profile of the issue and provided a focus on health inequalities across government, through the 2002 cross-cutting review which engaged 18 departments and other units.³⁴ The fruits of this review were spelled out in 82 commitments included in the Programme for Action and later reviewed in the 2007 status report.
23. The provision of enhanced information on health inequalities and their determinants has been fundamental to developing policy and strategy to address health inequalities. Information has enhanced the targeting of activities to those most in need, and has assisted in deciding the most appropriate interventions to address the determinants of health inequality.
24. The processes of establishing mechanisms to monitor inequalities in health, and of reviewing data needs to improve capacity to monitor inequalities in health and their determinants, have been undertaken in an incremental manner. The provision of such inequality data has facilitated the recognition and quantification of inequalities as well as the identification of appropriate targets (and target areas) and interventions to address them, and has enabled monitoring of progress.
25. The health inequalities targets were based on evidence including the identification of sections of the population at greatest risk of ill health and death. This has enabled key population groups to be targeted. Further evidence has been provided to assist in the focusing and monitoring of

³³ HM Government (2000) *The NHS Plan: A plan for investment, a plan for reform*.

³⁴ HM Treasury/Department of Health (2002) *Cross-Cutting Review of Health Inequalities: A Summary*.

national and local action (such as through the health poverty index, the local basket of indicators and community health profiles³⁵).

PRIORITY FOR MOTHERS AND CHILDREN

26. The report gave priority to parents and children, stating that this was the best way of reducing future health inequalities. It said that childhood was a critical and vulnerable stage where poor socio-economic circumstances had lasting effects. Early life experience was highlighted as a crucial influence on physical and mental health. It also said that policies that reduced such adverse influences may have multiple benefits, not only through the life course of that child but into the next generation by:

- **improving health and reducing health inequalities in women of childbearing age, expectant mothers and young children.**

Policy response

27. Action to support mothers, families and children has a high priority. Over the last 10 years there have been a series of major programmes and initiatives including the Sure Start programmes, the child poverty strategy, the extension of educational and employment opportunities and the teenage pregnancy strategy. The Every Child Matters strategy³⁶ promoted cross-cutting action on children across government departments, including in the field of health. A wide range of work has flowed from this umbrella initiative. A joint child health strategy between the Department of Health (DH) and the Department for Children, Schools and Families (DCSF) was published in February 2009.³⁷ The infant mortality aspect of the health inequalities target has also provided a focus on the health gap.

Maternity services

28. The Children's National Service Framework (NSF)³⁸ took a strategic view of the health needs of women of childbearing age, expectant mothers and young children. In particular, the 'maternity standard' of the NSF acknowledged the importance of addressing the needs of a woman and her partner before she becomes pregnant, throughout pregnancy and childbirth and as they embark on parenthood and family life. It noted that healthy mothers tended to have healthy babies, and that a mother who has received high-quality maternity care throughout her pregnancy is well placed to provide the best possible start for her baby.

29. The further development of maternity services was announced in 2007. *Maternity Matters*³⁹ promised a modernised maternity service delivering safety, quality and higher standards by the end of 2009. On the ground, however, maternity services have faced serious pressures, highlighted in recent reports by the Healthcare Commission⁴⁰ and the Confidential Enquiry into Maternal and Child Health (CEMACH).⁴¹ Despite overall increases in midwife numbers over the last 10 years, the rising birth rate – particularly in inner-city areas – has stretched maternity services in disadvantaged areas where pressures are greatest.

³⁵ Department of Health (2006) *Health Profile for England*.

³⁶ See: www.everychildmatters.gov.uk.

³⁷ Department for Children, Schools and Families/Department of Health (2009) *Healthy lives, brighter futures – the strategy for children and young people's health*.

³⁸ Department of Health (2004) *National Service Framework (NSF) for Children, Young People and Maternity Services*.

³⁹ Department of Health (2007) *Maternity Matters: Choice, access and continuity of care in a safe service*.

⁴⁰ Healthcare Commission (2008) *Towards better birth – A review of maternity services in England*.

⁴¹ Confidential Enquiry into Maternal and Child Health (2008) *Why children die: the report of a pilot confidential enquiry into maternal and child health*.

Early booking

30. Early antenatal booking is crucial for a healthy pregnancy, but many women in disadvantaged groups may delay seeking maternity care until they are five or more months pregnant. An indicator for early access to such care has been included in the 'Ensure Better Care for All' PSA Delivery Agreement (PSA 19), announced in October 2007. This will measure the percentage of women who have seen a midwife or a maternity healthcare professional for a health and social care assessment of needs, risks and choices by 12 completed weeks of pregnancy. PSA Delivery Agreement 12 ('Improve the health and wellbeing of children and young people') aims to improve health outcomes for all children and to narrow the gap between the most and least advantaged through action on five delivery priorities (breastfeeding, school lunches, child obesity, emotional health and wellbeing and improving services for disabled children).
31. Health inequalities are a key factor in maternal and child health; for some, especially the more vulnerable and disadvantaged, the outcomes are unacceptable. Some women are up to 20 times more likely to die from a pregnancy-related complication than others. Maternity Matters describes how future maternity services should address these challenges, including by improving outcomes for more vulnerable and disadvantaged families. Commissioners and providers will be able to use the health reform agenda to facilitate improvements and innovation in the maternity services they offer.
32. Further action to address health inequalities in this area has been promoted through the infant mortality review and the associated implementation plan. This identified the key interventions to reduce infant mortality and improve maternal and child health in disadvantaged groups and areas, including those outside the target group. A health inequalities national support team has been established to work with PCTs, local authorities and others to sharpen local delivery.

The wider, social determinants of health

POVERTY AND INCOME

33. The Acheson report recommended improvements in the living standards of the worst off. This group included people who are unemployed, lone parents, people with disabilities, pensioners, and people living in social housing. It noted the association of poor health with material disadvantage and the damage that persistent family and childhood poverty does to the health of future generations. It examined the needs of families with children, and pensioners, and recommended policies that would reduce income inequalities and improve the living standards of households in receipt of social security, including by:
 - **creating a fairer tax system** – the Acheson report showed that poverty fell disproportionately on children and that income support levels were insufficient to meet the basic needs of different ages
 - **uprating benefits and pensions** – the report identified that mothers, more often than not, go without when families experience food shortages and, as a result, they have nutritionally deficient diets. Poverty was also a barrier for older people to an adequate diet and heating
 - **reducing poverty in women of childbearing age** – in particular, the report showed that Income Support was insufficient to meet the costs of an adequate diet for expectant mothers, particular single women under the age of 25; despite being usually successful in protecting the diets of their children once they had given birth, such mothers often had nutritionally deficient diets themselves.

Policy response

Child poverty

34. Addressing the links between poverty, income and health identified in the Acheson report has been part of the Government's drive for social justice. (Figure A.12 in Chapter 4 sets out the number of children living in poverty between 1995/96 and 2006/07.) As Acheson noted, what happens to people in their early years – the circumstances in which they are born and brought up – has consequences throughout their lives. Child poverty was identified as a headline indicator for the health inequalities PSA target. Poor health was also an important dimension of child poverty.⁴² Meeting the 2010 child poverty target – to halve the number of children in relative low-income households between 1998/99 and 2010/11 – will also contribute three percentage points to narrowing the infant mortality gap, almost a third of the 10 per cent target. Good progress in tackling child poverty has been made. Between 1998/99 and 2006/07, 600,000 children were lifted out of relative poverty, and absolute poverty halved. Recent budget changes will lift around a further 500,000 children out of poverty.
35. The child poverty strategy, set out in the Child Poverty Review (2004), is based around four key themes: work for those who can; financial support for those who cannot; improving children's life chances; and tackling deprivation in communities. The strategy was reinforced by the Budget 2008 child poverty document⁴³ and the commitment in September 2008 to legislate to eradicate child poverty by 2020. Tackling health inequalities is a key part of improving children's life chances, and the Government recognised this in both documents.
36. A child's life chances should not be determined by their parents' capacity to earn and it is recognised that some parents face constraints that make it difficult for them to work, such as poor health or disability. Others may find that, even if they work, they struggle to earn a sufficient income to escape poverty and deprivation. The tax and benefit system provides financial and material support to assist these families while maintaining incentives to work. Child Benefit is a universal payment to help with the costs of raising children; it is available to all parents, whether in or out of work and regardless of income. Additional help then goes to those who need it most through the child. Since 1997 the Government has radically reformed the system of financial support for families through measures such as tax credits; along with other changes to the personal tax and benefit system, these reforms mean that by October 2008, families with children in the poorest fifth of the population will be on average £4,100 a year better off.

Poverty among older people

37. In terms of poverty and disadvantage for older people, housing needs continue to be at the heart of policy-making. The Disabled Facilities Grant (DFG) is a mandatory grant administered by local housing authorities to help fund the provision of adaptations to the homes of around 40,000 disabled and older people, enabling them to live as comfortably and independently as possible in their homes. In addition, the Warm Front programme administered by the Department for Environment, Food and Rural Affairs (Defra) provides grants to vulnerable households for heating, insulation and draught proofing.

⁴² HM Treasury (2004) *Child Poverty Review*.

⁴³ HM Treasury (2008) *Ending Child Poverty: Everybody's Business*.

38. The Older People's NSF (2001) focused on health and social care issues including age discrimination, access to services, falls, mental health in old age and healthy active ageing. It also set out clear national standards for the treatment and care of older people. In this 10-year strategy, the NSF sought to improve services for older people in all care settings, including hospitals. A renewed focus on prevention services for older people was announced by the Secretary of State for Health on 21 May 2008. This programme of work will develop further prevention services and explore potential new entitlements for older people, which will be developed over time.
39. These initiatives fit with the Acheson report and are crucial to raising awareness of the roles and responsibilities of different players, across central and local government and in the community, in tackling health inequalities.

EDUCATION

40. Acheson emphasised the multiple roles that education play in influencing health inequalities and the potential opportunities for the educational sector to improve health and other outcomes for the less well-off. It noted that education was a traditional – and one of the most important – routes out of poverty and disadvantage to a good job and adequate income. It highlighted four areas:
 - **providing additional resources for less well-off areas and improving educational attainment**
 - **developing high-quality pre-school education**
 - **developing 'health promoting schools'**
 - **improving nutrition at school.**

Policy response

Educational attainment and resources

41. Education has been a top priority over the last 10 years, with improving educational attainment a focus, particularly among disadvantaged groups and areas. (Figure A.20 in Chapter 4 shows GCSE attainment rates by ethnicity.) The Government has worked with local authorities on the redistribution of school funding to ensure that educational resources intended for deprived pupils are reaching those children. This work is due to continue over the next three years and Department for Children, Schools and Families will ensure that funding for deprived schools plays a key part in the review of the government's school funding formula for 2011/12.
42. The government's efforts to raise the standard and levels of education attainment, training and skills has also seen a number of successes. 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, as reported in the 2007 status report. Furthermore, the Skills for Life programme – the national adult literacy and numeracy strategy – has helped improve the literacy, language and numeracy skills of over 5.7 million adults since it launch in 2001. 2.8 million adults have achieved a national qualification, exceeding the Government's Public Service Agreement target to improve the literacy, language and numeracy skills level of 2.25 million adults by 2010. The Government is now committed to the new ambition of being

a world leader in skills. This includes ensuring that, by 2020, 95 percent of the working-age population has at least functional levels of literacy and numeracy. To support this aim, the Department for Innovation, Universities and Skills recently launched a refreshed Skills for Life strategy. Figure A.13 in chapter 4 includes data on adult literacy rates by social class.

43. Skilled for Health is a partnership between the Department of Health, the Department of Innovation, Universities and Skills and the community and learning development charity ContinYou. Skilled for Health is a national programme that sets out to combine skills (such as literacy, language and numeracy) development with health improvement. Low skilled individuals often have the biggest challenges in managing their health, and in accessing health services and so tend to have the worst health outcomes.

The key themes of Skilled for Health are:

- helping learners gain a better understanding of their own health and how to make better use of the NHS, whilst also improving their literacy, language and numeracy (LLN) skills
 - developing partnership working between health and LLN practitioners
 - providing an opportunity to test new approaches and heighten awareness of the LLN skills needs of NHS users
44. There have also been marked improvements in out-of-school services. The Extended Schools policy – an initiative that provides a varied menu of study support and activities combined with childcare in primary schools – has made significant progress, with at least 13,500 schools providing access to the core offer of these services. This integrated health and social care on school sites means that problems (including pupils' and parents' wider problems) getting in the way of children's learning can be more easily dealt with.

Pre-school education

45. High-quality pre-school education has been introduced through pre-school places for every three- and four-year-old on Sure Start local programmes, and now Sure Start Children's Centres are focusing on support for disadvantaged mothers and children, including preparing for school.
46. These Sure Start Children's Centres are supporting children under the age of five and their families by providing easy access to health services, parenting and family support and advice for parents, including through drop-in sessions, outreach services, integrated early education and childcare, and links to training and employment opportunities.
47. There are now nearly 3,000 centres in England – the Government is working towards a figure of 3,500 by 2010. These centres are helping to embed support for families in the early years. They are a key vehicle for improving health outcomes for young children and reducing health inequalities in outcomes between the most disadvantaged and the rest of the population. Recent evaluations show the increasing effectiveness of the programme in improving outcomes for children in disadvantaged areas.

Healthy schools

48. The National Healthy Schools Programme is an initiative that supports the links between health, behaviour and achievement using a whole-school approach. In 2005, the funding formula for local programmes was recast to add a weighting to those programmes with between 20 per cent and 50 per cent free school meals eligibility (FSME) – FSME is a recognised proxy for

deprivation. Since this change, the proportion of such schools achieving National Healthy Schools Status has moved from about 20 percentage points behind the average to being in line with the average.

School food

49. The Acheson report highlighted the importance of school food and improving cooking skills. The introduction of the national school fruit and vegetable scheme for primary school pupils aged 5–7 met a specific recommendation of the report.
50. Currently the Government is engaged in a £650 million partnership with schools, local authorities and parents in a six-year programme to transform school food. The programme includes:
 - introduction of new nutritional standards for school food. These standards are the bedrock of the drive towards better food in schools
 - establishment of the School Food Trust to support local authorities and schools in promoting healthy meals and to increase take-up
 - introduction of new qualifications and training for school caterers. All secondary pupils will have the opportunity of learning to cook through a ‘Licence to Cook’ programme from September 2008
 - extension of the new Ofsted inspection framework to include evidence on food and healthy eating.

EMPLOYMENT

51. The Acheson report described employment as the “the glue that keeps our society together”. Work provides purpose, income, social support and structure to life, as well as a means of participating in society. Unemployment is an important determinant of inequalities in health outcomes. The report recommended:
 - **improving opportunities for work**
 - **reducing the health consequences of unemployment**
 - **investing in training**
 - **supporting staff by improving the quality of work and reduce psychosocial work hazards.**

Policy response

52. The link between employment, education and disadvantage is shown by differences in unemployment rates by level of education (see Figure A.14 in Chapter 4: this shows that despite the falling rates of unemployment for all groups, pupils leaving at age 16 are more than three times more likely to be unemployed than graduates). Although action is in hand to improve this situation – such as reducing the proportion of working-age adults with no qualifications by around one-third between 1997 and 2007 (see Figure A.7a in Chapter 4) – the rising number of social security claimants suggests a continuing challenge. This is likely to be exacerbated by more difficult economic conditions.

Opportunities for work

53. Encouraging higher employment rates has been a key government objective. Despite a global slowdown, UK employment reached 29 million for the first time,⁴⁴ although further progress has already been affected by the intensification of said slowdown. The New Deal programme has provided targeted help for those without work to find and retain work, and the national minimum wage (NMW) has boosted incomes for low-paid workers. The NMW has also helped to narrow the pay gap between men and women, and almost 5.75 million families with children have benefited from revised tax credits. The combined effect of these policies has been to boost the weekly post-tax income of working families with children. Furthermore, the Pathways to Work programme has enabled people with long-term health problems and disabilities to move into work. This programme is now available for all new customers across the country and includes:
- more effective employment services and support through the creation of Jobcentre Plus from a merger of the Employment Service and Benefits Agency
 - new employment programmes to help people into a job or self-employment, including the New Deal schemes and the Pathways to Work programme, which gives people suffering from long-term disability or long-term illness tailored help to get back to work
 - improved incentives to work by providing greater support through the tax credit system, by substantially increasing childcare provision and introducing the NMW.
54. A key part of the programme has been the New Deal for Lone Parents that has helped nearly half a million lone parents into work since 1998. Alongside the New Deal there is a range of additional support to help lone parents move into work, including the national childcare strategy, the NMW and tax credits. Together these are making work possible for lone parents who choose to look for work, and making sure that work pays.

Integrating employment and skills services

55. Government employment and skills services are being better integrated to ensure that they enable people to get into work and to get on in work. People who are out of work can get the help they need to develop their skills and gain qualifications, find sustainable employment and progress in work through continued skills development. The transition between pre-employment support and in-work learning will be as seamless for the individual as possible.
56. Trials of an approach to integrated employment and skills services started in late 2008–09 in 12 Jobcentre Plus districts. Evaluation of these will inform further developments with the aim that fully integrated services will be available to every jobseeker from 2010/11.
57. In advance of a fully integrated service in the whole of England, the Government has put in place from April 2009 arrangements for more effective joined-up working by employment and skills services across the country, to improve delivery of skills support to jobseekers and employers, including a range of new measures announced specifically in response to the current economic climate.

Supporting staff reducing unemployment and reducing unemployment

58. In her review 'Working for a Healthier Tomorrow' published in March 2008, Dame Carol Black put forward a range of recommendations to the Government to improve the health of people

⁴⁴ Department for Work and Pensions (2007) *In work, better off: next steps to full employment*. Page 19.

of working age. The Government, in their response ‘Improving health and work: changing lives’, launched November 2008, outlined a programme of work designed to help people return and stay in appropriate work after periods of sickness absence. The Health, Work and Well-being agenda is the overarching Government strategy that governs a set of strategic initiatives, including the activities below, which are designed to contribute positively to reducing health inequalities.

59. Steps taken to support workers by improving health and wellbeing and reducing psychosocial work hazards include:
- refreshing our strategy on health, work and wellbeing, with a focus on people living in disadvantaged circumstances
 - producing a new mental and employment strategy for people of working age experiencing mental disorders, building on the existing Improving Access to Psychological Therapies (IAPT) programme and related activities by the Department for Work and Pensions
 - working with private sector employers to improve the health and wellbeing of their staff and of the communities of which they are part
 - creating a new Fit for Work service which will deliver early intervention for people who are absent from work owing to illness and ensure earlier access to treatment, thereby helping more people to return to work earlier.
60. Tackling depression, anxiety and stress through the £173 million IAPT programme, launched in September 2008, helps to maintain the health of the workforce and the employment prospects of individual workers. Supporting workers and retaining them in the labour market means that they avoid unemployment and the associated poor health prognosis and social consequences. The programme aims to treat almost one million patients over the next three years.
61. As highlighted in the Acheson report, programmes that reduce levels of long-term unemployment and inactivity and raise incomes are central to tackling inequalities. The unemployment rate fell by a quarter between 1997 and 2007 (see Figure A.15a in Chapter 4).

HOUSING AND ENVIRONMENT

62. The Acheson report noted the importance of shelter as a prerequisite for health. It said that people who are disadvantaged tend to suffer either a lack of housing or poor-quality housing. The fear of crime compounds the social exclusion of people living in disadvantaged areas. The report sets out areas for future policy development which will address health issues including:
- **improving the availability of social housing** for less well-off and homeless people
 - **improving the quality of housing**, given that poor quality housing is associated with poor health
 - **increasing the safety of the environment in which people live** and protecting local communities from high rates of crime.

Policy response

Housing availability and homelessness

63. Over 100,000 households have been helped into low-cost home ownership with government funding. The Government's investment in affordable housing through the Housing Corporation's National Affordable Housing Programme has been steadily rising and over the next three years (2008–11) the Government is investing a total of £8 billion in delivering affordable housing – a 50 per cent increase on the previous three years. It is also considering further proposals to provide reformed housing services and options which help and encourage people towards greater economic independence and social mobility, delivering greater fairness and making best use of resources.
64. Homelessness legislation has been an important instrument in reducing the homeless population, but a significant challenge remains. There have been reductions in:
 - the number of homeless families with children in bed and breakfast accommodation, from 6,960 to 1,030 since March 2002
 - the number of households living in temporary accommodation, from 101,000 to 74,690 between December 2004 and June 2008, a fall of 26 per cent
 - the number of homeless 16- and 17-year-olds in bed and breakfast accommodation, from 560 to 420 during 2008
 - the number of rough sleepers, from 1,850 to 483 between 1998 and 2008.
65. The statutory Homelessness Code of Guidance for Local Authorities (2006) has helped local authorities to ensure that households in temporary accommodation, within their district or outside, are able to access relevant support services such as health visitors and GPs.
66. Communities and Local Government (CLG) is working with the Department of Health to ensure improved access to health and social care services for people with multiple needs who are sleeping rough. *No One Left Out: Communities ending rough sleeping* (2008) sets out the ways in which Communities and Local Government (CLG) are working with DH to ensure improved access to health and social care services for people with multiple needs who are sleeping rough.

Housing quality

67. The Government made improving the quality of social housing a priority in 1997 and set a PSA target in 2001 to make all social homes decent by 2010. The document *Design and Quality Standards* (2007)⁴⁵ also sets out how the Housing Corporation intends to deliver on the Code for Sustainable Homes within its National Affordable Housing Programme. More decent homes for vulnerable groups and better standards of accommodation for those living in the private sector are also on the increase through a range of Government programmes and legislative processes.
68. Since 1990, local housing authorities have been under a statutory duty to provide grant aid to disabled people for a range of adaptations to their homes. The purpose of an adaptation is to modify disabling environments in order to restore or enable independent living, privacy, confidence and dignity for individuals and their families. Both adults and children are eligible,

⁴⁵ Housing Corporation (2007) *Design and Quality Standards*.

and 70 per cent of the Disabled Facilities Grant recipients are older people. In December 2005, means testing for families with disabled children was ended. The programme has proven to be very successful, with Government funding increasing from £57 million in 1997 to £146 million in 2008. The grant is subject to a maximum limit of £30,000 and a means test to ensure that funding goes to those most in need.

69. Under the Housing Act 2004 a private landlord who manages a House in Multiple Occupation (HMO) of three or more storeys, occupied by five or more people who form more than one household, will require a licence from the local authority. In addition all HMOs, regardless of whether they are licensable, are subject to management regulations to ensure that they comply with the minimum safety requirements and that facilities within them are maintained in good order.

Fuel poverty

70. The responsibility for tackling fuel poverty now lies with the new Department of Energy and Climate Change. £20 billion has been spent on fuel poverty benefits and programmes since 2000, and spending will continue at around this level. Despite this considerable investment, its impact has been offset by steep rises in fuel prices. These increases have aggravated the incidence of fuel poverty, and further price increases are likely to make matters worse for the most vulnerable and disadvantaged households.
71. The latest data shows around 3.5 million households in fuel poverty across the UK in 2006, an increase of one million households since 2005 (see Figure A.22a in Chapter 4). Around 2.75 million of these are vulnerable households, including those with children and/or older or disabled people.⁴⁶
72. Living in a cold and/or damp dwelling can contribute to, or exacerbate poor health. Action to address fuel poverty for vulnerable and disadvantaged groups has been focused through the Warm Front scheme. An evaluation of the scheme, was published in May 2008, showing that this and other schemes had assisted around 1.8 million households since 2000. Other improvements to the quality of the housing stock have been delivered through the Decent Homes Scheme and the Carbon Emissions Reduction Target (formerly the Energy Efficiency Commitment).⁴⁷

Environment and safety

73. A clearer understanding of the impact of a range of environmental factors on people's physical and mental health has resulted in greater attention being paid to environmental and regeneration issues. This extends to the direct relationship between the physical environment, as measured by proximity to green spaces, and people's levels of physical activity. To this end, Neighbourhood Renewal policies have been promoted in disadvantaged areas that focus on the improvement of local environments – to make them cleaner, safer and greener. These policies also take into account the needs of black and minority ethnic (BME) communities which, the Acheson report said, make up a high proportion of deprived neighbourhoods.

⁴⁶ Defra (2008) *The Sixth Annual Progress Report on Fuel Poverty*.

⁴⁷ Defra (2008) *Warm Front Better Health – Health Impact Evaluation of the Warm Front Scheme*.

MOBILITY, TRANSPORT AND POLLUTION

74. The Acheson report said that a high-quality public transport system promotes health indirectly through the achievement and maintenance of social networks. Furthermore, development of a healthy public transport system that is integrated with other forms of transport (for instance walking and cycling) and is affordable to the user, is crucial to the reduction of health inequalities. The report recognised that some forms of transport promote health directly by increasing physical activity and reducing obesity. Lack of transport may damage health by denying access to people, goods and services and by diverting resources from other necessities. The report also noted that transport may damage health directly, most notably by accidental injury and air pollution. Among the key recommendations were:

- **developing further high-quality public transport systems**
- **encouraging walking and cycling, and reducing the use and speed of motor vehicles**, as a way of decreasing pollution and the risk of accidents and improving road safety
- **making transport for pensioners and disadvantaged groups affordable**, to reduce barriers to health-promoting opportunities for this group.

Policy response

Public transport

75. The 10 year plan published in 2000⁴⁸ sets out a long-term increase in transport spending to improve public transport and address social exclusion and it has brought about some significant improvements in public transport. Minimum half-fare discounts on local bus services have been introduced for older and disabled people, and the rural and urban challenge schemes have enabled the provision of innovative bus services.

76. More recently, action to improve public transport in rural areas has been launched jointly by Defra and Natural England. It is aimed at providing more accessible, affordable transport in rural areas as well as increasing the opportunities to enjoy the countryside and open spaces.

Road safety, walking and cycling

77. Road safety is important, and the rate of child road accident casualties in disadvantaged areas fell significantly between 1998 and 2006 – from 447 per 100,000 resident population to 273 per 100,000.⁴⁹ Schemes such as Kerbcraft, a practical child pedestrian training scheme, have helped. The road safety strategy⁵⁰ continues to evolve against the 2010 PSA targets, and identifies the priority areas for making Britain's roads safer. A new strategy is in preparation for the post-2010 period.

78. Encouraging walking and cycling has important links with the obesity agenda, particularly for disadvantaged groups and areas. For example, Cycling England's budget has been doubled, with an extra £15 million over three years to improve cycle infrastructure and training provision to children.

⁴⁸ Department for Transport (2000) *Transport Ten Year Plan 2000*.

⁴⁹ Department of Health (2008) *2007 Status Report on the Programme for Action*. Page 36.

⁵⁰ Department for Transport (2007) *Tomorrow's roads: safer for everyone*.

79. Physical activity programmes have been developed against a backdrop of inequalities in participation by gender, age, ethnicity and socio-economic status. This has seen initiatives to encourage young people to walk or cycle safely to school, such as the Bikeability national cycle training programme, Links to Schools and the Walking Buses programme.

Pollution and sustainability

80. Pollution, along with accidents, is a key transport issue with health, safety and security identified as a strategic goal. This is evident in the Government's response to the recommendations in the Eddington report to improve transport's contribution to economic growth and productivity, and considered the part that transport will play in reducing carbon emissions as recommended by the Stern Review of the Economics of Climate Change.
81. This strategy also recognises that accessibility to services is not only a transport issue. It is about the range of opportunities and choices that people have in connecting with jobs, services and friends and families – and that different social groups have different transport needs and priorities. For example, good access to healthcare is particularly important for those with children and for older people. People with disabilities are less likely to drive and more likely to be dependent on public or community transport, or on lifts from family and friends. The strategy also notes that the projected ageing of the population provides an additional challenge and incentive to focus harder on the needs of users with a range of mobility issues.

NUTRITION AND AGRICULTURE

82. The Acheson report noted that the percentage of expenditure spent on food is usually higher in low-income households than among the better off. The result is that higher food prices have the greatest impact on the least able to bear them, leading to 'food poverty' among the most disadvantaged groups. The report drew attention to the multiple effects that the Common Agricultural Policy (CAP) has in improving the nutritional position of the less well-off and achieving public health goals. It highlighted four main areas for further government action to reduce inequalities, including:

- **reviewing the impact of CAP on health and health inequalities**
- **promoting the accessibility and availability of food to supply an adequate and affordable diet**, including improving retail provision for disadvantaged groups
- **reducing sodium in processed foods.**

Policy response

Common Agricultural Policy

83. The CAP is primarily a set of financial and economic instruments designed to influence food production, and is directed at producers and processors, not customers. It is at best a very blunt and inexact instrument for promoting nutrition policy. The operation of the CAP disproportionately affects poorer households as they devote a higher proportion of their disposable income to purchasing food. Government policy is to continue to move the CAP away from this approach in order to ensure healthy and fair competition across the food supply chain and to reduce the EU import tariffs that keep prices high.

84. Using the CAP to influence what farmers produce (through supporting market prices) has been very costly and has led to a wide range of serious problems, especially affecting poorer households as they devote a higher proportion of their disposable income to purchasing food. Government policy is to continue to move the CAP away from such market manipulation and to connect farmers more fully to market demand, ensuring healthy and fair competition across the food supply chain (including in production and distribution) with consumers receiving the benefits of that competition.
85. The UK has not participated in the CAP surplus food scheme to improve the nutritional policy of the less well-off. This is because it considers the policy to be ill thought out and believes that more effective ways of targeting disadvantaged groups and areas lie in programmes like Healthy Start and 5 A DAY.

Promoting accessibility and availability of food – Healthy Start

86. The importance of nutritional advice and support to disadvantaged families, particularly those with children, is at the heart of the Healthy Start scheme. This statutory scheme succeeded the Welfare Foods Scheme (introduced in 1940) and it was rolled out across the country by November 2006. It provides nutritional support to pregnant women and young children under the age of four in some of the most disadvantaged families.
87. Large and small retailers are crucial to the scheme's delivery, as they accept Healthy Start vouchers for milk, fresh fruit, fresh vegetables and infant formula milk to ensure that those on the scheme have access to these basic foodstuffs. The scheme also encourages breastfeeding and healthy food choices among families taking part, with midwives and health visitors routinely offering advice and support on these issues to applicants for the scheme. Their involvement in supporting applications also provides a mechanism for health professionals to identify clients who may be in greatest need of support, and an opportunity to encourage them to take part in locally available initiatives such as breastfeeding support groups and cooking skills classes.

5 A DAY

88. The 5 A DAY programme was introduced in 2002 and has made considerable progress in increasing awareness and understanding of the importance of consuming five portions per day of fresh fruit and vegetables – as shown by the Food Standards Agency's Consumer Attitudes Survey. Covering 66 PCTs and funded with £10 million from the National Lottery, 5 A DAY community initiatives have been established to help families on low incomes secure access to fruit and vegetables. An evaluation of the scheme showed that the most significant increase in fruit and vegetable consumption was among those from the most socially disadvantaged groups.⁵¹ An evaluation of these initiatives, published in 2005, is available on the Big Lottery Fund website.
89. Funding for community food initiatives in all PCTs has been provided since April 2006 as part of the Choosing Health allocation, focusing on people and families living in deprived communities. In 2008, the Healthy Weight, Healthy Lives cross-government strategy⁵² highlighted increased fruit and vegetable consumption as a priority area for improving diet.

⁵¹ See: www.biglotteryfund.org.uk/er_eval_schoolfruits-final_report-uk.

⁵² HM Government (2008) *Healthy Weight, Healthy Lives: A Cross-Government Strategy for England*.

Reducing salt in processed food

90. Work started in 2003 to reduce the UK's salt intake and has been taken forward in three main areas:
- setting voluntary salt reduction targets and working with all sectors of the food industry to reduce the levels of salt present in food
 - running a public awareness campaign to make consumers aware of the health risks associated with consuming a high level of salt and what they can do to reduce their intake
 - encouraging the use of front-of-pack signpost labelling by retailers and manufacturers to enable consumers to quickly identify those foods that have lower salt levels.
91. Average population intake has dropped from 9.5g in 2000/2001 to 8.6g in the first quarter of 2008, with reductions in salt levels of between 25 per cent and 50 per cent in many of the foods that contribute most to salt intake. There has been a tenfold increase in awareness of the 6g a day message; the number of consumers cutting down on salt has increased by around one-third; and the number of consumers trying to cut down on salt by checking labels has doubled.

Across the life course

MOTHERS, CHILDREN AND FAMILIES

92. The Acheson report considered health issues around mothers, children and families. The report developed its argument from the earlier section of the report, which dealt with the priority for mothers and children. In particular, this section considered the removal of barriers to work for parents who wished to combine work with parenting, for example by increasing access to quality, affordable and appropriate day care. Secondly, it looked at extra support for full-time parenting by improving the living standards of households in receipt of benefits. It also described how inequalities in nutrition in women and children influenced health and inequalities.
93. Thus the report highlighted the following recommendations:
- **reducing poverty by removing barriers to work**
 - **providing high-quality day care**
 - **improving the health and nutrition of women and children by improving their diet and reducing obesity**
 - **reducing smoking in pregnancy** to promote healthy birthweight and reduce the risk of sudden infant death syndrome
 - **providing social and emotional support for parents** to enhance the skills and capacity of disadvantaged parents
 - **promoting the health of looked-after children**
 - **fluoridating the water supply.**

Policy response

94. The care and support that parents provide, together with the social, emotional and physical environment and early learning behaviour, are all factors that influence health throughout childhood and early adult years. It is recognised now that there is an opportunity to tackle the adverse conditions of childhood and early years that affect some disadvantaged families. These conditions can be mitigated by actions that support parents and carers who live in disadvantaged areas or are vulnerable in other ways, in order to provide them with help to improve their life chances, particularly in childhood.

Pre-school day care

95. High-quality day care has been provided through the Neighbourhood Nursery initiative, located in disadvantaged areas as part of an overall programme to increase available day care places by 250,000.⁵³ Day care and nursery support also features in Sure Start Children's Centres. Some centres are attached to primary schools, while primary schools often have their own day care facilities.

Nutrition and obesity

96. The Infant Feeding Initiative, launched in 1999, was designed to reduce health inequalities by increasing the incidence and duration of breastfeeding in those groups of the population where breastfeeding rates were the lowest. The 2005 Infant Feeding Survey showed that, though breastfeeding initiation rates had increased from 69 per cent to 76 per cent, many mothers did not continue to breastfeed beyond the early weeks. Only around half of all mothers breastfed at six weeks, despite the recommendations that babies should be breastfed for at least the first six months.⁵⁴ The prevalence of breastfeeding at 6–8 weeks after birth is a key indicator in the child health and well being PSA (2007). This PSA has also encouraged the adoption of UNICEF's Baby-Friendly Hospital Initiative.
97. The Acheson report noted the strong social gradient of obesity among women (see Figure A.35 in Chapter 4). The incidence of obesity among women in disadvantaged groups was almost twice that in the most affluent groups. Maternal obesity is a risk factor in infant mortality. Child obesity rates are also linked to family income and socio-economic group. Obesity was a major theme in *Choosing Health* (2004)⁵⁵ and remains a major challenge – rates among children are rising, and are predicted to rise further. To address this issue, recently a £370 million strategy has been launched in order to halt and turn the tide of obesity in children and adults. The Healthy Weight, Healthy Lives (2007) programme sets out the Government's long-term plans for tackling obesity.

Smoking in pregnancy

98. While overall rates of smoking in pregnancy fell from 19 per cent to 17 per cent between 2000 and 2005, rates among women in the routine and manual group have increased slightly (see Figure A.23 in Chapter 4). These figures relate to the period before the introduction of smokefree legislation but underline the continuing challenge in this area. Action includes:
- advice and support to quit through GPs and midwives, and from NHS Stop Smoking Services

⁵³ Department of Health (2005) *Tackling Health Inequalities: Status Report on the Programme for Action*.

⁵⁴ Department of Health (2005) *Tackling Health Inequalities: Status Report on the Programme for Action*.

⁵⁵ Department of Health (2004) *Choosing Health: Making Healthy Choices Easier*.

- a dedicated NHS smoking in pregnancy helpline
- intensive support for the most vulnerable mothers under the age of 20 through the Family Nurse Partnership Programme.
- NHS marketing campaigns around smoking in pregnancy, signposting the availability of support available for mothers and fathers to quit.

Family support/health visiting

99. The evidence in the Acheson report highlighted the importance of health visitors in providing more support to young families and parents rather than a more generic, whole population approach. This approach has characterised work with health visitors as part of an overall approach to nursing – for example through *Liberating the Talents* (2002)⁵⁶ and the Chief Nursing Officer's review of the nursing contribution to vulnerable children and young people.⁵⁷ As part of *Modernising Nursing Careers* (2006),⁵⁸ the Secretary of State commissioned a review into the future role of the health visitor.⁵⁹ This approach was informed by the views of a wide range of stakeholders. The report makes a number of recommendations for the future of health visitors which were considered by the Government in its response.⁶⁰
100. As part of new programmes addressing health inequalities, the health of children and families is a key driver for the new Healthy Child Programme (HCP) and the Family Nurse Partnership (FNP). The CHPP for antenatal and early years focuses on support for parenting and the social development of babies and children, as well as developmental assessment and immunisation programmes. The FNP is an evidence-based programme aimed at the most vulnerable families. Specially trained nurses work with vulnerable first time young mothers from early pregnancy until their babies are two.

Looked-after children

101. Looked-after children are a key group experiencing health inequalities and disadvantage and statutory guidance for local authorities on promoting their health was published in 2002. The post of Children's Rights Director (CRD) was established through the Care Standards Act 2000. The CRD works with specific groups of particularly vulnerable children, including looked-after children, to ensure that their rights and welfare are properly safeguarded and promoted within the work of Ofsted. The CRD advises on changes needed to regulations, standards and government guidance about welfare in the services Ofsted inspects or reviews.
102. A new White Paper, *Care Matters: Time for Change* (2007), outlined a package of measures to improve the health outcomes of looked-after children through, for example, better joint working between local authorities and health bodies.⁶¹ This White Paper is supported by a new national indicator for local government on the emotional and behavioural health of looked-after children, and a commitment to revise the guidance on promoting the health of looked-after children to make it statutory for health bodies as well as local authorities.

⁵⁶ Department of Health (2002) *Liberating the Talents: Helping Primary Care Trusts and Nurses to Deliver the NHS Plan*.

⁵⁷ Department of Health (2004) *The Chief Nursing Officer's Review of the Nursing, Midwifery and Health Visiting Contribution to Vulnerable Children and Young People*.

⁵⁸ Department of Health (2006) *Modernising Nursing Careers: Setting the Direction*.

⁵⁹ Department of Health (2007) *Facing the Future: A Review of the Role of Health Visitors*.

⁶⁰ Department of Health (2007) *The Government Response to Facing the Future*.

⁶¹ Department for Education and Skills (2007) *Care Matters: Time for Change*.

Fluoridation

103. Acheson noted the importance of fluoridation in improving the oral health of disadvantaged groups and areas. The legislation on fluoridation has been reformed since publication of the report. The Water Act 2003 removed the veto that water companies had on new fluoridation schemes by empowering strategic health authorities (SHAs) to require a water company to fluoridate where they could show the local population was in favour. South Central SHA has been first to make use of these new powers.
104. Fluoridation is just one measure in the oral health strategy.⁶² It notes the major improvements in oral health as shown by lower rates of tooth decay in children and young people. However, inequalities, which reflect a strong association between dental disease and social disadvantage remain. So far, only water fluoridation has proved successful in combating this effect, but the plan advocates a common risk factor approach to reducing inequalities, recognising that poor diets, smoking, inadequate hygiene and excessive alcohol intake are common factors in causing obesity, heart disease, stroke and cancer, as well as oral diseases.

Young people and adults of working age

105. The report highlighted a number of issues affecting this group, such as employment, housing and the environment. This is described in the first part of this chapter. Specific issues were also identified as risk factors for this group, including suicide, particularly in young men and people who are known to be mentally ill, and unhealthy lifestyles. Services also needed to be flexibly delivered, in order to take account of different needs within this population. Suggested areas for development included preventing suicide and promoting healthier lifestyles. Health-related behaviour is an important determinant of health and inequalities in health, but its causes are complex. Policies to change risky behaviours need to act at different levels and may take time. Areas the report identified as having a strong social gradient and as amenable to action included:
- **promoting sexual health**, including reducing unwanted teenage pregnancy
 - **encouraging physical exercise**, including cycling and walking routes to school
 - **reducing tobacco smoking**, including restricting smoking in public places and increasing the real price of tobacco
 - **reducing alcohol-related harm**, including accidents and violence that add to the real cost of alcohol.

Policy response

106. Tailoring action on healthy lifestyles to target health inequalities and pave the way for improving the health of people in disadvantaged groups and areas has been difficult. The prevailing emphasis on whole population approaches does not always make these connections and can, as Acheson observed, improve overall health while widening health inequalities. This effect can be partly overcome by building a specific health inequalities element into the target. This has been the method used with smoking, where action to reduce smoking prevalence is based on a target with a health inequalities dimension.

⁶² Department of Health (2005) *Choosing Better Oral Health: An Oral Health Plan for England*.

Suicide

107. The Acheson report found that suicide was three times higher in males than females in 1996 and was more common in lower socio-economic groups (Figures A.26a and b in Chapter 4 show the latest data). Suicide is associated with unemployment, alcohol and drug misuse, imprisonment and mental disorder. Together with mental illness, suicide was identified as a priority in the 1999 public health White Paper.⁶³ This was followed by the adoption of an NSF on mental health in 2000. In addition, in 2002, the Government published the National Suicide Prevention Strategy for England, the first of its kind in the country, to support the target to reduce the death rate from suicide and undetermined injury by at least 20 percent by 2010.
108. This work on suicide and mental health has continued, guided by the recommendations outlined in reports by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. The aim of the inquiry is to improve mental health services and to help reduce the risk and future incidence of suicide. Although good progress has been made (with a reduction in in-patient suicides from 215 in 1997 to 145 in 2005), there is still a need for services to do more to improve security and safety in services, as well as improving the management of patients in the community.

Sexual health and teenage pregnancy

109. Poor sexual health can have enormous health consequences and there is evidence of significant inequalities in terms of infection rates, unintended conception rates and access to services. The rising rates of sexually transmitted infections (STIs) pose a serious policy challenge – with, for example, the rates of chlamydia more than doubling in young men and young women between 1998 and 2007.⁶⁴
110. The concerns of the Acheson report informed the Government's sexual health and HIV strategy, which highlighted the clear relationship between sexual ill health, poverty and social exclusion.⁶⁵ The strategy sought to reduce unintended pregnancy rates (including teenage pregnancies) and reduce the transmission of STIs (which disproportionately affect young people). Reducing conceptions and prevalence of chlamydia in under-18s are both indicators in the 2008/09 NHS Operating Framework, *Vital Signs*.
111. Action included in tackling sexual health has included:
- the National Chlamydia Screening Programme (launched in 2003), which offers opportunistic screening to all sexually active women and men, aged under 25 years, attending a variety of health and non-healthcare settings
 - the Condom Essential Wear Campaign (2006), which raises awareness about STIs while promoting condom use among sexually active 16–24-year-olds, and which set a national target for an appointment at a genito-urinary medicine clinic within 48 hours. By the target date of March 2008, 98.9 per cent of first attendees were offered an appointment within 48 hours.
112. To support delivery of the teenage pregnancy PSA target, £26.8 million of new funding for PCTs and SHAs has been made available in 2008/09 to improve women's access to contraception and to help reduce the number of teenage pregnancies. This funding is recurring for three years.

⁶³ Department of Health (1999) *Saving Lives: Our Healthier Nation*.

⁶⁴ Health Protection Agency (2008) *Sexually Transmitted Infections and Young People in the United Kingdom: 2008 Report*.

⁶⁵ Department of Health (2001) *The National Strategy for Sexual Health and HIV*.

113. There is a commitment to halve under 18 conceptions by 2010 through the Teenage Pregnancy Strategy launched in 1999, a key component of which is young people's access to confidential contraceptive and sexual health services. Since the start of the Strategy, the previous upward trend has been reversed and the rate reduced by 10.7%, with a steeper 24% decline in teenage births. Teenage pregnancy is prioritised in PSA 14 – increasing the number of young people on the path to success, as an indicator (112) in the Local Government National Indicator Set and as a Tier 2 vital sign in the NHS Operating Framework. Teenage pregnancy is the second most popular indicator prioritised by Local Area Agreements, chosen by 106/150 areas. Regarding the commitment to a PSHE/SRE certification programme for teachers and school nurses, the *Children's Plan* (2007)⁶⁶ included a committed to review the delivery of Sex and Relationships Education in schools. In response to the SRE review, published in October 2008,⁶⁷ Government announced its intention to make PSHE and SRE a statutory part of the curriculum at primary and secondary level.
114. A joint Department for Children, Schools and Families/Department of Health/Royal College of Midwives publication providing guidance on tackling some of these issues in the new NHS environment, including around maternity services,⁶⁸ is aimed particularly at those maternity practitioners not working specifically with pregnant teenagers, in order to help them understand their needs.

Physical exercise

115. Levels of physical activity at school – including through school sports – and in the community are linked to better health outcomes and the rise in obesity. While the link between physical exercise and social class is complex, the Acheson report shows that obesity in men and women was higher in disadvantaged groups than others.
116. A range of initiatives have promoted physical activity, including through improving poor-quality local environments that inhibit such activity, such as the Cleaner, Safer, Greener Communities Programme. The Local Exercise Action Pilot (LEAP, 2003) programmes were developed by Department of Health and Sport England to help people to become more active. *Choosing Health* (2004)⁶⁹ announced further support in this area, building on the lessons from the LEAPs. The PE and Sport Strategy for schools was introduced in 2003 to raise children's participation rates in physical exercise: in 2002, an estimated one in four children aged 5–16 were doing two hours' high-quality PE and sport each week; now, the figure is around six out of every seven pupils. A new ambition has been set for 2008 to 2011 to increase participation by a further three hours a week outside the school day, including 16–19-year-olds for the first time. This 'five' hour offer is being delivered through the PE and Sports Strategy for Young People.
117. More recently, the first ever National Play Strategy was launched in April 2008. The Government is funding 30 new adventure playgrounds; up to 3,500 play areas nationally will be developed to create fun, stimulating and accessible places to play, which will be inclusive for all children, including disabled children, and aimed particularly at 8–13-year-olds and those living in disadvantaged areas.

⁶⁶ Department for Children, Schools and Families (2007) *The Children's Plan: Building brighter futures*.

⁶⁷ Department for Children, Schools and Families (2008) *Review of Sex and Relationship Education in Schools: A report by the external steering group*.

⁶⁸ Department for Children, Schools and Families/Department of Health/Royal College of Midwives (2008) *Teenage Parents: Who Cares? A guide to commissioning and delivery maternity services for young parents*.

⁶⁹ Department of Health (2004) *Choosing Health: Making Healthy Choices Easier*.

118. *Healthy Weight, Healthy Lives* (2008)⁷⁰ strengthened this commitment to promote exercise, by ensuring that health and physical activity is built into the fabric of urban and rural spaces, and exploring ways of increasing off-peak access to facilities. More than 14,000 (56 per cent) schools in England have active travel plans and these are helping more children to walk or cycle.

Tobacco

119. Smoking had a high priority early: one of the Government's first White Papers on health was *Smoking Kills* (1998).⁷¹ It emphasised that smoking, more than any other identifiable factor, contributed to the gap in healthy life expectancy between the most deprived and the most advantaged. The Government had already announced its intention to ban tobacco advertising, and it also announced a series of measures to help people give up smoking. Action included:
- abolition of tobacco advertising early on in this Government's life (February 2003)
 - introduction of nicotine replacement therapy on prescription (April 2001) – a step highlighted by Acheson as a way of supporting disadvantaged groups who wanted to give up smoking
 - provision of comprehensive NHS smoking cessation services. Set up in 1999 in Health Action Zones, these services provide group therapy which is the most intensive model of support
120. A major step for the health of the nation – and for health inequalities – was taken on 1 July 2007, when all enclosed parts of work and public places in England became smokefree. Regulations have subsequently introduced hard-hitting picture warnings on all tobacco products, and further action has been supported by stop smoking social marketing campaigns to motivate and support smokers to stop.
121. Ten years after *Smoking Kills*, England and the UK have developed a reputation as a leader across the world in effective tobacco control. In 2007, an independent academic survey of tobacco control activity across 30 European countries ranked the UK as being most effective.⁷²

Alcohol

122. The *Saving Lives* White Paper⁷³ stressed the importance for health of tackling alcohol misuse. It declared its intention to produce a strategy to tackle alcohol misuse and harm and, in line with Acheson's broader vision of multi-sectoral working, it envisaged a partnership between relevant areas of government, services, industry and the public.
123. Since publication of the alcohol strategy⁷⁴ in 2004, benefits are beginning to be seen, including reductions in crime and city centre violence and early signs of an end to the continued increase in levels of alcohol consumption. In June 2007, *Safe, Sensible, Social: The Next Steps in the Alcohol Strategy* set out plans to build on these successes. In June 2008, the Youth Alcohol Action Plan was published.⁷⁵ It set out the Government's five priorities to: step up enforcement activity to address young people drinking in public places; take action with industry on young people and alcohol; develop a national consensus on young people and drinking; establish

⁷⁰ Department of Health (2008) *Healthy Weight, Healthy Lives: A cross government strategy for England*.

⁷¹ Department of Health (1998) *Smoking Kills: A White Paper on Tobacco*.

⁷² Raw, M and Joussens, L (2007) *Progress in Tobacco Control in 30 European Countries 2005–2007*.

⁷³ Department of Health (1999) *Saving Lives: Our Healthier Nation*.

⁷⁴ Department of Health (2004) *Alcohol Harm Reduction Strategy for England*.

⁷⁵ Department for Children, Schools and Families (2008) *Youth Alcohol Action Plan*.

a partnership with parents on teenage drinking; and support young people to make sensible decisions about alcohol.

124. The 2004 strategy also set out action to improve health and treatment services, including piloting early identification and brief advice schemes, auditing demand and provision of treatment services, and providing guidance to NHS commissioners in developing models of care. It also committed Government to combating alcohol-related crime and disorder, and to working with the alcohol industry on social responsibility. In 2006/07, 6 per cent of NHS hospital admissions (811,000) were alcohol-related, and this figure is increasing by 80,000 a year.
125. From April 2008, a new indicator was introduced to measure the rate of change in hospital admissions of alcohol-related conditions.⁷⁶ This indicator is included in the Home Office PSA to reduce drug and alcohol harm and in the CLG list of indicators for local authorities and their partners.
126. A National Support Team on alcohol-related harm will visit the 20 areas with the highest rate of admissions to support local delivery against the indicator. These areas are also receiving £3 million of funding in 2008/09. Forty-six of the 50 areas with the highest rate of admissions have included the indicator in either or both their PCT or LAA plans.

Drug misuse

127. Alongside alcohol, drug misuse is an issue that can particularly affect those in disadvantaged areas.⁷⁷ This is both in terms of individual use amongst young people and adults, and for those children living in households where one or both parents are misusing drugs. The 2008 Drugs Strategy placed a priority both on young people's drug use, and on tackling parental drug use. New guidance addressing the needs of parents, carers and children both individually and as a whole family is considered the most effective way of tackling the harms associated with drug use for vulnerable young people. Key commitments from the Drugs Strategy include giving drug misusing parents priority access to treatment, improving the quality of young people's substance misuse services and improving safeguarding arrangements and the links between adult treatment services and children's services.

Delivering young people meaningful and friendly services

Young-people friendly services

128. Services need to make sense to the target group if they are to be used and be effective. This is an important consideration in delivering services that relate to and meet young people's needs and approach to life. Efforts to ensure that programmes reach these groups include:
 - Building on the updated Healthy Child Programme for the early years, this guidance is now being extended to focus on 5-19 year olds. It will set out the good practice framework for the full range of services so that a universal preventive service promoting health and well-being is offered to all, with the delivery of progressive services for those with additional needs and risks;
 - *You're Welcome quality criteria*⁷⁸ sets out the principles that will help all health care settings to ensure they are young people friendly. The Teenage Health Demonstration Sites in Bolton, Hackney, Portsmouth and Northumberland tested out enhanced health services

⁷⁶ Department of Health (2007) *Vital signs*.

⁷⁷ HM Government (2006) *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*.

⁷⁸ Department of Health (2007) *You're Welcome quality criteria: Making health services young people friendly*.

for young people, was designed around their needs and showcased implementation of the criteria;

- DH commissioned the Royal College of Paediatrics and Child Health to produce an e-learning programme in adolescent health for health professional that has been rolled out to all doctors and nurses working with teenagers, to ensure they have the skills to effectively address all of their health needs. This e-learning programme is now being adapted for all youth workers;
- NHS Teen Life-Check – aimed at 12–15 year olds and is a confidential on-line tool that has been designed to empower young people to take greater control of their health and well-being and is available at <http://www.nhs.uk/teenlifecheck/>. This is being rolled out in Spearhead areas first; and
- A Healthy Further Education programme has been set up with the aim of creating across the FE Sector a learning environment where positive well-being is the expectation for all, producing learners and staff who are confident, healthy, safe, emotionally resilient and personally fulfilled. Initial priority is being given to establishing a Framework to support colleges and to identify good practice, particularly for the most vulnerable learners.

129. Reaching out to other key groups – including disadvantaged groups – is also necessary. Health trainers are a key tool to help promote healthier lifestyles and reduce health inequalities. They reach out to people who are in circumstances that put them at a greater risk of poor health and work with them to assess their health and lifestyle risks, helping to build their motivation to change.⁷⁹ Health trainers have facilitated behaviour change and provided advice, motivation and practical support to individuals in their local communities since 2006.
130. A social marketing strategic framework *Ambitions for Health* was published by the Department of Health in July 2008. The social marketing framework and action plan will be backed up a £3 million partnership fund for Special Health Authorities (spread over 3 years). The health partnerships programme aims to build and support the capacity of the third sector to address the key public Health priorities: There will be a particular emphasis on working in deprived areas and addressing health inequalities.

Older people

131. The Acheson report considered health inequalities among older people (65 years and over). It noted the complications caused by data limitations – occupation was not included on death certificates over 75 – which reduced the scope for a health inequalities approach. It said that a key issue for this group was the prevention of morbidity, given that unskilled manual workers over 65 had a higher prevalence of long-standing illness compared with other groups. The report observed that the promotion of health among older people required action on some of the social determinants of health, including:
- **promoting material wellbeing** – linked to the earlier recommendations in the report around poverty and income
 - **improving quality of homes**
 - **promoting mobility, independence and social networks**
 - **developing health and social services for this group.**

⁷⁹ Department of Health (2004) *Choosing Health: Making Healthy Choices Easier*.

Policy response

132. Action to promote the material wellbeing of older people has been discussed earlier in this chapter. In terms of health and social care, the key instrument for addressing these needs in this group is the Older People's NSF.⁸⁰ Its focus is on age discrimination, falls, mental health in old age and healthy active ageing, and it sets out clear national standards for the treatment and care of older people.
133. The NSF provided a 10-year strategy to improve services for older people in all care settings including hospital. It has eight standards, which set out how improved health and social care service delivery for older people could be achieved. Although progress has been made since the NSF was published, there is evidence that implementation has been patchy (for example in relation to intermediate care and basic services). The result is that many older people are not guaranteed access to these services.
134. A package has been developed, providing a renewed focus within the NHS at local level, to work in partnership with social care providers, local government and older people themselves to provide services to older people which promote their health and wellbeing and which enable them to live independently within their own homes. It is designed to build on current services and introduces:
- a new focus on innovative healthcare such as telecare and telehealth, which help older people to manage their conditions in their own homes
 - work to help the NHS provide better services for falls, fractures and osteoporosis
 - work to continue to reduce audiology waiting times
 - a review of foot care to ensure services such as toenail cutting are more accessible to older people.

Housing issues

135. In terms of housing and housing quality, older people in disadvantaged groups and areas have benefited from mainstream programmes to increase the proportion of vulnerable households living in private sector decent homes from 42.9 per cent in 1996 to 68 per cent in 2006.
136. Local housing authorities have helped fund the provision of adaptations to disabled and older people, including the provision of ramps, door widening, stairlifts, level access showers and grab rails, with funding increased from £57 million in 1997 to £146 million in 2008. The Housing and Older People Development Group, an independent body supported by CLG and Department of Health, was set up to advise on older people's housing needs.
137. The Social Exclusion Unit published *A Sure Start to Later Life: Ending Inequalities for Older People* (2006) to tackle exclusion in later life, and set out cross-government actions to ensure that these needs are addressed. This was followed up by a cross-government strategy,⁸¹ which addresses older people's housing needs and aspirations and outlines plans for ensuring availability of appropriate housing to relieve pressures on homes, health and social care services.
138. The Warm Front programme, administered by Defra, provides grants to vulnerable households for heating, insulation and draught-proofing measures, which will also be important in achieving the thermal comfort criterion of the decent homes standard.

⁸⁰ Department of Health (2001) *National Service Framework for Older People*.

⁸¹ Communities and Local Government (2008) *Lifetime Homes, Lifetime Neighbourhoods: A National Strategy for Housing in an Ageing Society*.

Other dimensions of health inequalities

Ethnicity and gender

139. The Acheson report highlighted issues of ethnicity and gender as important dimensions of health inequalities – some of the specific issues around age were dealt with in the sections on young people and older people.

Ethnicity

140. The Acheson report noted that BME groups had different social identities and experience of health inequalities and disadvantage. Infant mortality rates are highest in mothers born in Pakistan and the Caribbean⁸² but babies born to mothers from other groups have some of the lowest rates, below the national average. Health behaviours such as smoking also vary widely between BME groups, and the ability to identify and respond to different needs was identified as a key issue. The areas identified by the Acheson report for development included:

- **recognising the needs of BME groups in the development and implementation of health inequalities policies, and reducing poverty**
- **developing services sensitive to the needs of BME groups**
- **considering BME needs in planning and resource allocation.**

Gender

141. The Acheson report observed that gender, like socio-economic status, had shaped individual opportunities and experiences across the life course. It said that while many experiences of childhood were similar for boys and girls, they were exposed to different risks. Men and women occupied different positions in the labour market and the home.

142. It observed that mortality was greater in males for all ages – the gap is greatest at 20–24 years as a result of accidents and suicide. Since Acheson reported there has been a slight narrowing in the mortality gap between men and women, as male life expectancy is increasing at a faster rate. Women often have higher morbidity rates for some mental health issues – with lone mothers especially at risk – and in disability, especially at older ages. The report highlighted the need for action in the following areas:

- **reducing mortality from accidents and suicide in young men**
- **improving the health of disadvantaged women with young children**
- **reducing the onset of disability in older women.**

Policy response

143. Many of the Acheson report's specific recommendations on reducing ethnic and gender inequalities in health are also covered in the part of the report dealing with the wider, social determinants. Poverty and disadvantage are key themes, together with specific issues concerning discrimination, accidents and suicide, and disability.

⁸² Department of Health (2008) *Tackling Health Inequalities: 2007 Status Report on the Programme for Action*.

Health issues

145. The implications of these issues for health inequalities can be seen through the impact on the target that highlights the strong link between disadvantage and ill-health. The life expectancy element of the target is based on the experience of the spearhead areas – those with the worst health and deprivation indicators. These areas cover 28 per cent of the general population but 44 per cent of the BME population and 53 per cent of the Muslim population, particularly Pakistani and Bangladeshi communities who have the highest levels of ill-health, once the age structures of the different faith groups have been taken into account.

Equality issues

146. In terms of the wider dimensions, there has been greater emphasis on bringing together action on equality issues over the past decade. For example, the Equality Bill, published on 27 April 2009, will introduce a new, integrated public sector duty: the Equality Duty. It will replace the existing duties on race, disability and gender, and extend to cover the protected characteristics of age, sexual orientation and religion or belief. The duty will apply to NHS bodies, and require them to have due regard to the need to eliminate unlawful discrimination, advance equality and foster good relations.
147. One of the key patient rights in the NHS Constitution published this year states “You have the right not to be unlawfully discriminated against in the provision of NHS services, including on grounds of gender, race, religion or belief, sexual orientation, disability (including learning disability or mental illness) or age”. The Equality Bill reinforces this commitment by outlawing age discrimination in the provision of public services. The Secretary of State for Health has asked Sir Ian Carruthers, Chief Executive of the South West Strategic Health Authority, and Jan Ormondroyd, Chief Executive of Bristol City Council, to lead a national review on what actions need to be taken to banish age discrimination in health and social care.’
148. The Bill will also require the Department of Health, Strategic Health Authorities and Primary Care Trusts to give due consideration to addressing the inequalities of outcome associated with socio-economic disadvantage when they are developing their strategies. This will provide statutory underpinning for work that many organisations are already doing to tackle health inequalities.
149. Action to promote equality in health and social care, including the health needs of BME communities and other disadvantaged groups, takes place in the context of the drive to increase health overall and to reduce health inequalities.
150. The Department of Health’s strategy is to build equality and human rights into all aspects of its work, including policy development, NHS and social care delivery, and workforce issues. In so doing, it aims to ensure that services are responsive to the diverse needs of all sections of the community. Equality and human rights were a core element of the Health and Social Care Standards and Planning Framework 2005/06–2007/08 and a core principle within the NHS Operating Frameworks for 2007/08 and 2008/09.
151. At local level, PCTs and local authorities are required to work in partnership with local communities through a joint strategic needs assessment (JSNA) to establish the current and future health and wellbeing needs of the population and to tackle inequalities, with a specific focus on age, ethnicity, disability, gender, religion and migrant populations.

152. Specific work programmes have been put in place to promote equality and human rights in healthcare and to tackle health inequalities amongst minority communities, including:
- Pacesetters, a programme that aims to reduce inequalities for patients and staff subject to discrimination and disadvantage, particularly arising from ethnicity, gender or disability, by effective community engagement
 - the *Delivering Race Equality in Mental Health Care* five-year action plan⁸³
 - the Race for Health programme, which supports PCTs working with local BME communities to improve access, experience and health outcomes
 - a local action framework project to improve service design and delivery.⁸⁴
153. The Darzi final report makes clear that the NHS has a wider social duty to promote equality through the services it provides, and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.⁸⁵ This will be assisted by the publication of the *Single Equality Scheme 2007–2010* that covers all aspects of age, religion or belief and sexual orientation. This work will be overseen by an Equality and Diversity Council to inform and embed equality in the NHS.

The role of the NHS

155. The Acheson report treated the NHS differently from the other areas of policy development. It said that equity – the principle of matching needs and services – was a founding principle of the NHS. It examined some of the management and operational issues around healthcare provision and the impact on health inequalities, particularly in relation to:
- **access to (and quality of) services**
 - **the distribution of resources across the NHS**
 - **the need for additional capacity to tackle health inequalities.**

Policy response

156. There have been many developments in the organisation, structure and financing of the NHS in the 10 years since Acheson reported, in particular the publication of *The NHS Plan* (2000)⁸⁶ – a 10-year plan for investment and reform that reaffirmed the core principle of the NHS as a universal service, free at the point of use. It combined this with a commitment to modernise the service shaped around the needs and expectations of patients and the public. This document first announced the Government's intention to establish national health inequalities targets. It pledged to reduce inequalities in access to services as well as to act on some of the contributory factors, such as smoking, as well as promoting joint working across government.

⁸³ Department of Health (2005) *Delivering Race Equality in Mental Healthcare: An action plan for reform inside and outside services*.

⁸⁴ Department of Health (2008) *Human Rights in Healthcare – A Framework for Local Action*.

⁸⁵ Department of Health (2008) *High Quality Care for All: NHS Next Stage Review*.

⁸⁶ HM Government (2000) *The NHS Plan: A plan for investment, a plan for reform*

157. The *High Quality Care for All: NHS Next Stage Review Final Report* (Darzi) demonstrated that the NHS has a role in promoting equality through the services it provides, paying particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population. The interim report⁸⁷ looked at how the NHS can become fairer, more personalised, more effective and safer. Central to the review are the principles of fairness – ensuring services are equally available to all, taking full account of personal circumstances and diversity, and personalised services tailored to the needs and wants of each individual, especially the most vulnerable and those in greatest need.⁸⁸

Access issues

158. *The NHS Plan* had emphasised the need for national priorities and national standards to improve NHS performance and achieve greater equity. A small number of national targets on access and quality issues, including waiting times, supported these standards. Guidance on the best treatment was provided by the National Institute for Health and Clinical Excellence (NICE) to ensure a faster, more uniform uptake of treatments. The Plan gave a new emphasis to prevention and to working in partnership with other agencies to tackle the causes of ill-health that lead to health inequalities.
159. It acknowledged the persistence of the ‘inverse care law’ in many parts of the country. This states that communities in the greatest need are least likely to receive the treatment they require. This inequality was part of the legacy inherited by the NHS at its formation in 1948 and was a key issue for Acheson. It sought new ways to address this issue, including through a more equitable distribution of GP and primary care staff, making equitable access to services part of the new NHS performance framework, and a more equitable NHS spending formula. The inverse care law remains a significant challenge to delivering equal access to health services. This was acknowledged in *Our NHS, our future*, which set out further plans to strengthen primary care provision in disadvantaged areas by setting up new health centres in some of the most deprived communities.
160. Commissioning is a key vehicle to achieving greater equity in access to, and quality of, health services. World Class Commissioning introduced in 2007 set out a new approach to commissioning for health and care services, and it underpins many of the objectives of current health policy. By working in partnership with the NHS, social care and local government, a joint approach has been developed to meet the needs and priorities of the local population and improve health outcomes.
161. One of the aims of World Class Commissioning is to reduce inequalities between the areas with the worst and best health. Health inequalities are often exacerbated by a lack of access to appropriate services in the community. An assurance process that identifies health inequalities and life expectancy as core business outcomes for every PCT will assist the achievement of this aim.
162. The Quality and Outcomes Framework (QOF) addresses the need to reduce health inequalities in primary care. The QOF system is based on the recorded prevalence of disease and ensuring that GP practices serving disadvantaged areas with a higher prevalence of disease get more funds to address these issues. Independent research shows that QOF has resulted in a narrowing of the gap between the quality of care in deprived and more affluent areas.⁸⁹ In addition, the agreement between NHS Employers and the BMA for the GP contract 2009/10 includes moving to a full prevalence adjustment for QOF payments by April 2010. This will be a major step forward

⁸⁷ Department of Health (2007) *Our NHS, our future*.

⁸⁸ Department of Health (2008) *High Quality Care for All: NHS Next Stage Review Final Report*.

⁸⁹ Doran, T, et al. (2008) The effect of financial incentives on inequalities in the delivery of primary clinical care in England: analysis of clinical activity indicators for the quality and outcomes framework. *Lancet*, vol. 372.

in making sure that QOF payments are fairly related to the needs of patients within a practice population, thereby redistributing money to more deprived areas and creating better incentives for case-finding.

Resources

163. Acheson welcomed the progress made in recent years to a more equitable approach to allocating health service and other resources, but highlighted that more needed to be done. In 1997, the Advisory Committee on Resource Allocation (ACRA) was established as the successor to the Resource Allocation Group to oversee the development of the weighted capitation formula used to inform revenue allocations to NHS organisations. In particular, ACRA was charged with advising the Secretary of State for Health on:
 - [recommending] a distribution of resources across primary and secondary care that supports equitable access to healthcare for all;
 - [ensuring] equal opportunity of access to healthcare for people at equal risk; and
 - [contributing to] the reduction in avoidable health inequalities.
164. For the 2001/02 and 2002/03 revenue allocations, a health inequalities adjustment was introduced into the funding formula. This was an interim adjustment that targeted a proportion of the overall allocation for those health authorities that were judged as having the poorest health outcomes.
165. Prior to the 2003/04 revenue allocations, ACRA carried out a wide-ranging review of the formula. The new formula contained an adjustment for unmet need, that is, the need for healthcare over and above that accounted for by the age of the population. This formula has been used to inform revenue allocations to the NHS from 2003/04 to 2008/09.
166. The weighted capitation formula was extended to primary care with the introduction of the primary medical services component (replacing the previous General Medical Services Cash Limited and Non-Cash Limited resources) into the formula in 2006/07. The age- and sex-related needs and additional need adjustments for this component of the formula were based on research used to derive a new resource allocation formula as part of the new GP contract introduced in 2004/05.
167. The weighted capitation formula is used to determine each PCT's target share of the resources available. The level of increase which all PCTs receive in order to deliver on local and national priorities is determined by the Pace of Change policy. The Pace of Change policy is decided by ministers for each round of the allocations in light of the commitment to bring all PCTs to their target allocation as soon as is practicable, while ensuring that all PCTs receive sufficient extra funding to enable them to deliver on national and local priorities.
168. A faster Pace of Change policy was adopted in 2006/07 and 2007/08. By the end of 2007/08 no PCT was more than 3.5 per cent below its target (with one exception following PCT reconfigurations). This new approach helped many spearhead areas whose financial allocation runs behind the target set by the ACRA process through the Pace of Change policy. This has involved moving PCTs towards their target allocation as quickly as practicably possible. The Pace of Change policy has been frozen for 2008/09, pending a new formula for 2009/10 and beyond.

169. In the 2006/07 and 2007/08 PCT revenue allocations, additional resources of £550 million were identified to support the delivery of some of the commitments in *Choosing Health* to enable PCTs to deliver on initiatives which included sexual health services, chlamydia screening, school nurses and health trainers, many of whom contribute to reducing health inequalities. From 2008/09, this funding has been included in PCT baselines.
170. Pending revision of the formula, the Hospital and Community Health Services (HCHS) allocation formula was supplemented by an interim health inequalities adjustment in 2001/02 and 2002/03, designed to help those health authorities with the worst outcomes, pending the introduction of a new formula for 2003/04, which included an element for unmet need.
171. It should be noted that the local spending experience has differed from the national plans. It has varied over the last few years, either through underspends or through year-on-year pressures, for example to balance budgets. Such pressures can distort plans and priorities and weaken the impetus within NHS organisations to improve health and tackle health inequalities or support partners in this work.

Building capacity

172. The Acheson report declared that in order to take forward a new agenda to tackle health inequalities, the skills, resources and capacity of organisations to work together needed strengthening, including the public health function of the NHS and cross-government working.
173. The *Programme for Action* (2003) emphasised the importance of systems and processes to this new agenda, specifically the idea of 'mainstreaming' health inequalities in the work of major national programmes. This approach was aimed at embedding health inequalities as a regular part of NHS and other business, rather than as a separate programme or projects.
174. Equally, it highlighted the roles and responsibilities of key players, from the parts played by local professionals in the NHS and local government, to those played by local, regional and central government. Partnership working, notably through the Local Strategic Partnerships trailed in *The NHS Plan*, was seen as critical in moving this work forward.
175. The Director of Public Health (DPH) has a lead role in protecting and improving the health of the local population, reducing health inequalities and ensuring the quality and safety of patient services. The *Our health, our care, our say* (2006) White Paper recommended joint DPH appointments between PCTs and local authorities as best practice.
176. Following the publication of the Local Government and Public Involvement in Health Act 2007, local government and PCTs have a statutory requirement to undertake JSNAs. In their new roles, DPHs will work in partnership with the Director of Adult Social Services and the Director of Children's Services to undertake JSNAs, which is vital in ensuring World Class Commissioning and the delivery of more equitable services.

Next steps

177. Much has been done in tackling health inequalities since the Acheson inquiry reported in 1998. The health of the disadvantaged groups and areas has improved in real terms, all groups have longer life expectancy, and infant mortality rates are at their lowest-ever level, but health inequalities persist. A wider perspective on developments in inequalities between 1998 and 2008 is set out in Chapter 4. Important issues and challenges remain.
178. *Health Inequalities: Progress and Next Steps* (2008) sets out a new ambition in looking beyond the current target date to a new strategic objective for the post-2010 period. It reiterates some familiar themes drawn from the lessons of the last 10 years:
- action must be taken at all levels down to ward and practice level, and with a crucial but limited role for central government
 - empowering people and communities to take control of their own lives on a range of issues, not just health, is crucial
 - local government has a key role in tackling health inequalities, providing local leadership on a range of wider services
 - the NHS has an important role in assessing local needs, delivering accessible services and working with local partners
 - there is a need to support disadvantaged communities that face the greatest challenges.
179. It also injects new urgency into meeting the 2010 target. It assesses progress to date, sets out proposals for further action and highlights some key issues to engage further with partners and stakeholders, particularly around the wider determinants of health.
180. The Acheson report will continue to be relevant in the post-2010 period. Its scientific and evidence-based approach to identifying potential areas for policy development will inform future work including the Post-2010 Strategic Review of Health Inequalities. Its recommendations will remain an important reference point against which new proposals will be judged. Its overall assessment is a reminder of the stubborn and persistent nature of health inequalities and the determination and commitment needed to tackle them.

Chapter 4: Developments over the last 10 years – indicator trends

Introduction

1. This chapter sets out developments over the last 10 years using the indicator trends based on the framework developed by the World Health Organization (WHO) Commission on Social Determinants of Health. A proposed operational approach and indicator set to measure social determinants of health and health equity on a wider basis was developed as part of the Commission's work.
2. This approach was set out in a draft paper discussed at the International Union for Health Promotion and Education symposium in Vancouver in summer 2007. The Vancouver paper set out a framework as shown in Table 3.

Table 3: WHO CSDH framework – operational components and sub-themes

1.	Socio-economic and political context	
	a.	Political system: governance
	b.	Economic and labour system
	c.	Social policies
	d.	War, conflict and militarisation
	e.	Values of solidarity
	f.	Values of inclusive citizenship
2.	Social stratification	
	a.	Economic status
	b.	Education
	c.	Occupation
	d.	Gender
	e.	Ethnicity/race and religion
3.	Differential exposures, vulnerabilities and consequences	
	a.	Material circumstances
	b.	Health-related behaviours and biological factors
	c.	Social cohesion/social capital
	d.	Psychosocial factors
	e.	Health system
4.	Differential outcomes in health	
	a.	Mortality
	b.	Morbidity
	c.	Disability
	d.	Health status

It also presented a set of possible indicators and indicator sources for each of the themes and sub-themes of the framework.

3. The approach taken in this supplement has been to:
 - select a **subset** of the full WHO list of proposed indicators rather than attempting to be comprehensive
 - attempt to provide a set of indicators to cover the **full breadth of the framework**
 - focus on those indicators that were considered most pertinent to the **UK situation**
 - attempt to be consistent with **existing UK government department targets/indicators** in appropriate topic areas to ensure read-across with national activity
 - identify, wherever possible, indicators for which a **10-year trend** could be identified
 - incorporate, where appropriate, the **existing set of headline indicators** (as published in the 2007 Status Report on the Programme for Action)
 - enhance the presentation of the **inequalities dimensions** of the indicators
 - draw together in one document information from a wide variety of existing primary and secondary sources, using (where appropriate) published commentary extracted directly from those sources.
4. For each of the indicators selected, data is presented in the form of a chart and brief commentary is provided. In most cases, data and commentary have been taken from published primary or secondary sources, with the source identified. Where possible, data has been presented to illustrate trends over the last 10 years or so. In some cases additional data has been presented in the form of an accompanying table when this is considered to provide added value. Such tables may for example present longer time trends or a more detailed breakdown relevant to interpreting progress. In a few cases we have been unable to identify suitable time trend data. However, if snapshot data is available and in addition some form of inequalities analysis is possible, then this data has been presented.
5. Following our understanding of the requirements of the WHO framework, the data for individual indicators is presented broken down by dimensions of inequality, particularly for theme four (differential outcomes in health) and to a lesser extent for theme two (social stratification). Many of the remaining indicators provide relevant trend information on a broad range of drivers of health inequality (e.g. poverty, employment and education). During development of the indicator set it was decided to enhance coverage of the inequalities dimensions of the indicators. The indicators presented in this chapter need to be considered alongside the **headline indicators** published in the 2007 Status Report on the Programme for Action. The latter explicitly address the gradient between the most and least advantaged sections of the population. Taken together, these two closely related sets of indicators combine to provide a rich source of information on recent UK trends in health inequality.

Table 4: Selected indicators from the WHO framework

Socio-economic and political context		
Political system: governance	Voice and accountability	
A.1: Percentage voter turnout at Parliamentary elections		
Economic and labour systems	Economic system	Income distribution
A.2: Gender pay gap: gap between women's and men's median hourly earnings		
Economic and labour systems	Economic system	Income redistribution
A.3: Original income and final income		
Economic and labour systems	Labour market	Employment by sector
A.4: Employment by industry		
Social policies	Education	Government commitment to education
A.5: Education spending as a percentage of GDP		
Social policies	Education	Commitment to education for all
A.6: Percentage of 16-year-olds with at least five GCSEs or equivalent at grades A*-C		
Social policies	Education	Commitment to education for all
A.7a: Working-age adults with no qualifications		
A.7b: Working-age adults with no qualifications by selected subgroups		
Social policies	Health	Resources used in the health sector
A.8: Government and household expenditure on healthcare as a percentage of GDP		
War, conflict and militarisation		
A.9a: Applications received for asylum, excluding dependants		
A.9b: Applications received for asylum, excluding dependants, by age and gender		
Values of inclusive citizenship		
A.10a: Trends in incidence of crime (reported in the British Crime Survey)		
A.10b: Perceptions of anti-social behaviour by personal characteristics		
Social stratification		
Economic status	Income inequality	
A.11: Income inequality (Gini coefficient)		
Economic status	Poverty	
A.12: Children living in low-income households		
Education	Access to economic and educational opportunities	
A.13: Adult literacy by household social class and ethnicity		
Education	Differentials in returns to education	
A.14: Unemployment by level of education		
Occupation	Unemployment or underemployment	
A.15a: Unemployment rate		
A.15b: Employment rate gaps		
Occupation	Unemployment or underemployment	
A.16: Part-time employment rate by gender		
Gender	Access to economic and educational opportunities	
A.17a: Labour participation rate by gender		
A.17b: Average length of absence from work following birth		
Gender	Social prestige of women	
A.18a: Domestic violence		
A.18b: Domestic violence victimisation rate		
Ethnicity/race and religion	Socio-economic disadvantage	
A.19a: Employment rate by ethnicity		
A.19b: Occupational attainment of employees by gender, socio-economic group and ethnicity		
Ethnicity/race and religion	Socio-economic disadvantage	
A.20: Percentage of Year 11 pupils attaining at least five GCSEs at grades A*-C, by ethnicity		

Differential exposures, vulnerabilities and consequences	
Material circumstances A.21: Households living in non-decent homes	Housing conditions
Material circumstances A.22a: Households in fuel poverty A.22b: Households in fuel poverty (full income definition)	Housing conditions
Health-related behaviours and biological factors A.23a: Smoking prevalence overall and by socio-economic (manual or non-manual) group A.23b: Adult smoking prevalence by Government Office region A.23c: Adult smoking prevalence by gender and age A.23d: Adult smoking prevalence by ethnicity and gender	Smoking
Health-related behaviours and biological factors A.24a: Excessive alcohol consumption by socio-economic group A.24b: Average adult weekly alcohol consumption by Government Office region	Alcohol consumption
Social cohesion/social capital A.25a: Proportion of population who rarely or never spend time with friends, colleagues or others A.25b: Proportion of population who rarely or never spend time with friends, colleagues or others – gender gap	Social isolation
Psychosocial factors A.26a: Suicide mortality rate by gender and age A.26b: Suicide rates by deprivation twentieth and gender	Negative life events
Psychosocial factors A.27a: Self-reported life satisfaction by social grade A.27b: Self-reported life satisfaction by gender and age	Subjective wellbeing
Health system A.28a: Number of GPs per 100,000 population A.28b: Number of GPs per 100,000 population by area deprivation	Availability (access to services)
Health system A.29: Childhood immunisation rates	Contact (access to services)

Differential outcomes in health	
Mortality A.30a: Life expectancy at birth by social class A.30b: Life expectancy at age 65 by social class	Life expectancy at birth and 65
Mortality A.31a: Infant mortality rate by socio-economic group A.31b: Infant mortality rate by ethnic group	Infant mortality ratio
Mortality A.32a: Ischaemic heart disease mortality rate by social class and socio-economic group A.32b: Coronary heart disease mortality rate by local authority area	Cardiovascular
Mortality A.33: Lung cancer mortality rate by social class and socio-economic group	Cancer
Mortality A.34: Cerebrovascular disease mortality rate by social class and socio-economic group	Cardiovascular
Morbidity A.35: Prevalence of obesity in adults by gender and by income quintile	Prevalence of obesity in adults
Morbidity A.36: Prevalence of hypertension in adults by income quintile	Prevalence of hypertension in adults
Morbidity A.37: Prevalence of mental ill health by household income	Prevalence of major depression among adults
Disability A.38: Prevalence of limiting long-standing illness by socio-economic group	
Health status A.39a: Self-reported health status A.39b: Adults' self-assessed general health by social class and gender	

6. Different dimensions addressed by the indicators are summarised in the table below.

Dimensions identified are:

- **time trend:** continuous, or selected years
- **area:** regional breakdown or international comparison
- **gender:** where this is identified
- **age:** comparative age groups; where an indicator shows only an age subgroup (such as adults of working age) this is not indicated on the table
- **children:** where children are explicitly identified (usually as the focus of the indicator)
- **ethnicity:** either by a range of specific ethnic backgrounds or by 'white, non-white'
- **lone parents:** where this is identified
- **deprivation/socio-economic classification/income/expenditure:** these categories are interrelated, covering income group, deprivation status, occupation, social class, National Statistics Socio-economic Classification (NS-SEC), ACORN category (see page 75), housing tenure etc.
- **employment:** either employed or unemployed, or occupational status
- **educational attainment:** GCSE passes, or highest qualification achieved
- **disability:** where this is indicated.

7. In the table below letters are used to illustrate the following:

- **C** indicates that the dimension is shown in a chart
- **D** that the dimension is included within a data table
- **T** that the dimension is covered in the text.

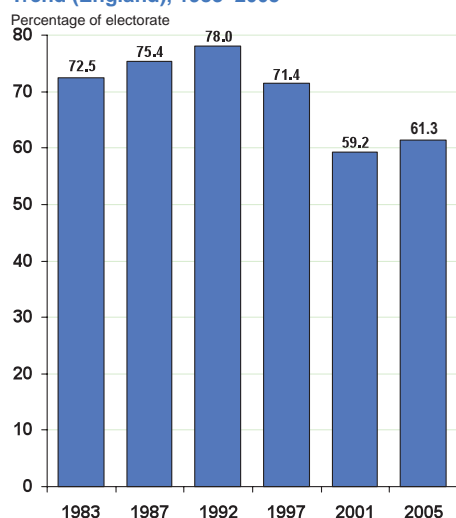
Table 5: Comparative dimensions presented for each indicator

Indicator	Comparative dimensions shown												
	Time trend	Area	Gender	Age	Children	Ethnicity	Lone parenthood	Deprivation	Socio-economic classification	Income/ expenditure	Employment	Educational attainment	Disability
1 Percentage voter turnout at Parliamentary elections	C,D	T	D	D		C, D, T			C, D, T				
2 Gender pay gap	C,D		C,D										
3 Original income and final income									C, D				
4 Employment by industry	C, D, T		C, D, T							C, D, T			
5 Education spending as percentage of GDP	C, D, T	T											
6 Percentage of 16-year-olds with at least five GCSEs at grades A*-C	C, D				C, D							C, D	
7 Working-age adults with no qualifications	C, T	C	T	T		C				T	C, T	C, T	
8 Government expenditure on health as a percentage of GDP	C, T	T											
9 Applications received for asylum, excluding dependants	C		C	C, T		T							
10 Crime and anti-social behaviour	C, D, T	C, T	C	C, T		C			C, T				
11 Income inequality (Gini coefficient)	C, D, T		T						C, D	T			
12 Child poverty: Children living in low-income households	C, D, T	T			C, D, T	T	T		C, D, T	T	T	T	
13 Adult literacy						C, T			C, T			C, T	
14 Unemployment by level of education	C										C, T	C, T	
15 Unemployment rate	C, T			C, T		C, T	C, T				C	C, T	C, T
16 Part-time employment rate	C		C, T						D		D, T		
17 Labour participation rate	C, T		C, T			C, T	T					C, T	
18 Domestic violence	C, T		T	C, T		C, T			C, T				
19 Employment rate and occupational attainment	C, T		C, T			C, T			C, T				
20 Percentage of 16-year-olds with at least five GCSEs	C, D					C, D, T						C, D, T	
21 Households living in non-decent homes	C, D, T					D		C, D, T					
22 Households in fuel poverty	C, T	C, T				C, T		C		C, T			
23 Smoking prevalence	C, T	C, T	C, T	C, T		C, D, T			C, T				
24 Excessive alcohol consumption	C, D	C, T	C, D, T						C, D, T				
25 Proportion of population who rarely or never spend time with friends, colleagues or others		C, T	C	T						T			
26 Suicide mortality rate	C, D, T	T	C, D, T	C, D, T				C, T					
27 Self-reported life satisfaction			C, T	C, T					C, T		T		
28 Number of GPs per 100,000 population	C, T							C, T					
29 Childhood immunisation rates	C, D	T			C								
30 Life expectancy at birth and 65	C, D, T		C, D, T						C, D, T				
31 Infant mortality rate	C, D, T					C, T	T		C, D, T				
32 Ischaemic heart disease mortality rate	C, T	C, T	C, T						C, T				
33 Lung cancer mortality rate	C, T		C, T						C, T				
34 Cerebrovascular disease mortality rate	C, T		C, T						C, T				
35 Prevalence of obesity in adults	C, T		C, T							C, T			
36 Prevalence of hypertension in adults	C, T		C, T							C, T			
37 Prevalence of mental ill health	C, T		C, T							C, T			
38 Prevalence of limiting long-standing illness	C, D								C, D, T				
39 Self-reported health status	C		C						C				

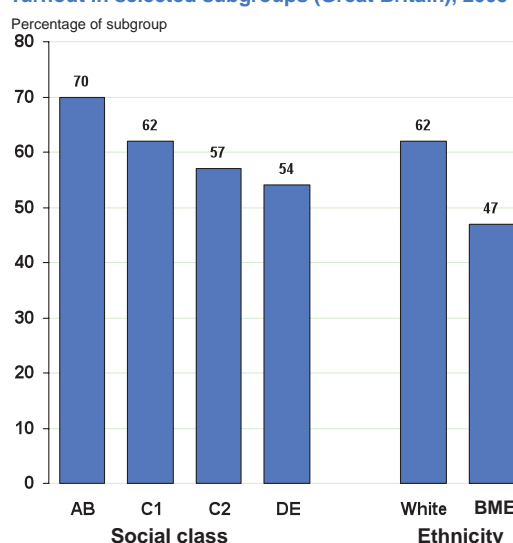
Note: C = dimensions shown in chart; D = dimensions included within data tabulation; T = dimensions covered in text

A.1: Socio-economic and political context – Political system: governance: Voice and accountability
Percentage voter turnout at Parliamentary elections

Trend (England), 1983–2005



Turnout in selected subgroups (Great Britain), 2005



Source: (to 2001) House of Commons library research paper 03/59.
 (2005) The Electoral Commission (2005) *Election 2005: turnout*.

Notes: 2005 data based on sample of 10,986 British adults 'absolutely certain' to vote.
 ABC1s = Managers, administrators, professionals and clerical workers.
 C2DEs = Skilled and unskilled manual workers, those on long-term benefit and the retired drawing a state pension.
 Source: The Electoral Commission (2005) *Election 2005: turnout* (p.25).

Turnout at Parliamentary elections
Valid votes as percentage of electorate
 England

	1945	1950	1951	1955	1959	1964	1966	1970	(Feb) 1974	(Oct) 1974	1979	1983	1987	1992	1997	2001	2005
%	73.4	84.4	82.7	76.9	78.9	77.0	75.9	71.4	79.0	72.6	75.9	72.5	75.4	78.0	71.4	59.2	61.3

Source: (to 2001) House of Commons Library, Research Paper 03/59.
 (2005) The Electoral Commission (2005) *Election 2005: turnout* (Table 4, p.22).

Estimated turnout by subgroup, 2001–05

Great Britain	2001 turnout (%)	2005 turnout (%)	Change 2001–05 (percentage points)
Total	59	61	+2
Gender			
Men	61	62	+1
Women	58	61	+3
Age			
18–24	39	37	-2
25–34	46	48	+2
35–44	59	61	+2
45–54	65	64	-1
55–64	69	71	+2
65+	70	75	+5
Social class			
AB	68	70	+2
C1	60	62	+2
C2	56	57	+1
DE	53	54	+1
Ethnicity			
White	60	62	+2
BME	47	47	-

Notes: 2005 data based on sample of 10,986 British adults 'absolutely certain' to vote.
 ABC1s = Managers, administrators, professionals and clerical workers.
 C2DEs = Skilled and unskilled manual workers, those on long-term benefit and the retired drawing a state pension.
 Source: The Electoral Commission (2005) *Election 2005: turnout* (p.25).

Recent voter turnout is well below historic norms. There was a modest increase in 2005 above the turnout achieved in the General Election of 2001. The overall turnout figure for 2005 masks considerable variation in participation rates across constituencies. Turnout ranged from 76.4 per cent in Dorset West to 41.5 per cent in Liverpool Riverside.

by ETHNICITY

People from black and minority ethnic (BME) communities had a lower propensity to vote than the population as a whole, according to the estimates developed by MORI (from polling during the election campaign) and the British Election Study (BES).

According to a post-election survey of BME attitudes towards the 2005 General Election conducted by MORI on behalf of the Electoral Commission, self-reported turnout varied among different BME communities. Turnout was higher among the main Asian national-origin groups (i.e. Indian, Pakistani and Bangladeshi) than among the main Black groups (African and Caribbean). Lower still, however, was turnout among the Mixed-race group and 'others'. As with the British population as a whole, abstention was highest among younger BME people, but for BME communities it appears that this 'young' group includes not only 18–24-year-olds but also 25–34-year-olds, whose turnout was just as low.

by SOCIAL GROUP

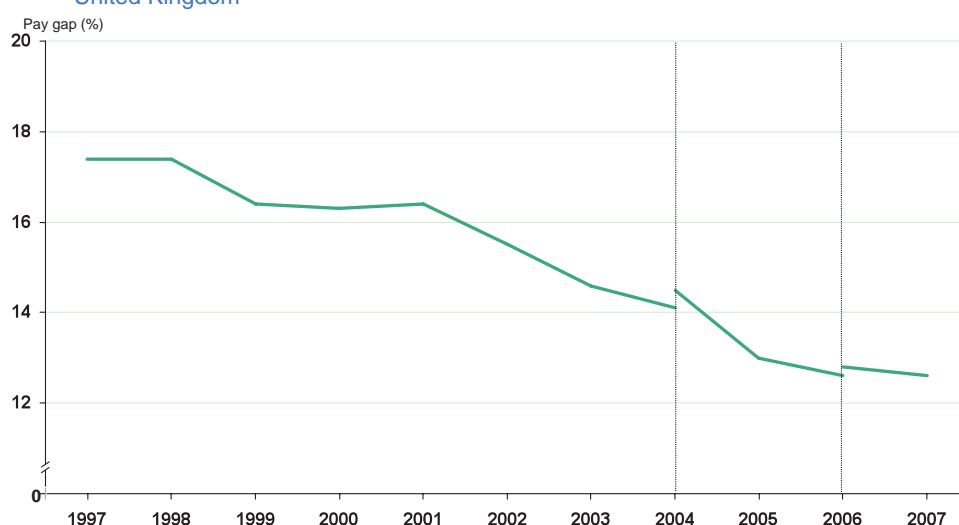
As at previous General Elections, there was a strong association in 2005 between turnout and constituency characteristics, in terms not only of seat type (i.e. marginality) but also of socio-economic profile and degree of affluence. Put simply, turnout was generally higher the more affluent the area and/or the more marginal the seat. Statistical analysis for the Electoral Commission shows strong correlations between a constituency's turnout and the housing profile and extent of car ownership within that constituency. Similarly, even after allowing for the marginality (or otherwise) of the constituency, there is an association between turnout and indicators of the social characteristics of the constituency such as the percentage who say they are in good health or the percentage who are manual workers. The BES survey found self-reported turnout of 49 per cent among those living in households with an annual income of £15,000 or less compared with 68 per cent among those in all other households.

Election 2005: turnout, The Electoral Commission
www.electoralcommission.org.uk/document-summary?assetid=47256

MORI (2005) *Black and Minority Ethnic Survey*. Research study conducted for the Electoral Commission
www.electoralcommission.org.uk/document-summary?assetid=47260

A.2: Socio-economic and political context – Economic and labour systems: Income distribution

Gender pay gap: gap between women's and men's median hourly earnings, 1997–2007
United Kingdom



Notes: 1997–2004 excludes supplementary information. 2006–07 is based on new methodology. Hourly earnings, excluding overtime, for full-time employees on adult rates, whose pay for the survey period was unaffected by absence. Source: Office for National Statistics (2007) 2007 Annual Survey of Hours and Earnings (p.6).

Gap between women and men's median hourly earnings, excluding overtime (expressed as a percentage of men's median earnings)

Full-time employees on adult rates, whose pay for the survey period was unaffected by absence

United Kingdom

Pay gap (%)	Excluding supplementary surveys								Including supplementary surveys			Revised methodology	
	1997	1998	1999	2000	2001	2002	2003	2004	2004	2005	2006	2006	2007
Pay gap (%)	17.4	17.4	16.4	16.3	16.4	15.5	14.6	14.1	14.5	13.0	12.6	12.8	12.6

Notes: Results for 2004 and earlier exclude supplementary surveys. In 2006 there were a number of methodological changes. Source: Office for National Statistics (2007) First Release: 2007 Annual Survey of Hours and Earnings (p.6).

by GENDER

The gender pay gap (as measured by the median hourly pay of full-time employees, excluding overtime) narrowed between 2006 and 2007 to its lowest value since records began. The gap between women's median hourly pay and men's was 12.6 per cent in April 2007 (expressed as a percentage of the men's median), compared with a gap of 12.8 per cent recorded in April 2006. The median hourly rate for men went up 2.8 per cent to £11.96, while the rate for women increased by 3.1 per cent to £10.46.

Although median hourly pay provides a useful comparison between the earnings of men and women, it does not necessarily indicate differences in rates of pay for comparable jobs. Pay medians are affected by the different work patterns of men and women, such as the proportions in different occupations and their length of time in jobs.

Office for National Statistics Annual Survey of Hours and Earnings
www.statistics.gov.uk/StatBase/Product.asp?vlnk=13101

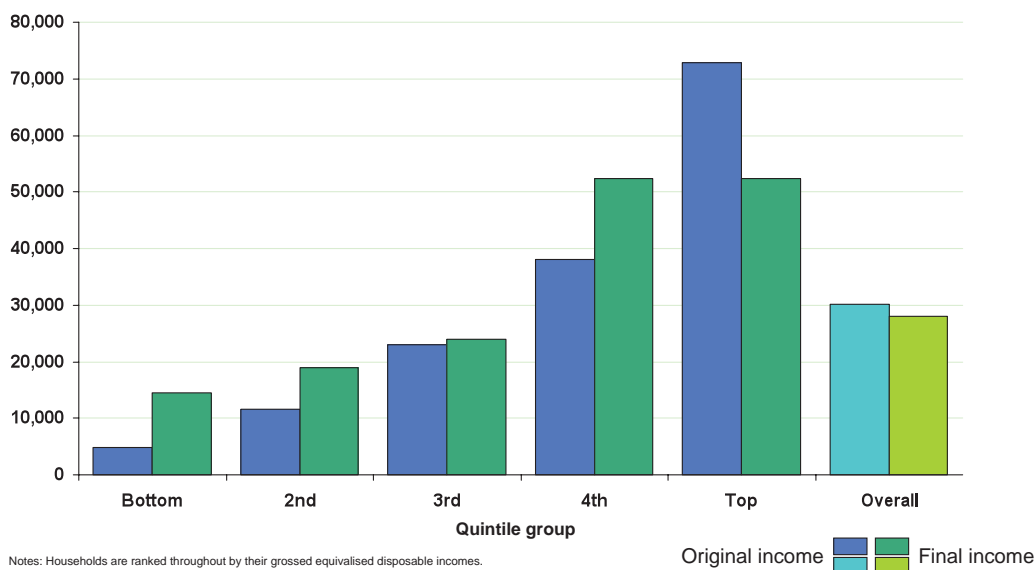
Indicator **A.4** shows employment by industry, by gender. **A.16** shows part-time employment rates by gender. **A.17a** shows labour participation rates by gender.

A.3: Socio-economic and political context – Economic and labour systems: Income redistribution

Original income and final income

By quintile groups for all households, United Kingdom, 2006/07

Average annual income per household (£)



Notes: Households are ranked throughout by their grossed equivalised disposable incomes.

Average income figures are unequivalised.

Source: 'The effects of taxes and benefits on household income, 2007/07'. *Economic & Labour Market Review* (2)7:37–47, A1–A27.

Percentage shares of household income and Gini coefficients, 2006/07

Quintile group	Percentage shares of equivalised income of all households			
	Original income	Gross income	Disposable income	Post-tax income
Bottom	3	7	7	6
2nd	7	11	12	11
3rd	15	16	16	16
4th	24	23	22	22
Top	51	44	42	44
All households	100	100	100	100
Decile group				
Bottom	1	3	3	2
Top	33	29	27	29
Gini coefficient (per cent)	52	38	34	39

Notes: The Gini coefficient is a measure of the dispersion of each definition of income. Households are ranked by equivalised disposable incomes. Quintile totals shown may not sum to 100 due to rounding.

Government intervention through the tax and benefit system alters the distribution of incomes between households, and thus the magnitude of income inequalities. To capture the redistributive effects of taxes and benefits, analyses distinguish between original income, gross income, disposable income and post-tax income. Some analyses go further and take account of welfare services received by households, such as healthcare and education, and impute a monetary value to these 'benefits in kind' to arrive at a final income figure.

Original income is income before government intervention, i.e. the income coming into a household from employment, occupational pensions, investments etc. before any tax is paid or any cash benefits are received.

Gross income is original income together with cash benefits received by a household, for example the state retirement pension.

Disposable income is income after direct taxes are deducted, i.e. gross income less income tax, employee's national insurance contribution and council tax.

Post-tax income takes account of indirect taxes such as VAT and duty on cigarettes, alcohol, petrol etc.; in other words it is disposable income less indirect taxes.

Final income takes account of goods and services that the Government provides which are either free or subsidised at the point of use. The imputed value of these ‘benefits in kind’ is based on the estimated cost of providing them. For example, the benefit in kind from the NHS is estimated according to the age and sex composition of the household – the imputed benefit is relatively high for young children, lower for older children and younger adults, and then higher again for older adults.

The chart above presents information on inequalities in original and final income; the table beneath presents information on inequalities in original, gross, disposable and post-tax income. The chart is based on unequivalised income, while the table is based on equivalised income (equivalisation adjusts household incomes to recognise differing demands on resources on the basis of household size and composition).

In general, households in the upper part of the income distribution pay more in taxes than they receive in benefits, while the reverse is true for those in the lower part of the distribution. **Taxes and benefits therefore reduce income inequality.** In 2006/07, before taxes and benefits, the top fifth of households had an average of £72,900 per year in original income from sources such as earnings, occupational pensions and investments. This is around 15 times as great as the figure of £4,900 for the bottom fifth. After taking account of taxes and benefits, the top fifth had an average final income of £52,400 compared with £14,400 for the bottom fifth of households, a ratio of four to one. (These figures are unequivalised income.)

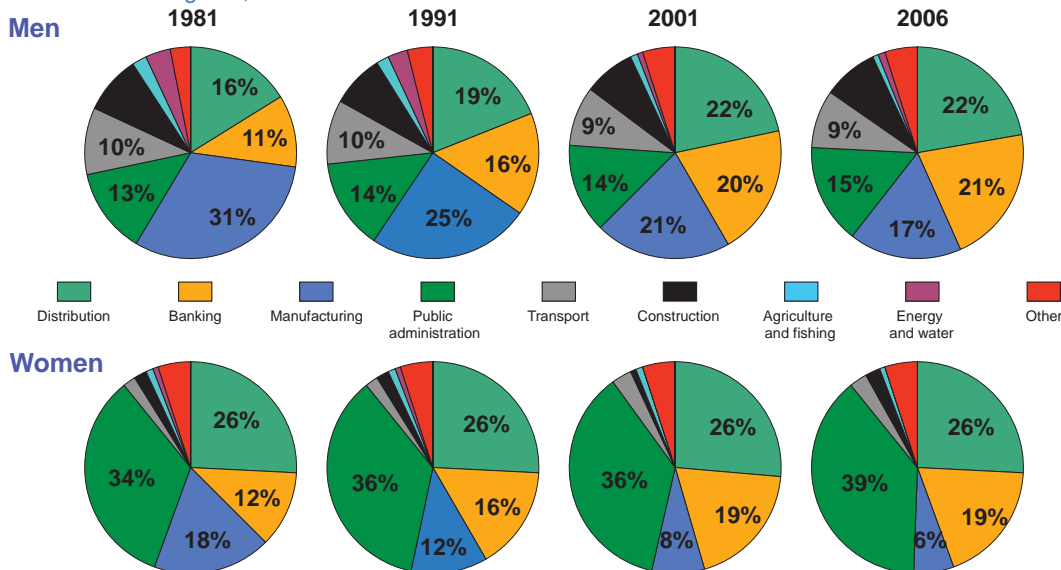
Indicator A.11 presents data about income distribution as measured by the Gini coefficient for each year from 1981 to 2006/07, which shows different trends in income inequality depending on the measure of income and the time period selected. More detail on the redistributive effects of taxes and benefits can be found in the following Office for National Statistics (ONS) publication:

Jones, F (2008) The effects of taxes and benefits on household income, 2006/07
Economic & Labour Market Review (2)7: 37–47, A1–A27
www.statistics.gov.uk/elmr/07_08/downloads/ELMR_Jul08_Jones.pdf

A.4: Socio-economic and political context – Economic and labour systems: Employment by sector

Employment by industry

United Kingdom, 1981–2006



Note: Data refers to June of each year.
 Source: Office for National Statistics (2007) *Social Trends* (no 37) table 4.9; p.48; Office for National Statistics (2005) *Social Trends* (no 35) p.52; Office for National Statistics (2004) *Social Trends* (no 34) p.59.
 Data from the Short-term Turnover and Employment Survey.

Employee jobs by gender and industry

United Kingdom

	Percentages			
	Men		Women	
	1981	1991	2001	2006
Distribution, hotels and restaurants	16	19	22	22
Banking, finance and insurance	11	16	20	21
Manufacturing	31	25	21	17
Public administration, education and health	13	14	14	15
Transport and communication	10	10	9	9
Construction	9	8	8	8
Agriculture and fishing	2	2	1	1
Energy and water	4	3	1	1
Other services	3	4	5	5
All employee jobs (=100%) (millions)	13.1	12.0	13.1	13.5

	Percentages			
	Men		Women	
	1981	1991	2001	2006
Distribution, hotels and restaurants	26	26	26	26
Banking, finance and insurance	12	16	19	19
Manufacturing	18	12	8	6
Public administration, education and health	34	36	36	39
Transport and communication	2	2	3	3
Construction	2	2	1	2
Agriculture and fishing	1	1	1	1
Energy and water	1	1	-	-
Other services	5	5	5	5
All employee jobs (=100%) (millions)	10.2	11.8	12.9	13.3

Notes: Data refers to June each year and not seasonally adjusted.
 'Other services' comprise community, social and personal services including sanitation, dry cleaning, personal care and recreational, cultural and sporting activities.
 Percentages may not sum to 100 due to rounding.
 Source: Office for National Statistics (2007) *Social Trends* (no 37) table 4.9, p.48; Office for National Statistics (2005) *Social Trends* (no 35) p.52; Office for National Statistics (2004) *Social Trends* (no 34) p.59.

by GENDER

Over the last 25 years the UK economy has experienced structural change. Overall changes are reflected in the industry breakdown of employee jobs by gender. In June 1981, 31 per cent of male employee jobs were in manufacturing but by June 2006 this had fallen to 17 per cent. The proportion of female employee jobs in the manufacturing sector also fell over the period, from 18 per cent to 6 per cent. The largest increase in both male and female employee jobs over the period was in the banking, finance and insurance industries, which accounted for around one in five of both male and female employee jobs in June 2006, compared with around one in ten in June 1981.

In 1981, a higher number of employee jobs were performed by men (13.1 million) than by women (10.2 million). However, by 2006 the gap between the sexes had narrowed, with 13.5 million

employee jobs being performed by men compared with 13.3 million being performed by women. Note that the pie charts and table are based on jobs rather than people – one person may have more than one job, and jobs may vary in the number of hours' work they involve.

A different approach to analysis presents data on the distribution of occupations among all in employment. The **pattern of occupations** followed by men and women is quite different: male employees are most likely to be employed as managers or senior officials while female employees are most likely to be employed in administrative and secretarial work. Around one in seven (14 per cent) of female employees work in personal service (for example hairdressers and child care assistants) and one in eight (12 per cent) work in sales and customer service – occupations which are far more uncommon among male employees. Only the professional occupations, associate professional and technical occupations (such as nurses, financial advisers and IT technicians) and the elementary occupations (such as catering assistants, bar staff and shelf fillers) are almost equally likely to be followed by both male and female employees: between around one in seven and one in nine are employed in each of these groups of occupations.

ONS, *Social Trends*

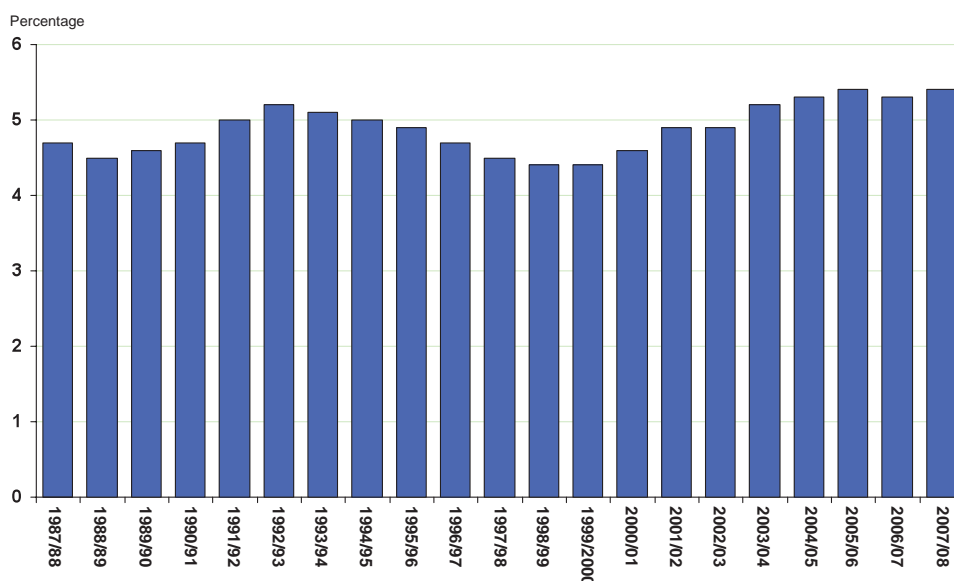
www.statistics.gov.uk/StatBase/Product.asp?vlnk=5748&Pos=&ColRank=1&Rank=422

Indicator **A.2** shows the gender pay gap. **A.16** shows part-time employment rates by gender. **A.17a** shows labour participation rates by gender.

A.5: Socio-economic and political context – Social policies: Government commitment to education

Education spending as a percentage of GDP

United Kingdom, 1987/88–2007/08



Note: Data on financial year basis.
Source: HM Treasury; Public Expenditure Statistical Analyses (via DCSF).

Total education spending as a percentage of GDP

United Kingdom

Year	Percentage	Year	Percentage
1978/79	5.1	1993/94	5.1
1979/80	4.9	1994/95	5.0
1980/81	5.2	1995/96	4.9
1981/82	5.2	1996/97	4.7
1982/83	5.1	1997/98	4.5
1983/84	5.1	1998/99	4.4
1984/85	4.9	1999/2000	4.4
1985/86	4.6	2000/01	4.6
1986/87	4.8	2001/02	4.9
1987/88	4.7	2002/03	4.9
1988/89	4.5	2003/04	5.2
1989/90	4.6	2004/05	5.3
1990/91	4.7	2005/06	5.4
1991/92	5.0	2006/07	5.3
1992/93	5.2	2007/08	5.4

Notes: Data on financial year basis.
Figures up to and including 1986/87 are based on HM Treasury defined functions, while those from 1987/88 are based on the UN Classification of the Functions of Government; there is therefore a break in the time series after 1986/87.
Source: HM Treasury; Public Expenditure Statistical Analyses (via DCSF).
www.dcsf.gov.uk/rsgateway/DB/TIM/m002002/index.shtml
www.dcsf.gov.uk/rsgateway/DB/VOL/v000823/index.shtml

Education spending as a proportion of Gross Domestic Product (GDP) fell during the 1990s, from 5.2 per cent in 1992/93 (financial year) to a low of 4.4 per cent in 1998/99 and 1999/2000. Since then, the proportion of GDP spent on education in the UK has increased, and stood at 5.4 per cent in 2007/08.

Expenditure on education services by central and local government in the UK in 2007/08 (financial year) is estimated to have totalled £76.2 billion, including £4.4 billion directly on under-fives, £45.4 billion on primary and secondary education, £8.7 billion on post-secondary non-tertiary education and £11.5 billion on tertiary education. Expenditure on education services by central and local government in the UK increased by some 49 per cent in real terms (i.e. at 2006/07 price levels) between 1995/96 (£47.4 billion) and 2006/07 (£70.7 billion).

DCSF (2008) *Education and Training Statistics for the United Kingdom 2008*
www.dcsf.gov.uk/rsgateway/DB/VOL/v000823/index.shtml

Indicator **A.6** shows the percentage of 16-year-olds with at least five GCSEs at grades A*–C. **A.20** shows similar data broken down by ethnicity.

A.6: Socio-economic and political context – Social policies: Commitment to education for all

Percentage of 16-year-olds with at least five GCSEs or equivalent at grades A*–C

England, 1996/97–2006/07



Source: Department for Children, Schools and Families (2008) Statistical first release (SFR 01/2008) GCSE and equivalent examination results in England 2006/07 (Revised).

Percentage of 16-year-olds with at least five GCSEs or equivalent at grades A*–C

England

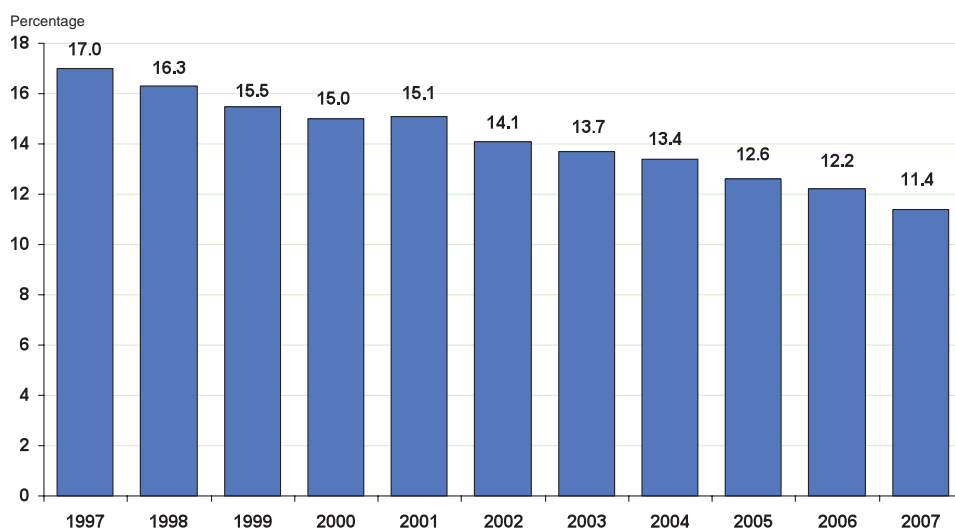
1996/97	45.1
1997/98	46.3
1998/99	47.9
1999/00	49.2
2000/01	50.0
2001/02	51.6
2002/03	52.9
2003/04	53.7
2004/05	56.3
2005/06	58.5
2006/07	60.8

Notes: Figures take account of grades achieved in previous academic years.
 Figures for 2006/07 are revised, all other figures are final.
 Percentages from 1996/97 include GCSEs and GNVQs.
 Percentages from 2003/04 include GCSEs and other equivalent qualifications approved for use pre-16.

The percentage of 16-year-olds with at least five GCSEs at grades A*–C continues to rise.

Indicator **A.20** shows the percentage of Year 11 pupils with at least five GCSEs at grades A*–C by ethnicity. **A.5** shows education spending as a percentage of GDP.

A.7a: Socio-economic and political context – Social policies: Commitment to education for all
Working-age adults with no qualifications
 England, 1997–2007



Note: Figures cover women aged 19–59 and men aged 19–64.
 Source: Department for Innovation, Universities and Skills (2008) *The level of highest qualification held by adults: England 2007*. (SFR 05-2008) (Table 1).

In 2007, 11.4 per cent of people aged 19–59/64⁹⁰ in England had no qualifications. This equates to 3.4 million people out of 29.6 million. Women were slightly more likely than men to possess no educational qualifications (11.8 per cent versus 11.0 per cent). The gap between men and women has narrowed over time, from 3.2 percentage points in 2001 to 0.8 percentage points in 2007.

The proportion of people aged 19–59/64 in England with no qualifications continues to fall. There was a reduction of 0.8 percentage points between 2006 and 2007 (from 12.2 per cent), and there was a 3.7 percentage point decrease between 2001 and 2007. This is the equivalent of around 0.9 million fewer people with no qualifications.

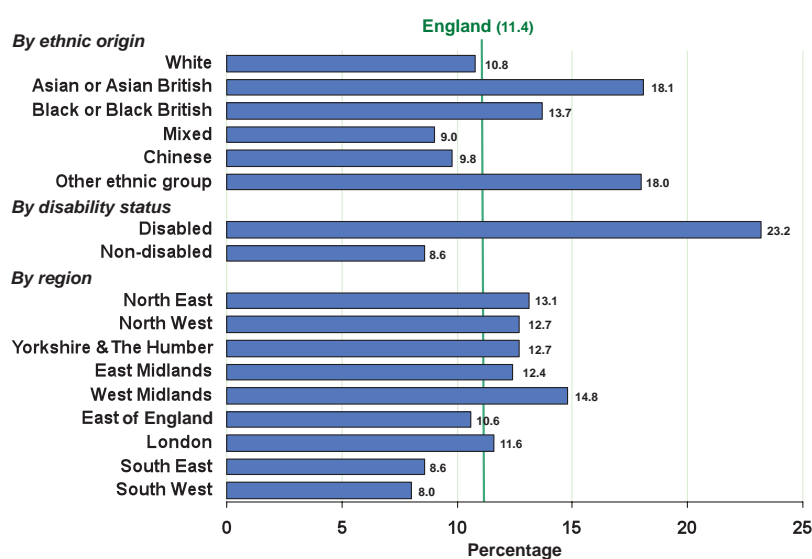
The proportion of people with no qualifications tends to increase with age. Less than 8 per cent of those aged 19–34 had no qualifications in 2007, compared with 20.1 per cent of those aged 55–64.

People who are unemployed were more than twice as likely in 2007 as employees aged 19–59/64 to have no qualifications (16.7 per cent versus 7.0 per cent), and those who are economically inactive were even more so (26.3 per cent).

Department for Innovation, Universities & Skills (2008)
The Level Of Highest Qualification Held By Adults: England 2007 (Revised)
 (DIUS SFR 05/2008)
www.dfes.gov.uk/rsgateway/DB/SFR/s000798/DIUSSFR05-2008.pdf

⁹⁰ Men aged 19–64 and women aged 19–59.

A.7b: Socio-economic and political context – Social policies: Commitment to education for all
Working-age adults with no qualifications – by selected subgroups
 England, 2007 Q4



Note: Figures cover women aged 19–59 and men aged 19–64.
 Source: Department for Innovation, Universities and Skills (2008) *The level of highest qualification held by adults: England 2007*. (SFR 05-2008) (Table 1).

Individuals who were classified as disabled were more likely in 2007 to have no qualifications than the non-disabled (23.2 per cent versus 8.6 per cent). This difference was even greater for those whose disability was most acute (long-term disability affecting both day-to-day and work-related activities) of whom nearly a third (30.0 per cent) had no qualifications.

Individuals with an Asian or Asian British background and those from ‘other’ ethnic groups were most likely to have no qualifications (18.1 and 18.0 per cent respectively), while those from a Mixed ethnic or Chinese background were least likely (9.0 and 9.8 per cent respectively).

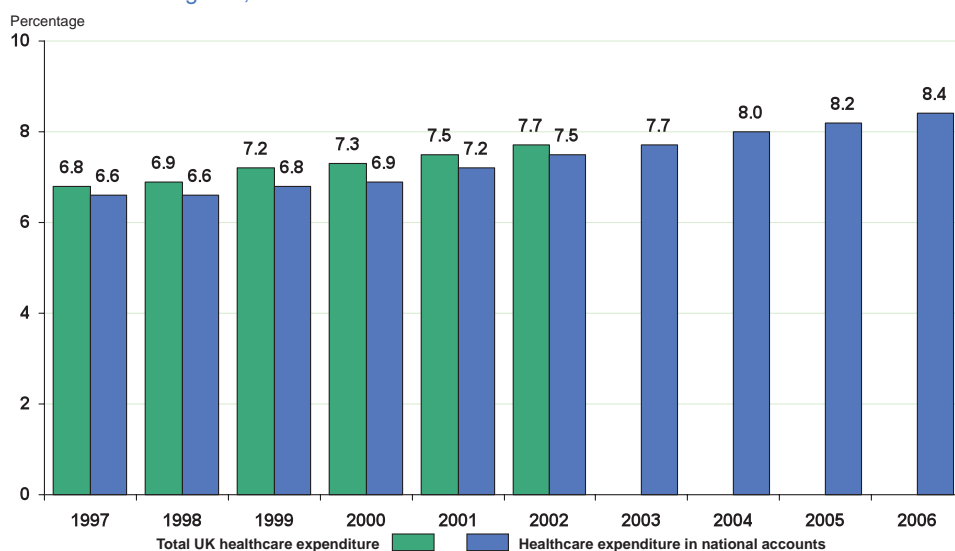
Regions in the Midlands, the North and London had higher proportions of working-age adults with no qualifications than the East, South East and South West – ranging from 14.8 per cent in the West Midlands to 8.0 per cent in the South West.

Indicators **A.5**, **A.6** and **A.20** cover aspects of education spending and attainment. Indicators **A.2**, **A.3**, **A.4**, **A.14**, **A.15**, **A.16**, **A.17** and **A.19** cover various aspects of employment and earnings. Indicator **A.13** covers adult literacy.

A.8: Socio-economic and political context – Social policies: Resources used in the health sector

Government and household expenditure on healthcare as a percentage of GDP

United Kingdom, 1997–2006



Source: Office for National Statistics (2008) *Expenditure on Health Care in the UK 1997–2006* (Table 2).

ONS makes available two sets of estimates of expenditure on healthcare in the UK, reflecting two different uses:

- (i) **total UK healthcare expenditure estimates.** These are the best estimates for comparing the level of healthcare expenditure across countries. The data is only available for the years 1997 to 2002. In addition to government and household expenditure on healthcare, these estimates include other types of healthcare spending, including by charities.
- (ii) **estimates of healthcare expenditure from the UK National Accounts.** These are not the best estimates for making international comparisons of the level of healthcare expenditure, because they only cover government and household expenditure on healthcare. Nevertheless, they give an indication of how UK healthcare expenditure may have changed in more recent years. The data is available for years up to 2006.

Total UK healthcare expenditure was estimated at 7.7 per cent of GDP for 2002, the last year for which figures are available. Since then, the estimate of UK healthcare expenditure as a percentage of GDP from the National Accounts has risen by 0.9 percentage points, from 7.5 per cent in 2002 to 8.4 per cent in 2006.

These figures include public and private healthcare expenditure in the UK. For the National Accounts-based series, public expenditure comprises government current and capital expenditure, while private expenditure comprises household expenditure on health. In 2006, the public share of expenditure according to the National Accounts-based series was 87.3 per cent, having increased from 84.0 per cent in 1997.

Office for National Statistics (2008)

Expenditure on Health Care in the UK 1997–2006

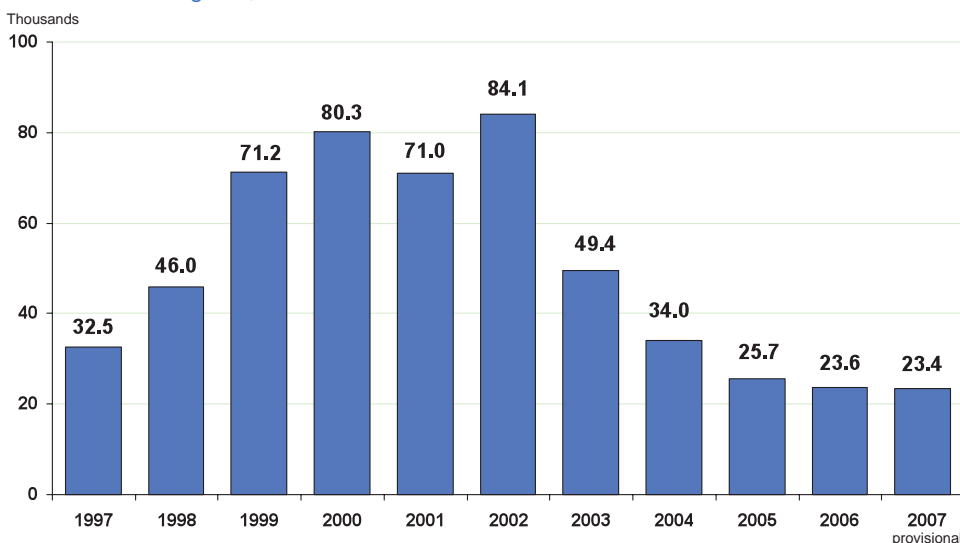
www.statistics.gov.uk/CCI/article.asp?ID=1988&Pos=2&ColRank=2&Rank=224

According to the Organisation for Economic Co-operation and Development (OECD), the estimate of UK healthcare expenditure from the National Accounts of 8.4 per cent of GDP in 2006 compares with an average of 8.9 per cent across OECD countries. In terms of per capita spending on health, the United Kingdom closely matches the OECD average, with spending of US\$2,760 in 2006 (adjusted for purchasing power parity), compared with an OECD average of US\$2,824.

Organisation for Economic Co-operation and Development (2008)
OECD Health Data 2008: How Does the United Kingdom Compare
www.oecd.org/dataoecd/46/4/38980557.pdf

Indicator **A.28** shows the number of GPs per 100,000 population.

A.9a: Socio-economic and political context – War, conflict and militarisation
Applications received for asylum, excluding dependants
 United Kingdom, 1997–2007

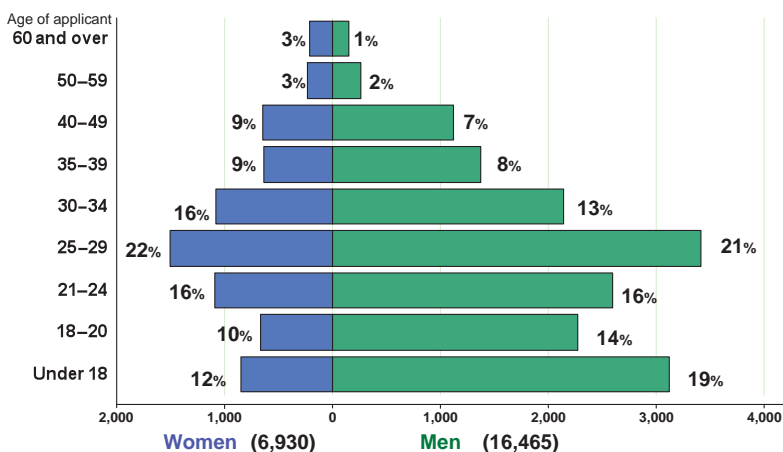


Source: Home Office (2008) Home Office Statistical Bulletin: Asylum Statistics United Kingdom 2007.

Excluding dependants, the number of asylum applications received in 2007 was 23,430, 1 per cent less than in 2006 (23,610), continuing the fall from the peak of 84,130 in 2002.

Including dependants, the number of asylum applications received in 2007 was 28,300, similar to the number received in 2006 (28,320).

A.9b: Socio-economic and political context – War, conflict and militarisation
Applications received for asylum, excluding dependants
 United Kingdom, by age and gender, 2007



Note: There were 35 applications where the applicant's gender was unknown.
 Source: Home Office (2008) Home Office Statistical Bulletin: Asylum Statistics United Kingdom 2007.

The majority of principal applicants in 2007 were under 35 years old (80 per cent), 16 per cent aged between 35 and 49, and just 4 per cent aged 50 or older. 70 per cent of principal applicants in 2007 were male, compared with 70 per cent in 2006 and 71 per cent in 2005. Over three-quarters of both male and female applicants in 2007 were less than 35 years old, similar to 2006 and 2005 figures.

The nationalities accounting for the most applicants in 2007 were Afghan (2,500 applicants; 11 per cent of total applications), Iranian (2,210; 9 per cent), Chinese (2,100; 9 per cent), Iraqi (1,825; 8 per cent) and Eritrean (1,810; 8 per cent). Compared with 2006, applications increased from nationals of Afghanistan (by 4 per cent), China (by 8 per cent) and Iraq (by 93 per cent). Applications fell from nationals of Iran (by 7 per cent) and Eritrea (by 30 per cent).

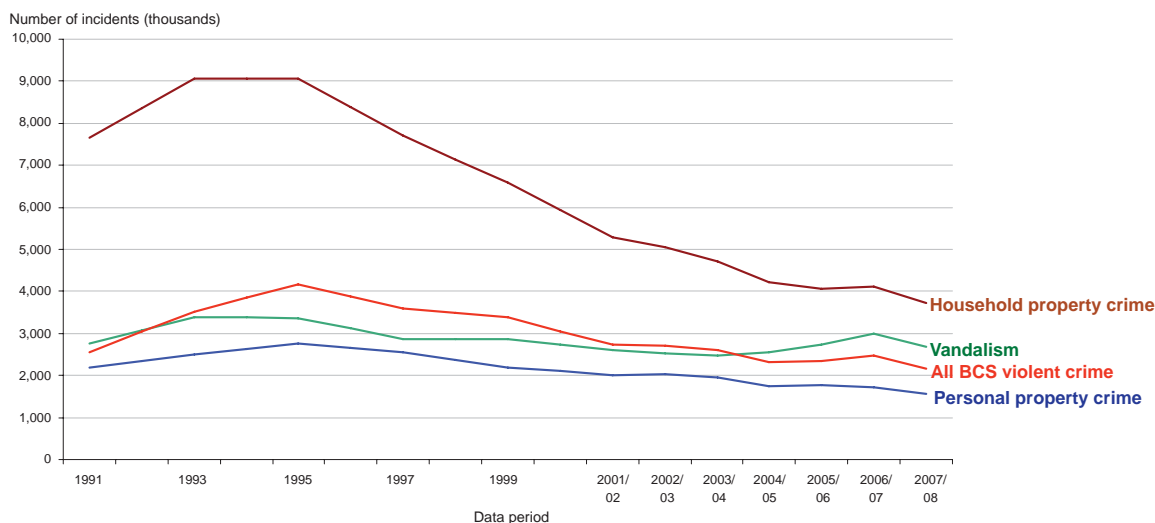
There were 4,870 dependants accompanying or subsequently joining principal applicants in 2007, an average of one dependant for every five principal applicants. However, this average varied greatly between different nationalities. Most dependants (80 per cent) in 2007 were under 18 and a little over half (56 per cent) were female.

Home Office (2008)

Home Office Statistical Bulletin: Asylum Statistics United Kingdom 2007

www.homeoffice.gov.uk/rds/pdfs08/hosb1108.pdf

A.10a: Socio-economic and political context – Values of inclusive citizenship
Trends in incidence of crime (reported in the British Crime Survey)
 England and Wales, 1991–2007/08



Notes: Household property crime includes burglary and vehicle, bicycle and other household thefts.
 Personal property crime includes thefts from the person and other thefts of personal property.
 More complete descriptions of categories can be obtained from the glossary of the British Crime Survey.
 From 2001/02, figures relate to interviews carried out in that financial year and incidents experienced in the 12 months prior to interview.
 Source: Home Office (2008) *Home Office Statistical Bulletin: Crime in England and Wales 2007/08* (Table 2.01).

Trends in BCS incidence of crime

	Number of incidents (000s)									
	1991	1995	1997	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08
Property crime										
Vandalism	2,759	3,366	2,866	2,603	2,535	2,465	2,564	2,731	2,993	2,689
Household	7,651	9,060	7,697	5,275	5,057	4,717	4,227	4,060	4,108	3,734
Person	2,177	2,750	2,556	2,011	2,034	1,947	1,738	1,772	1,715	1,557
Violent crime										
All BCS violent crime	2,556	4,176	3,593	2,728	2,714	2,597	2,320	2,349	2,471	2,164
All BCS crime	15,142	19,351	16,712	12,618	12,341	11,725	10,850	10,912	11,287	10,143

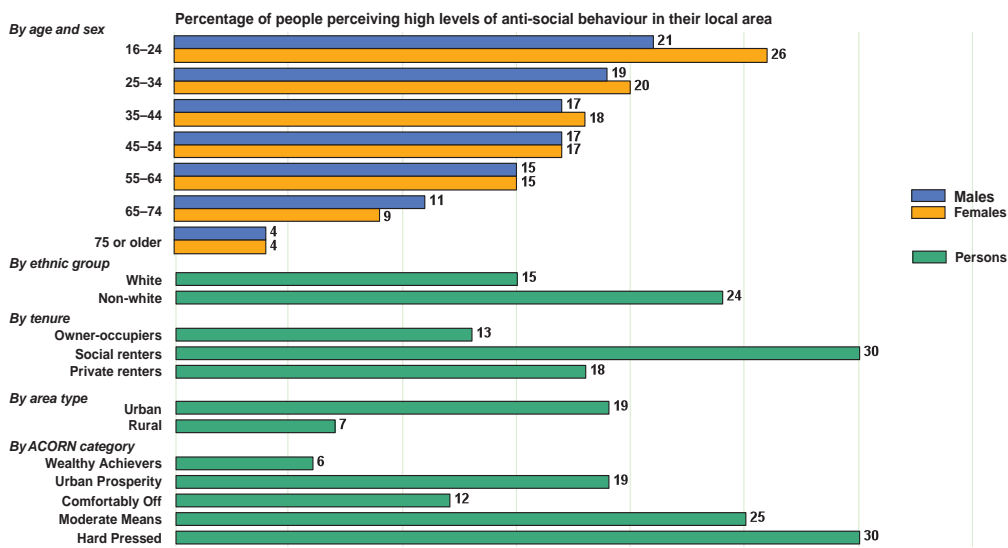
See graph above for definitions.
 Source: Home Office (2008) *Home Office Statistical Bulletin: Crime in England and Wales 2007/08* (Table 2.01).

The British Crime Survey (BCS) is a nationally representative survey of adults living in private households. For the crime types it covers, the BCS can provide a better reflection of the true extent of household and personal crime than police recorded crime statistics, because it includes crimes that are not reported to the police and crimes that are not recorded by them. BCS violent crime includes wounding, assault with minor injury, assault with no injury and robbery. Sexual offences are not included.

Long-term trends show that BCS crime rose steadily from 1981 through to the early 1990s, peaking in 1995. Crime then fell, making 1995 a significant turning point. The fall was substantial until 2004/05, when BCS crime levels stabilised until the further decline in 2007/08. BCS crime is now at its lowest ever level since the first results in 1981.

All household and personal crime remains at significantly lower levels compared with its highest point in 1995. Since 1995, vehicle-related thefts, domestic burglary and other household thefts have each fallen by over a half (66 per cent, 59 per cent and 53 per cent respectively). Vandalism as measured by the BCS has fallen by 20 per cent over the same period. The BCS also shows that since 1995 overall violent crime has fallen by 48 per cent, assault with minor injury by 65 per cent, assault with no injury by 42 per cent and wounding by 49 per cent.

A.10b: Socio-economic and political context – Values of inclusive citizenship
Perceptions of anti-social behaviour by personal characteristics
 England and Wales, 2007/08



Note: This measure is derived from responses to seven individual anti-social behaviour strands as described in the text.
 Source: Home Office (2008) *Home Office Statistical Bulletin: Crime in England and Wales 2007/08* (Table 5.04).

The BCS measures high levels of perceived anti-social behaviour by means of responses to questions about perceptions of seven individual anti-social behaviour issues:

- noisy neighbours or loud parties;
- teenagers hanging around on the streets;
- rubbish or litter lying around;
- vandalism, graffiti and other deliberate damage to property;
- people using or dealing drugs;
- people being drunk or rowdy in public places; and
- abandoned or burnt-out cars.

ACORN ('A Classification of Residential Neighbourhoods') classifies households into one of 56 ACORN types according to demographic, employment and housing characteristics of the surrounding neighbourhood. Further details are available in the glossary of *Crime in England and Wales 2007/08*.

The 2007/08 BCS found that perceptions of high levels of anti-social behaviour decreased with age. Both men and women aged 16 to 24 years were generally more likely to perceive high levels of anti-social behaviour (21 per cent and 26 per cent respectively) than older age groups. Those aged 75 years and over were least likely to perceive high levels (4 per cent of both men and women).

There were considerable variations across ACORN categories, between urban and rural areas, and by type and tenure of accommodation in the level of perceptions of anti-social behaviour. Those living in 'Hard Pressed' ACORN areas were considerably more likely to perceive high levels of anti-social behaviour (30 per cent) than those in other ACORN areas, in particular 'Wealthy Achiever' areas (6 per cent). Thirty per cent of people living in social rented accommodation perceived high levels of anti-social behaviour, compared with 18 per cent of people in private rented accommodation and 13 per cent of those in owner-occupied accommodation.

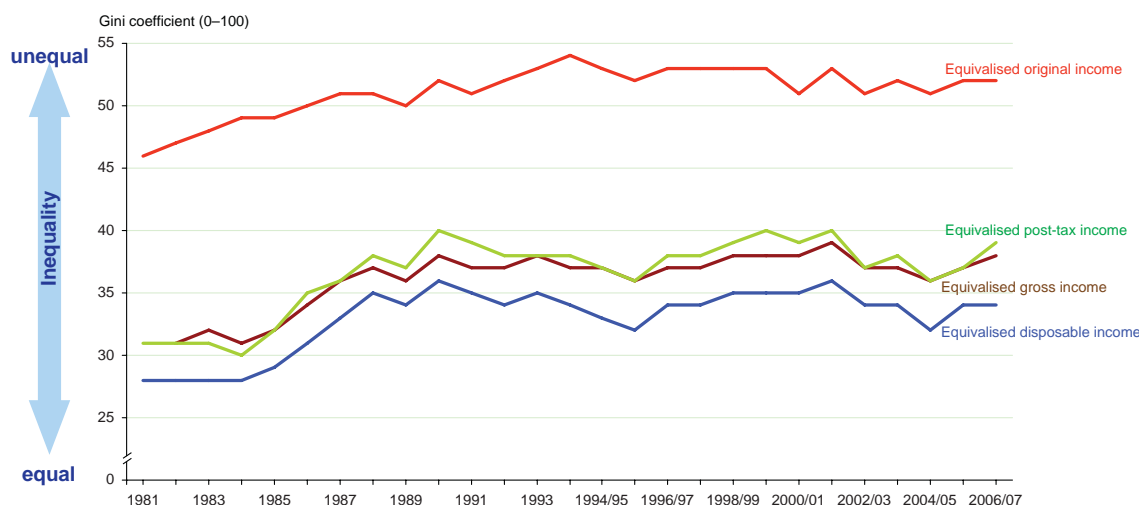
Indicator **A.18** covers domestic violence.

Additional breakdowns by personal characteristics can be found in Table 5.04 (page 137) of:
 Home Office (2008)

Home Office Statistical Bulletin: Crime in England and Wales 2007/08

www.homeoffice.gov.uk/rds/pdfs08/hosb0708.pdf

A.11: Social stratification – Economic status: Income inequality
Income inequality (Gini coefficient)
 Great Britain, 1981–2006/07



Source: Office for National Statistics (2008) *The effects of taxes and benefits on household income, 2006/07* (Appendix 1, Table 27).

Gini coefficients 1980 to 2006/07

Percentages	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993
Equivalised original income	44	46	47	48	49	49	50	51	51	50	52	51	52	52
Equivalised gross income	31	31	31	32	31	32	34	36	37	36	38	37	37	38
Equivalised disposable income	28	28	28	28	28	29	31	33	35	34	36	35	34	35
Equivalised post-tax income	30	31	31	31	30	32	35	36	38	37	40	39	38	38

	1993/94	1994/95	1995/96	1996/97	1997/98	1998/99	1999/2000	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07
Equivalised original income	54	53	52	53	53	53	53	51	53	51	52	51	52	52
Equivalised gross income	37	37	36	37	37	38	38	38	39	37	37	36	37	38
Equivalised disposable income	34	33	32	34	34	35	35	35	36	34	34	32	34	34
Equivalised post-tax income	38	37	36	38	38	39	40	39	40	37	38	36	37	39

Source: Jones, F (2008) *The effects of taxes and benefits on household income, 2006/07* (Appendix 1, Table 27). *Economic & Labour Market Review* 2(7): 37–47, A1–A27. www.statistics.gov.uk/elmr/07_08/downloads/ELMR_Jul08_Jones.pdf

The most widely used summary measure of inequality in the distribution of household income is the Gini coefficient. The Gini coefficient is a measure of the extent to which different groups of households receive differing shares of total national household income.

For example, the bottom 5 per cent of households might only have a 1 per cent share of total household income. The bottom 10 per cent of households might have a 3 per cent share; the bottom 20 per cent might have an 8 per cent share, and so on. The Gini coefficient is a measure of the overall extent to which these groupings of households, from the bottom of the income distribution upwards, receive less than an equal share of income. The lower its value, the more equally household income is distributed.

Office for National Statistics (2008)
Measuring inequality of household income: the Gini coefficient
www.statistics.gov.uk/about/methodology_by_theme/gini/default.asp

The Gini coefficients for gross, disposable and post-tax income all increased between 2004/05 and 2006/07. The increase in 2005/06 was primarily due to increased inequality of original income, with faster growth in wages and salaries and self-employment income in the upper part of the distribution compared with the lower part. This was to some extent reversed in 2006/07, although lower growth in average income from cash benefits compared with earnings had the effect of increasing inequality.

This followed a period between 2001/02 and 2004/05 when income inequality was falling. Over this period, there was a slight fall in inequality of original income due to faster growth in income from earnings and self-employment at the bottom end of the income distribution. Policy changes such as the increases in the national minimum wage, increases in tax credit payments, and the 2003/04 increase in National Insurance contributions will also have resulted in small reductions in inequality of disposable and post-tax income during this period. Inequality of disposable income increased in the late 1980s and, despite periods of both rising and falling inequality since 1990, has remained higher than it was in the late 1970s and early 1980s.

The Institute for Fiscal Studies has investigated some of the possible reasons for the higher level of inequality since 1990. There has been an increase in wage inequality, and particularly in the gap between wages for skilled and unskilled workers. Suggested reasons include skills-biased technological change, a decline in the role of trade unions, and a growth in self-employment income.

There has also been a decrease in the rate of male participation in the labour market, often in households where there is no other earner, as well as increased female participation among those with working partners. This has led to an increased polarisation between two-earner and zero-earner households. In the late 1990s, the proportion of people in workless households started to fall slowly, probably contributing to the small reduction in inequality of original income seen since 2001/02.

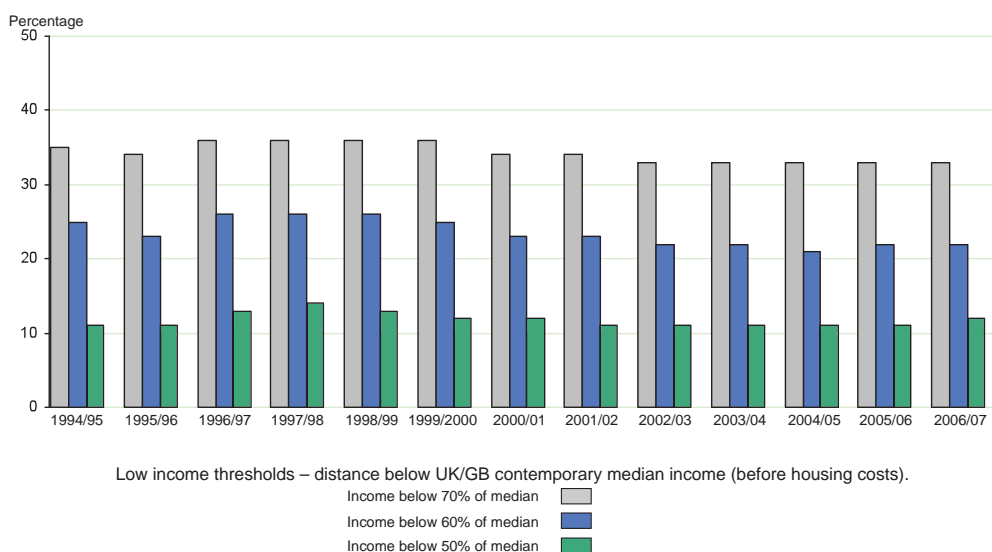
The difference between the Gini coefficients for original and post-tax income can be seen as a measure of monetary redistribution through the tax and benefit system (that is, one which excludes the effect of benefits in kind). To some extent this will be cyclical. While the Gini coefficient for original income was rising steadily throughout the 1980s, the Gini coefficient for post-tax income was stable for the first half of the 1980s but then rose sharply in the second half of the decade. This implies that through the early 1980s there was an increasing amount of redistribution, with a decreasing amount through the late 1980s.

Through the recession of the early 1990s and the subsequent early recovery, inequality of original income continued to increase, but more slowly, and increasing redistribution saw inequality of post-tax income gradually fall until 1995/96. In the late 1990s, inequality of original income was largely unchanged, while the level of redistribution started to decline again, resulting in a gradual increase in inequality of post-tax income until 2001/02.

Jones, F (2008) The effects of taxes and benefits on household income, 2006/07.
Economic and Labour Market Review 2(7): 37–47, A1–A27
www.statistics.gov.uk/elmr/07_08/downloads/ELMR_Jul08_Jones.pdf

The chart and table above are based on various measures of income: original income, gross income, disposable income, and post-tax income. These different measures are described at indicator **A.3**, which focuses on comparison of inequalities in original and final income.

A.12: Social stratification – Economic status: Poverty
Children living in low-income households
 England, 1994/95–2006/07



Notes: Estimates are for England only and are shown for single years. These may differ from estimates published elsewhere as three-year averages. Medians are based on United Kingdom data from 2002/03 onward and Great Britain data to 2001/02. A child is an individual under 16 years of age, or an unmarried 16 to 19-year-old in full-time education. Source: Department for Work and Pensions (2008) *Households Below Average Income, HBAI 1994/95–2006/07*.

Percentage of children living in households below thresholds of UK/GB contemporary median income
 England

	50%	60%	70%
1994/95	11	25	35
1995/96	11	23	34
1996/97	13	26	36
1997/98	14	26	36
1998/99	13	26	36
1999/2000	12	25	36
2000/01	12	23	34
2001/02	11	23	34
2002/03	11	22	33
2003/04	11	22	33
2004/05	11	21	33
2005/06	11	22	33
2006/07	12	22	33

Notes: Estimates are for children in England only and are shown for single years. These may differ from estimates for England published elsewhere as three-year averages. Medians are based on United Kingdom data from 2002/03 onward and Great Britain data to 2001/02. Source: Department for Work and Pensions (2008) *Households Below Average Income (HBAI)*.

Children are disproportionately present in low-income households. In 2006/07, 2.4 million children in England were living in relative low-income households (defined as households with below 60 per cent of median income before deduction of housing costs). This represents a fall of 500,000 since 1996/97. In percentage terms, after rising to a peak of 26 per cent in early 1996/97, the proportion of children in relative low-income households fell between 1997/98 and 2004/05 to 21 per cent, and then levelled off at 22 per cent in 2005/06 and 2006/07.

The proportion of children living in households with absolute low incomes (i.e. incomes below 60 per cent of the 1998/99 median) showed a large fall from 26 per cent in 1998/99 to 13 per cent in 2006/07 on the before housing costs measure.

Groups with an above average risk of low income in 2006/07

In 2006/07, 18 per cent of the UK population lived in households with below 60 per cent of contemporary median income before housing costs. The following were among the groups who were more likely to be in relative low-income households:

- **Children** – in particular, children in workless lone-parent families, children of couples where the parents were unemployed or worked only part-time, and those in families with three or more children.
- **Older pensioners** – those over 85 had a higher risk of low income than the overall UK population.

- **Workless households** – over half of working-age adults in workless households were living in low-income households on a before housing costs basis.
- **Ethnic minorities** – households headed by a member of certain ethnic minorities were more likely to have low incomes. This was particularly the case for households headed by someone of Pakistani or Bangladeshi ethnic origin, with 51 per cent of this group living in households with below 60 per cent of median income before housing costs.
- **Disabled people** – individuals in families containing one or more disabled people who were not in receipt of disability benefits were more likely to live in low-income households than those in families with no disabled person.
- **Social rented sector tenants** – individuals in this group were more likely to live in low-income households than other tenure types, with more than 30 per cent living in households with below 60 per cent of median income before housing costs.
- **Adults with no educational qualifications** – working-age adults with no educational qualification were about twice as likely to live in low-income households as those with a qualification below degree level.
- **Region/country** – individuals living in the North East of England were most likely to live in low-income households on a before housing costs basis. Those living in the South East and the East of England were least likely to live in low-income households.

Department for Work and Pensions (2008)

Households Below Average Income:

An analysis of the income distribution 1994/95–2006/07

www.dwp.gov.uk/asd/hbai.asp

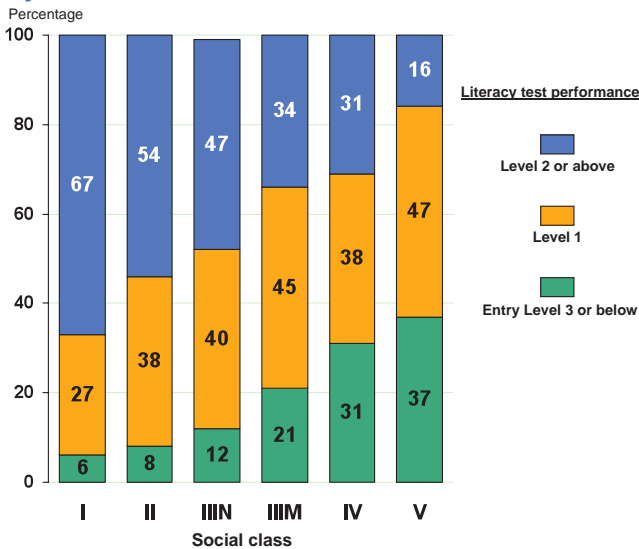
Indicator **A.21** covers households living in non-decent homes and **A.22** shows households in fuel poverty. A range of other indicators are presented that examine aspects of adult employment and earnings.

A.13: Social stratification – Education: Access to economic and educational opportunities

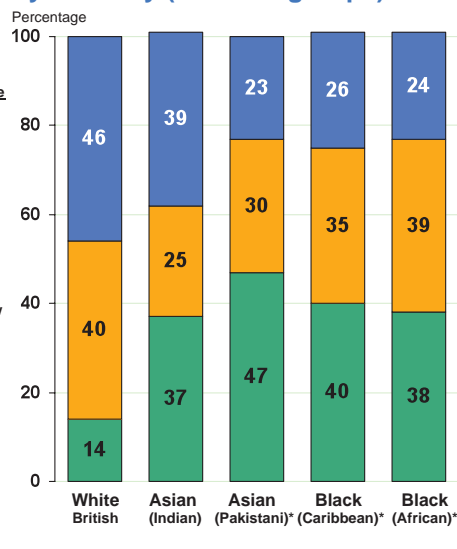
Adult literacy

England, 2002/03

by household social class



by ethnicity (selected groups)



Notes: Numbers may not sum to 100 due to rounding.

Base: all respondents with literacy level.

Source: Department for Education and Skills (2003) *The Skills for Life survey: A national needs and impact survey of literacy, numeracy and ICT skills.*

Literacy (reading) in English Language

Levels	An adult classified at this level...
Entry Level 1	<ul style="list-style-type: none"> Understands short texts with repeated language patterns on familiar topics Can obtain information from common signs and symbols
Entry Level 2	<ul style="list-style-type: none"> Understands short straightforward texts on familiar topics Can obtain information from short documents, familiar sources and signs and symbols
Entry Level 3	<ul style="list-style-type: none"> Understands short straightforward texts on familiar topics accurately and independently Can obtain information from everyday sources
Level 1	<ul style="list-style-type: none"> Understands short straightforward texts of varying length on a variety of topics accurately and independently Can obtain information from different sources
Level 2 or above	<ul style="list-style-type: none"> Understands a range of texts of varying complexity accurately and independently Can obtain information of varying length and detail from different sources

Around one in six respondents (16 per cent) to the *Skills for Life* survey were classified at Entry Level 3 or below in the literacy test. On this basis, it is estimated that 5.2 million adults in England had Entry Level 3 or lower-level literacy in 2002/03.

Only a minority of those surveyed (44 per cent) achieved Level 2 or above in the literacy test, which means that approximately 17.8 million adults had literacy skills at Level 1 or below in 2002/03.

by SOCIAL CLASS

Literacy test performance decreased with every step down from Social Class I to Social Class V. Respondents in Social Class I were roughly four times as likely as those in Social Class V to reach Level 2 or above (67 per cent compared with 16 per cent). More than one-third of those in Social Class V were classified at Entry Level 3 or below, including 12 per cent at Entry Level 1 or below.

by ETHNICITY

In the literacy test, respondents from the White British ethnic group tended to achieve higher levels of performance than respondents from other ethnic groups. Only 14 per cent of White British respondents were classified at Entry Level 3 or below, and 46 per cent achieved Level 2 or above.

Respondents from the Asian (Indian) ethnic group achieved the second-best levels of performance. Nearly four in ten (39 per cent) achieved Level 2 or above in the literacy test, only 7 percentage points short of the White British figure. However, they were much more likely to be classified at Entry Level 3 or below than the White British (37 per cent compared with 14 per cent). Literacy test performance varied a great deal among the Asian (Indian) ethnic group, with almost equal numbers at Level 2 or above as at Entry Level 3 or below.

Black Caribbeans and Black Africans were at least as likely as respondents from the Asian (Indian) ethnic group to be classified at Entry Level 3 or below (40 per cent and 38 per cent respectively), but much less likely to achieve Level 2 or above (26 per cent and 24 per cent respectively, compared with 39 per cent of the Asian (Indian) ethnic group).

Respondents from the Asian (Pakistani) ethnic group performed least well. Around one in four (23 per cent) achieved Level 2 or above in the literacy test – similar to the figures for the two Black ethnic groups – but nearly half were classified at Entry Level 3 or below, including 29 per cent in the lowest two Entry Levels or below.

Clearly, language had a large impact on these figures. Only a minority of respondents from Indian, Pakistani or Black African backgrounds spoke English as a first language. Given this fact, it can be argued that these ethnic groups performed relatively well on the literacy test. For example, only 45 per cent of the Indian/Indian-British respondents spoke English as a first language, yet 39 per cent achieved Level 2 or above.

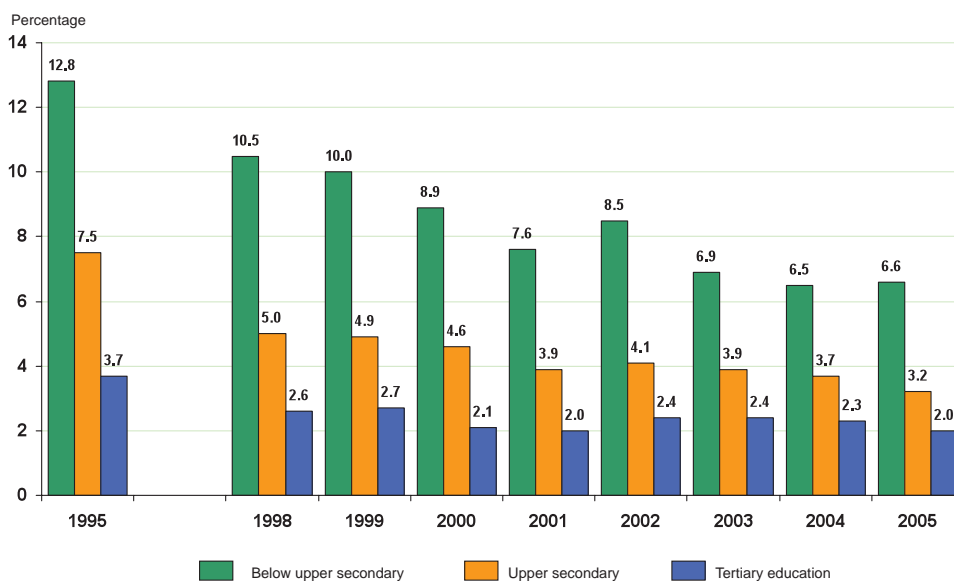
Analysis of other groups is included in:

Department for Education and Skills (2008)

The Skills for Life survey: A national needs and impact survey of literacy, numeracy and ICT skills
www.dfes.gov.uk/research/data/uploadfiles/RR490.pdf

Indicator **A.14** shows unemployment by level of education. **A.5** shows education spending as a percentage of GDP. **A.6** shows the percentage of 16-year-olds with at least five GCSEs at grades A*–C, while **A.20** shows these data by ethnicity.

A.14: Social stratification – Education: Differentials in returns to education
Unemployment by level of education
 United Kingdom, 1995–2005

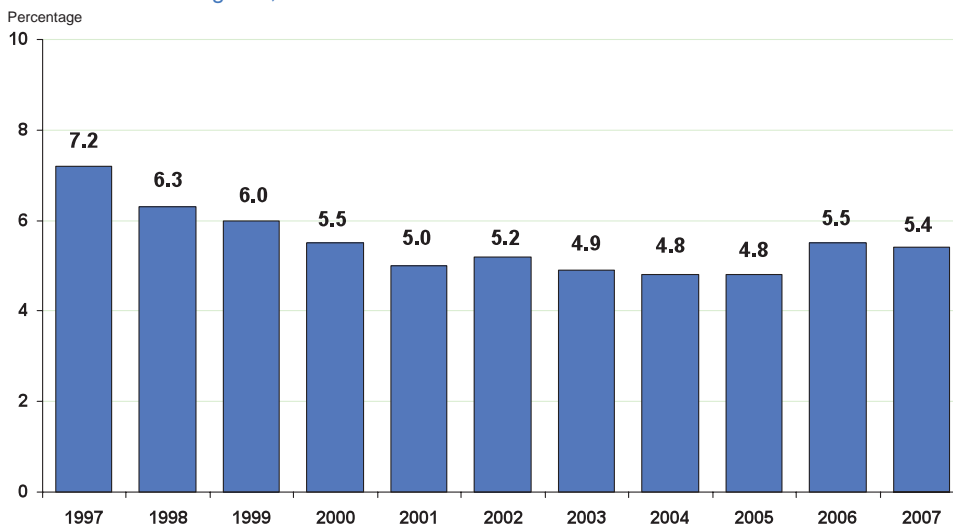


Note: Number of 25–64-year-olds in unemployment as a percentage of the labour force aged 25–64.
 Source: Organisation for Economic Co-operation and Development (2007) *Trends in unemployment rates by educational attainment (1991–2005)*
 Extract from *Education at a Glance 2007* (OECD) (Table A8.4a).

Unemployment is higher among those with low qualifications. In the UK in 2005, the average unemployment rate among those with education below upper secondary level was 5 percentage points higher than among those with tertiary education. However, the difference in unemployment rates between these groups has fallen since 1995, when the difference was 9 percentage points.

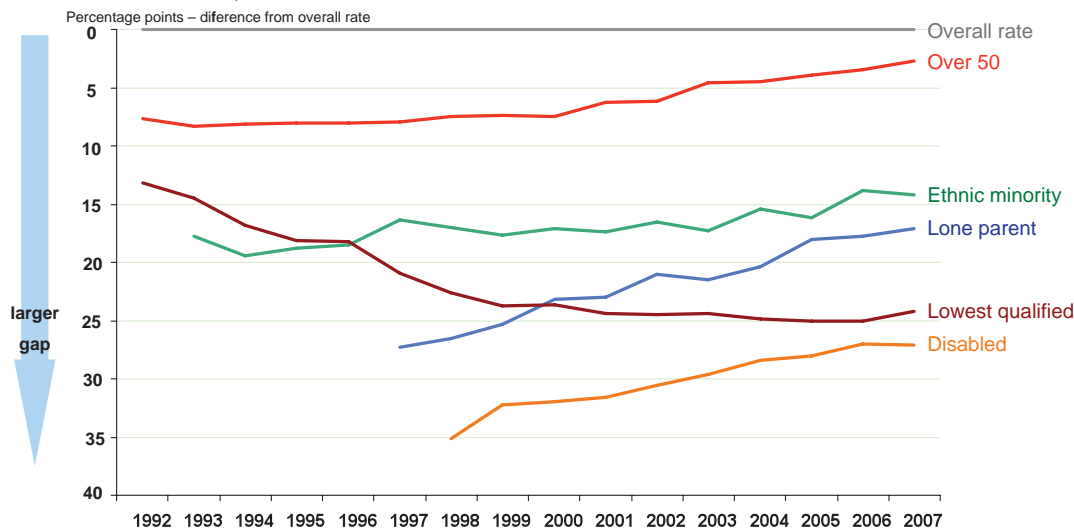
Indicator **A.15** shows the unemployment rate overall. **A.7** covers working-age adults with no qualifications. **A.4**, **A.16**, **A.17** and **A.19** cover various aspects of employment.

A.15a: Social stratification – Occupation: Unemployment or underemployment
Unemployment rate
 United Kingdom, 1997–2007



Note: Figures represent total unemployed as a percentage of all economically active people.
 Source: Office for National Statistics (2008) *Social Trends 38* (Figure 4.14).

A.15b: Social stratification – Occupation: Unemployment or underemployment
Employment rate gaps: the difference between employment rates of disadvantaged groups and the overall rate
 Great Britain, 1992–2007



Notes: The employment rate is the proportion of working-age people in employment. Working age is 16–59 for women and 16–64 for men.
 Ethnicity data (used to determine the 'Ethnic minority' employment rate) from spring 2001 onwards is based on the new ethnicity variable in the Labour Force Survey and is not directly comparable with previous years.
 In 2007 all data from the Labour Force Survey moved from a seasonal to a calendar quarter basis. Figures shown refer to the spring quarter (March–May) of each year, except those for 2007 which refer to calendar Q2 (April–June). Because the data is not seasonally adjusted, it is not possible to directly compare 2007 data with previous years.
 Source: Department for Work and Pensions (2007) *Opportunity for all: Indicators update 2007*.

Among people of working age, the employment rates for lone parents, the over-50s, the lowest-qualified, people with disabilities, and people from BME communities were lower than the national employment rate.

Between 1997 and 2006, there was a rise in the employment rates of the over-50s, from 64.7 per cent to 70.9 per cent, and of lone parents, from 45.3 per cent to 56.6 per cent. The employment rate of disabled people increased from 38.1 per cent in 1998 to 47.4 per cent in 2006, and the employment rate of ethnic minority people increased from 56.2 per cent to 60.6 per cent over the same period. The employment rate for the lowest-qualified fell from 51.7 per cent in 1997 to 49.4 per cent in 2006.

Spring 2006 was the last Labour Force Survey spring quarterly dataset (i.e. based on seasonal quarters) to be published. The Labour Force Survey moved to calendar quarters from the second quarter (Q2) of 2006. Because the data is not seasonally adjusted, it is not possible to directly compare 2007 Q2

with the spring quarters of previous years. The 2007 figures were 71.6 per cent for over-50s, 47.2 per cent for disabled people, 60.1 per cent for BME people, 57.2 per cent for lone parents, and 50.1 per cent for the lowest-qualified.

The gap between the employment rate for most of these groups and the overall rate narrowed between 1997 and 2006 – from 7.9 percentage points to 3.5 percentage points for the over-50s, 27.3 to 17.8 percentage points for lone parents, 35.1 to 27.0 percentage points for people with disabilities, and 17.0 (in 1998) to 13.8 percentage points for BME people. There was an increase in the employment rate gap for the lowest-qualified, from 20.9 percentage points in 1997 to 25.0 percentage points in 2006. In 2007 (calendar Q2 data) the figures were 2.7 percentage points for over-50s, 17.1 percentage points for lone parents, 27.1 percentage points for people with disabilities, 14.2 percentage points for ethnic minority people, and 24.2 percentage points for the lowest-qualified.

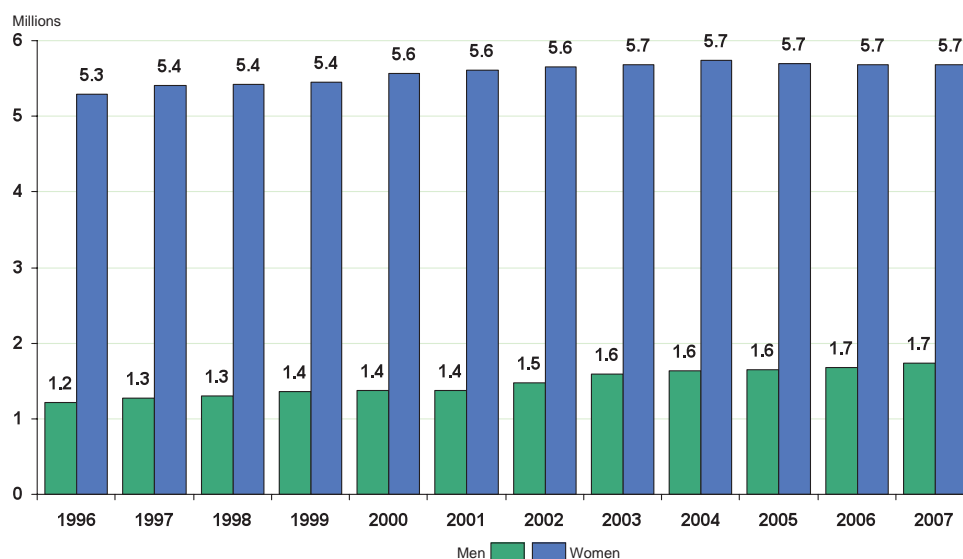
Department for Work and Pensions (2007)

Opportunity for all: Indicators update 2007

www.dwp.gov.uk/ofa/reports/2007/OpportunityforAll2007.pdf

Indicators **A.4**, **A.7**, **A.14**, **A.16**, **A.17** and **A.19** also cover various aspects of employment.

A.16: Social stratification – Occupation: Unemployment or underemployment
Part-time employment rate by gender
 United Kingdom, 1996–2007



Source: Office for National Statistics (2008) *Annual Abstract of Statistics 2008* (Table 7.2).

Seven-and-a-half million people work part-time (about one-quarter of all those in employment). Women are much more likely to work part-time than men. Two-fifths of employed women work part-time compared with just over one in 10 employed men. Men work part-time when they are younger and studying, or when they are older and starting to reduce their engagement with the labour market. Otherwise men who work part-time are often those who are unable to find full-time work, either because no suitable jobs are available or because they are unable to fill the full-time jobs that are available. By contrast, however, women part-time workers can be found at all ages. Part-time work thus plays a part in women's lifetime patterns of employment, in a way that it does not for men.

Occupational distribution of women employees, 2003/04

	Part-time	Full-time	(%) All
Managers and senior officials	4	15	11
Professional occupations	8	14	11
Associate technical and professional	11	17	15
Administrative and secretarial	22	23	23
Skilled trades	2	2	2
Personal services	17	12	14
Sales and customer services	16	7	11
Process, plant and machine operatives	2	3	3
Elementary occupations	18	5	11

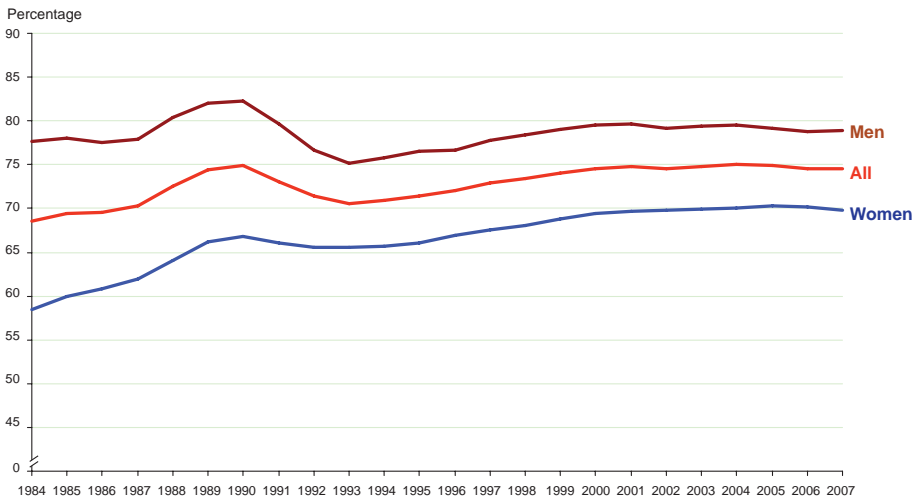
Source: *The Part-Time Pay Penalty*, Manning, A. and Petrongolo, B. (2005), London: Women and Equality Unit, Department of Trade.

There is a strong occupational and industrial divide between part-time and full-time work. Part-time work is concentrated in the service sectors and is rarely found at management levels. It is generally of poorer quality than full-time work. Part-time work is typically lower-paid, in both the short and the longer term. There is usually limited access to training and under-utilisation of skills. Part-time work may involve atypical hours and shift working, the jobs are less stable than full-time jobs, and part-time workers are less likely to be represented by trade unions. Part-time jobs with very short hours seem to be of particularly poor quality and more insecure. Part-time work does not necessarily offer flexibility in terms of work schedules, although it is more likely to do so than full-time work. Part-time workers are just as likely to be satisfied with their jobs as full-time workers. Women in part-time jobs are the most likely to be satisfied with their hours and pay, and most say that they choose to work part-time to fit with their family responsibilities. Part-time work can be a trap, however, and moving to full-time work will often involve a change of employer.

Department for Work and Pensions (2006)
Part-time work and social security: increasing the options
www.dwp.gov.uk/asd/asd5/rports2005-2006/rrep351.pdf

Indicator **A.2** shows the gender pay gap. **A.4** shows employment by industry, arranged by gender. **A.17a** shows labour participation rates by gender.

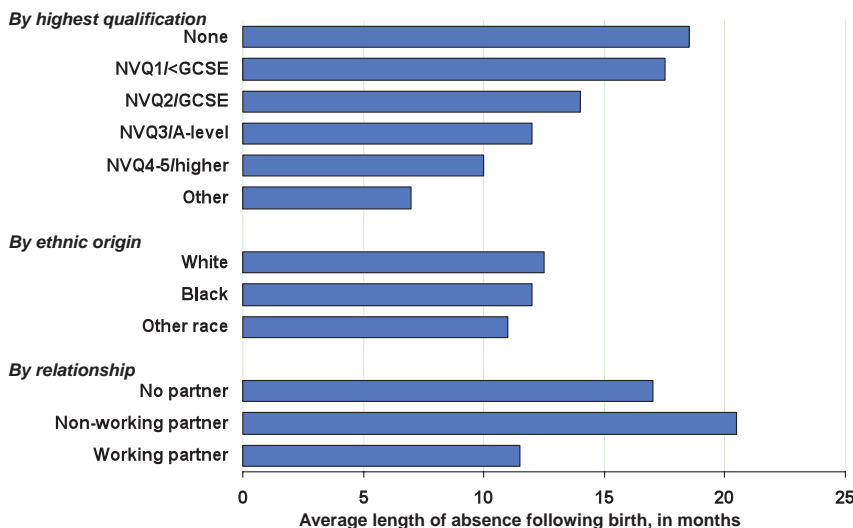
A.17a: Social stratification – Gender: Access to economic and educational opportunities
Labour participation rate by gender
 Great Britain, 1984–2007



Notes: The labour participation rate is the proportion of working-age people in employment. Working age is 16–59 for women and 16–64 for men. Figures refer to the spring (March–May) of each year, except 2007 which refers to Q2 (April–June). Figures for 1992 onwards are seasonally adjusted, and are not directly comparable with earlier figures which are not seasonally adjusted. Source: Office for National Statistics (2007) *Opportunity for all: Indicators update 2007*.

Employment rates for men were just over 10 percentage points higher than those for women in 1997, compared with 8.6 percentage points in 2006; this indicates some narrowing of the employment gap. In 2007 the gap was 9.1 percentage points. (As of Quarter 2 of 2006, the Labour Force Survey moved to a calendar quarter basis – January–March, April–June, etc. However, seasonally adjusted data was available at a national level throughout the period analysed here, and so the figures remain comparable.)

A.17b: Social stratification – Gender: Access to economic and educational opportunities
Average length of absence from work following birth
 Great Britain, 1999–2003



Note: This study used two data sources: the first 13 waves from the British Household Panel Survey (BHPS), covering the years 1991–2003, and the first five waves from the Families and Children Study (FACS), covering the years 1999–2003. Information on all adults from the BHPS was combined with data on families from the FACS to create a large sample of families, which was used in the specific analysis of newborns and school entry, and a comparison sample containing individuals over all stages of the lifetime, including before, throughout and after family formation. The lengths of absence recorded here are the averages among those women who returned to work during the lifetime of their presence on the panel; hence, they understate the true average length of absences, but they do indicate the nature of the differences across groups. Source: Department for Work and Pensions (2006) *Newborns and new schools: critical times in women's employment*.

Women with lower levels of education were observed to take longer absences than the more educated. This may reflect relative wages or employment opportunities across education groups, with the more highly educated forgoing higher earnings by remaining absent. Ethnic group appeared to have little impact on the average length of absence. The presence of a partner was related to a shorter length of absence, but only if the partner was working. Women with non-working partners took longer absences on average than lone mothers, which may reflect the fact that women with partners not in work tend to have poorer work opportunities themselves (either through a matching in education and work skills between the woman and her partner, or through local economic conditions).

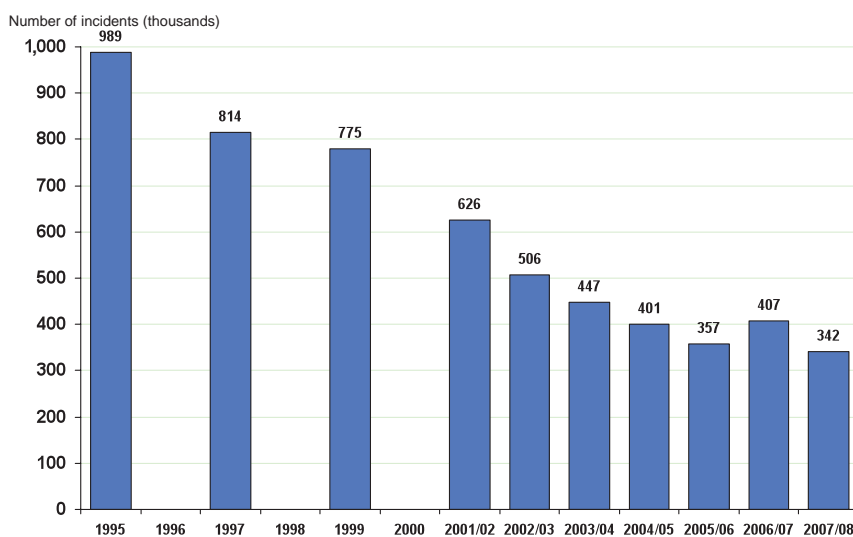
Department for Work and Pensions (2006)

Newborns and new schools: critical times in women's employment

www.dwp.gov.uk/asd/asd5/rports2005-2006/rrep308.pdf

Indicator **A.2** shows the gender pay gap. **A.4** shows employment by industry, arranged by gender. **A.16** shows part-time employment rates for men and women.

A18a: Social stratification – Gender: Social prestige of women
Domestic violence
 England and Wales

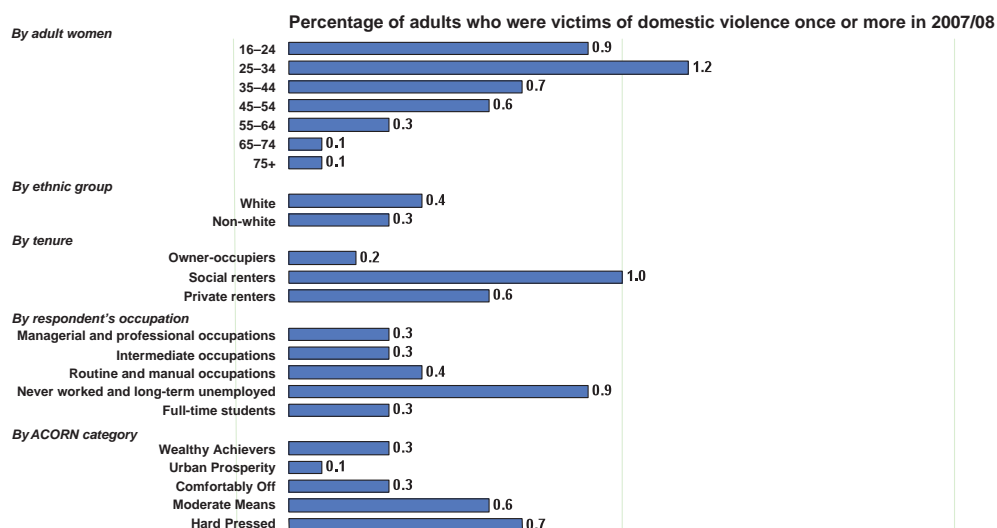


Notes: 'Domestic violence' includes woundings, assaults with minor injury and assaults with no injury that involve partners, ex-partners or other relatives or household members. The figures relate to adults aged 16 and over.
 Source: Home Office (2008) *British Crime Survey 2007/08* (Table 2.01).

Domestic violence accounted for about one in six violent incidents in 2007/08, as measured on the main British Crime Survey (BCS) (based on incidents reported to BCS interviewers face-to-face – the BCS also includes a self-completion module on inter-personal violence, which suggests a far greater experience of domestic violence). In the majority of incidents of domestic violence the victims were women (85 per cent). Domestic violence was the only category of violence for which the risk for women (0.6 per cent) was significantly higher than for men (0.2 per cent).

Following a peak in 1995, there was a large and statistically significant fall of 65 per cent in domestic violence. The largest part of this reduction occurred between 1995 and the 2002/03 BCS.

A.18b: Social stratification – Gender: Social prestige of women
Domestic violence victimisation rate
 England and Wales, 2007/08



Note: ACORN – 'A Classification of Residential Neighbourhoods' – classifies households according to demographic, employment and housing characteristics of the surrounding neighbourhood.
 Source: Home Office (2008) *British Crime Survey 2007/08* (Tables 3.01a, 3.02).

Among adult women, those in younger age groups are at the highest risk of domestic violence. In 2007/08, 0.9 per cent of women aged 16–24 years and 1.2 per cent of women aged 25–34 years were victims of domestic violence. The proportion of women who were victims of domestic violence was lower in other age groups and decreased with age.

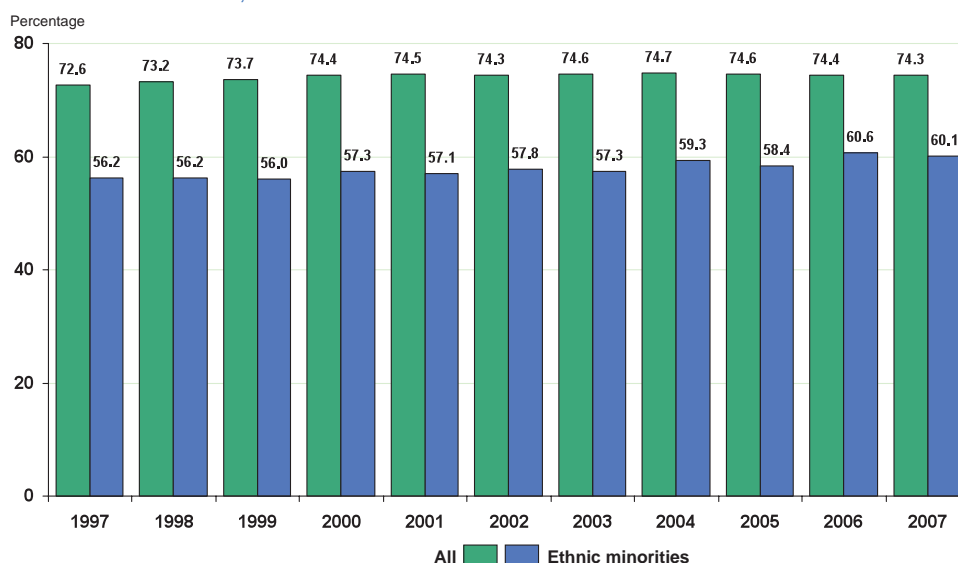
In 2007/08 those living in 'Hard Pressed' ACORN areas were at greater risk of domestic violence than those in other ACORN areas.

Adults living in social-rented accommodation are at greater risk of domestic violence than those in private-rented or owner-occupied accommodation (in 2007/08, 1.0 per cent compared to 0.6 and 0.2 per cent respectively). Adults in the White ethnic group are at a slightly higher risk of domestic violence than those in non-white ethnic groups (in 2007/08, 0.4 per cent compared to 0.3 per cent), although this is not a statistically significant difference.

Data covering a range of additional groups are presented in Tables 3.01 and 3.02 of:
Home Office (2008)
Crime in England and Wales 2007/2008
www.homeoffice.gov.uk/rds/crimeew0708.html

Indicator **A.10a** covers trends in incidents of reported crime more generally.

A.19a: Social stratification – Ethnicity/race and religion: Socio-economic disadvantage
Employment rate by ethnicity
 Great Britain, 1997–2007



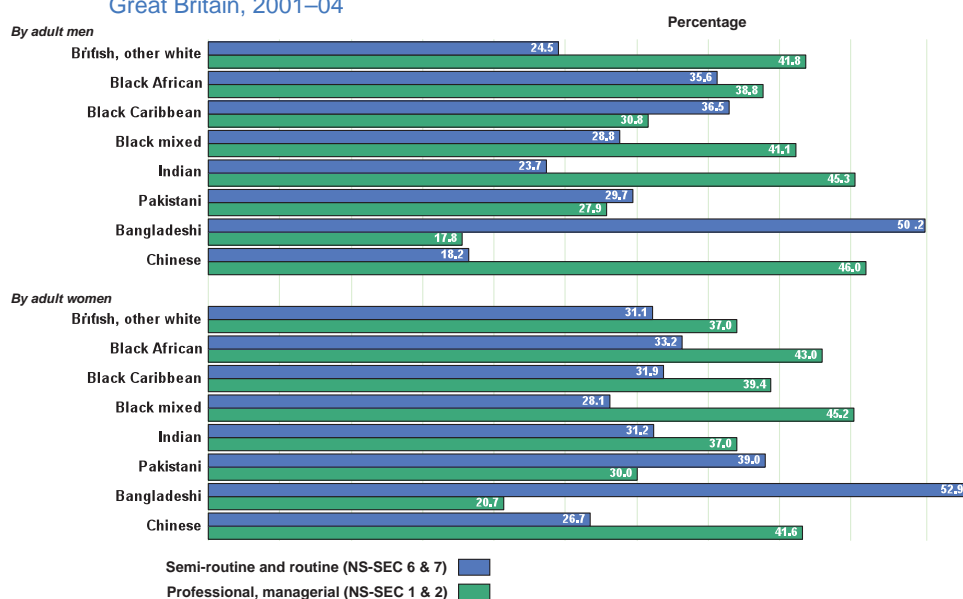
Notes: The employment rate is the proportion of working-age people in employment. Working age is 16–59 for women and 16–64 for men. Ethnicity data from spring 2001 onwards is based on the new ethnicity variable in the Labour Force Survey and is not directly comparable with previous years. In 2007 all data from the Labour Force Survey moved from a seasonal to a calendar quarter basis. Figures shown refer to the spring quarter (March–May) of each year, except those for 2007 which refer to calendar Q2 (April–June). Because the data is not seasonally adjusted, it is not possible to directly compare 2007 data with previous years. Source: Department for Work and Pensions (2007) *Opportunity for all: Indicators update 2007*.

The employment rate of ethnic minority people increased from 56.2 per cent in 1998 to 60.6 per cent in 2006. Spring 2006 was the last Labour Force Survey spring quarterly dataset (i.e. based on seasonal quarters) to be published. The Labour Force Survey moved to calendar quarters from the second quarter (Q2) 2006. Because the data is not seasonally adjusted, it is not possible to directly compare 2007 Q2 with the spring quarters of previous years. The employment rate of ethnic minority people in 2007 was 60.1 per cent.

The gap between the employment rate of ethnic minority people and the overall rate narrowed from 17.0 percentage points in 1998 to 13.8 percentage points in 2006. In 2007 (calendar Q2 data) the gap was 14.2 percentage points.

Department for Work and Pensions (2007)
Opportunity for All: Indicators update 2007
www.dwp.gov.uk/ofa/reports/2007/OpportunityforAll2007.pdf

A.19b: Social stratification – Ethnicity/race and religion: Socio-economic disadvantage
Occupational attainment of employees by gender, socio-economic group and ethnicity
 Great Britain, 2001–04



Note: 'Occupational attainment' shows the proportion of employees in selected NS-SEC categories. 'Employees' exclude the self-employed and the unemployed.
 Source: Department for Work and Pensions (2006) *Ethnic penalties in the labour market: Employers and discrimination*.

Research published by the Department for Work and Pensions (DWP) on ethnic penalties in the labour market found that groups such as Bangladeshis, Black Caribbeans and Black Africans who had high rates of unemployment also had high proportions in semi-routine and routine work. This was particularly striking in the case of Bangladeshi men, 50 per cent of whom were in semi-routine and routine work. Black Caribbeans and Black Africans came next, with 37 per cent and 36 per cent respectively in this kind of less skilled work. Conversely, the Chinese (46 per cent) and Indian (45 per cent) groups had the highest proportions in professional and managerial work, slightly higher than among the British and other White comparison group (42 per cent). However, the Black Mixed group, which had quite a high rate of unemployment, came quite close to the White comparison group in the proportion holding professional and managerial jobs (41 per cent).

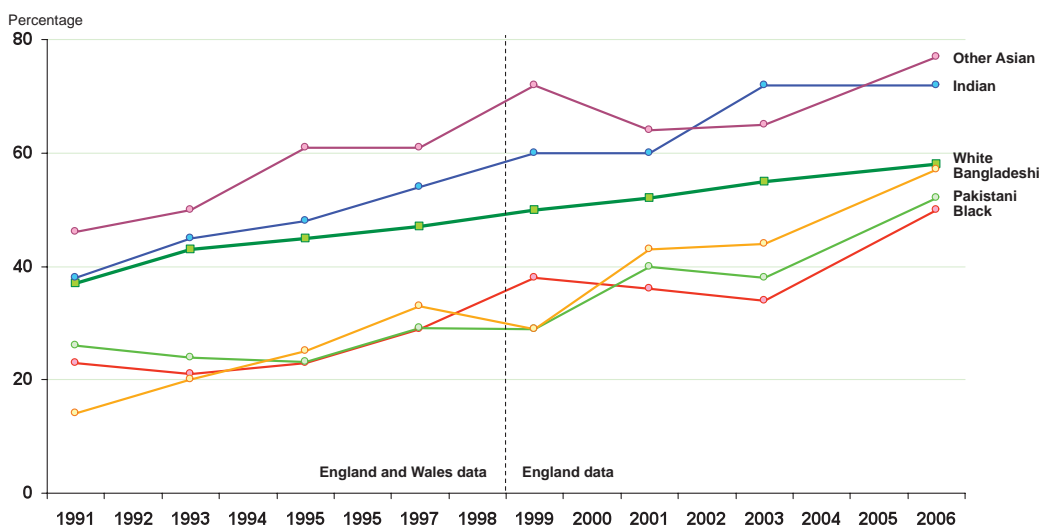
Similarly to men, there was a very high proportion (53 per cent) of Bangladeshi women in semi-routine and routine work, while Chinese and Indian women had relatively high proportions in professional and managerial work (42 per cent and 37 per cent respectively). However, they were joined by women in the Black African (43 per cent), Black Caribbean (39 per cent) and Black Mixed (45 per cent) groups, who were all quite successful in accessing these occupations. Further investigation suggested that the majority of these more successful women were found in the lower managerial and professional occupations rather than in the higher levels. The presence of high proportions of Black Caribbean women in occupations such as nursing has long been a feature of the British labour market and of the NHS in particular, but the presence of high proportions of Black African and Black Mixed women in these occupations is less well-known.

About a quarter of ethnic minorities were employed in the distribution or hotel and restaurant industry sectors, compared with under a fifth of white people.

Department for Work and Pensions (2006)
Ethnic penalties in the labour market: Employers and discrimination
www.dwp.gov.uk/asd/asd5/report_abstracts/rr_abstracts/rra_341.asp

Indicators **A.4**, **A.7**, **A.14**, **A.15**, **A.16** and **A.17** also cover various aspects of employment.

A.20: Social stratification – Ethnicity/race and religion: Socio-economic disadvantage
Percentage of Year 11 pupils attaining at least five GCSEs at grades A*–C, by ethnicity
 England and Wales (prior to 1999); England (from 1999)



Notes: Information on academic attainment is taken directly from administrative records in 2003 and 2006 where available and from survey responses in previous years. Year 11 pupils are those aged 15 at the start of the academic year. Data from 1997 includes equivalent GNVQ qualifications achieved in Year 11. Source: Department for Children, Schools and Families (2008) *Youth Cohort Study and Longitudinal Study of Young People in England: The Activities and Experiences of 16-Year-Olds: England 2007*.

Percentage of Year 11 pupils attaining at least five GCSEs at grades A*–C by ethnicity
 England and Wales (prior to 1999); England (from 1999)

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
All	37	42	44	46	49	51	54	58								
White	37	43	45	47	50	52	55	58								
Black	23	21	23	29	38	36	34	50								
Asian	33	36	38	45	48	45	48	64								
- Indian	38	45	48	54	60	60	72	72								
- Pakistani	26	24	23	29	29	40	38	52								
- Bangladeshi	14	20	25	33	29	43	44	57								
- other Asian	46	50	61	61	72	64	65	77								
Other ethnic group	*	37	46	47	42	53	56	56								
Weighted sample	24,922	18,020	15,899	14,662	12,899	15,714	13,178	19,114								

Notes: Information on academic attainment is taken directly from administrative records in 2003 and 2006 where available and from survey responses in previous years. Year 11 pupils are those aged 15 at the start of the academic year. Data from 1997 includes equivalent GNVQ qualifications achieved in Year 11. *Represents a cell size of less than five or an insufficient base. Department for Children, Schools and Families (2008) *Youth Cohort Study and Longitudinal Study of Young People in England: The Activities and Experiences of 16-Year-Olds: England 2007*.

Data on GCSE attainment shown in the chart and table above are from the Youth Cohort Study (based on a sample of pupils, and therefore subject to sampling error), which provides a longer time series of attainment by ethnicity. The data shows that the proportion of pupils in Year 11 attaining five good GCSEs increased for all ethnic groups between 1991 and 2006, but that differences remained between ethnic groups, with lower than average attainment among pupils of Pakistani and Black ethnic origins. However, the large rises between 2003 and 2006 for Pakistani, Bangladeshi and Black ethnic groups are noteworthy. For instance, the proportion of pupils in Year 11 of Black ethnic origin attaining five good GCSEs rose from about a third to a half between 2003 and 2006.

Department for Children, Schools and Families (2008)
*Youth Cohort Study and Longitudinal Study of Young People in England:
 The Activities and Experiences of 16 Year Olds: England 2007*
www.dcsf.gov.uk/rsgateway/DB/SBU/b000795/index.shtml

More detailed information by ethnicity on GCSE attainment (at Key Stage 4), as well as attainment at Key Stages 1 to 3, is available for recent years based on data from the National Pupil Database, which includes all pupils in maintained schools. Information for 2006/07 for pupils in England shows that:

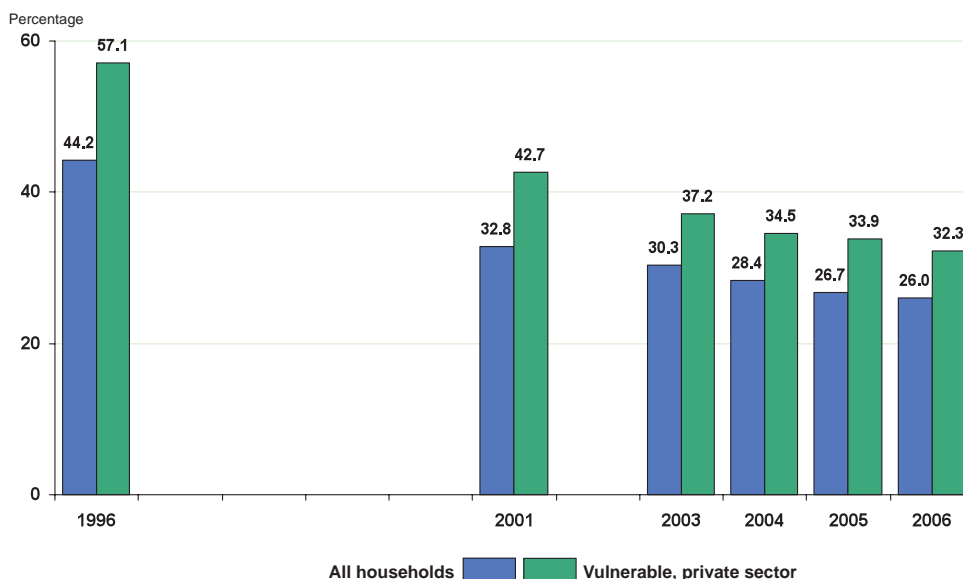
- Chinese pupils, pupils of Mixed White and Asian heritage and Indian pupils consistently achieved **above** the national average across Key Stage 1, Key Stage 2 and Key Stage 4 (GCSE). For example, at Key Stage 1 mathematics, 95 per cent of Chinese pupils and 93 per cent of Mixed White and Asian heritage pupils achieved the expected level or above, compared with 90 per cent nationally.
- Gypsy/Romany and Traveller of Irish heritage pupils performed considerably **below** the national average across Key Stages 1, 2 and 4 (GCSE). However, it should be noted that very small numbers of pupils were recorded in these two categories. For example, at Key Stage 2, around a third of both Traveller of Irish heritage and Gypsy/Romany pupils achieved the expected level or above in KS2 English, compared to at least three-quarters of all pupils on average.
- All the minority ethnic groups within the Black category and pupils of Mixed White and Black Caribbean heritage were consistently **below** the national average across Key Stages 1, 2 and 4 (GCSE). For example, in Key Stage 2 mathematics, 66 per cent of pupils in the Black category achieved the expected level or above compared with 77 per cent of all pupils nationally.
- However, the results for minority ethnic groups within the Black category and pupils of Mixed White and Black Caribbean heritage had generally improved across each Key Stage, resulting in most cases in a narrowing of the attainment gap in many subjects. For example, the gap between each of these groups and the average for all pupils narrowed for those achieving at least five A*–C grades at GCSE or equivalent.
- Bangladeshi and Pakistani pupils performed **below** the national average across all Key Stages. For example, at Key Stage 1 reading, 77 per cent of Pakistani pupils and 79 per cent of Bangladeshi pupils achieved the expected level compared with 84 per cent of all pupils nationally.
- Bangladeshi pupils' relative attainment was closer to the national average at GCSE and equivalent, with 58.4 per cent achieving at least five A*–C grades at GCSE or equivalent compared with 59.3 per cent of all pupils nationally. When looking at pupils attaining at least 5 A*–C grades at GCSE or equivalent including English and mathematics, there was a gap of 4 percentage points between Bangladeshi pupils and all pupils.
- Pakistani pupils' relative attainment of at least five A*–C grades at GCSE and equivalent was 6 percentage points below the national figure (53.0 per cent compared with 59.3 per cent), increasing to a difference of 9 percentage points from the national average when English and mathematics were included.

(Key Stage National Curriculum assessments are reported at the end of Key Stage 1, Key Stage 2 and Key Stage 3. Key Stage 1 teacher assessments are published in reading, writing, mathematics and science and Key Stage 2 and Key Stage 3 tests in English, mathematics and science. The Key Stage assessments and tests measure the extent to which pupils have the specific knowledge, skills and understanding that the National Curriculum expects pupils to have mastered by the end of the Key Stage.)

Department for Children, Schools and Families (2007)
National Curriculum Assessment, GCSE and Equivalent Attainment and Post-16 Attainment by Pupil Characteristics, in England 2006/07
www.dcsf.gov.uk/rsgateway/DB/SFR/s000759/index.shtml

Indicator **A.6** shows the overall percentage of 16-year-olds with at least five GCSEs at grades A*–C. Indicator **A.5** shows education spending as a percentage of GDP.

A.21: Differential exposures, vulnerabilities and consequences – Material circumstances: Housing conditions
Households living in non-decent homes
 England, 1996–2006



Source: Communities and Local Government (2008) *English House Condition Survey 2006 Headline Report – Decent Homes and Decent Places*.

Percentage of group living in non-decent homes (based on the fitness standard)

	1996	2001	2003	2004	2005	2006
All households	44.2	32.8	30.3	28.4	26.7	26.0
Non-vulnerable private households	39.0	29.2	27.8	26.6	24.7	24.2
Vulnerable private households	57.1	42.7	37.2	34.5	33.9	32.3
Social tenants	52.3	38.3	34.2	30.3	27.9	27.6
Non-white minority ethnic households	52.6	39.0	34.6	32.8	31.0	n/a
White households	43.7	32.3	29.9	28.0	26.3	n/a

Source: Communities and Local Government (2008) *English House Condition Survey 2006 Headline Report – Decent Homes and Decent Places*.

The definition of what is a decent home has been 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.

For a dwelling to be considered ‘decent’ it must:

- meet the statutory minimum standard for housing
- be in a reasonable state of repair
- have reasonably modern facilities and services
- provide a reasonable degree of thermal comfort.

‘Vulnerable households’ are households in receipt of at least one of the principal means-tested or disability-related benefits.

More detailed information on definitions is available from the *English House Condition Survey 2006 Headline Report* (see below).

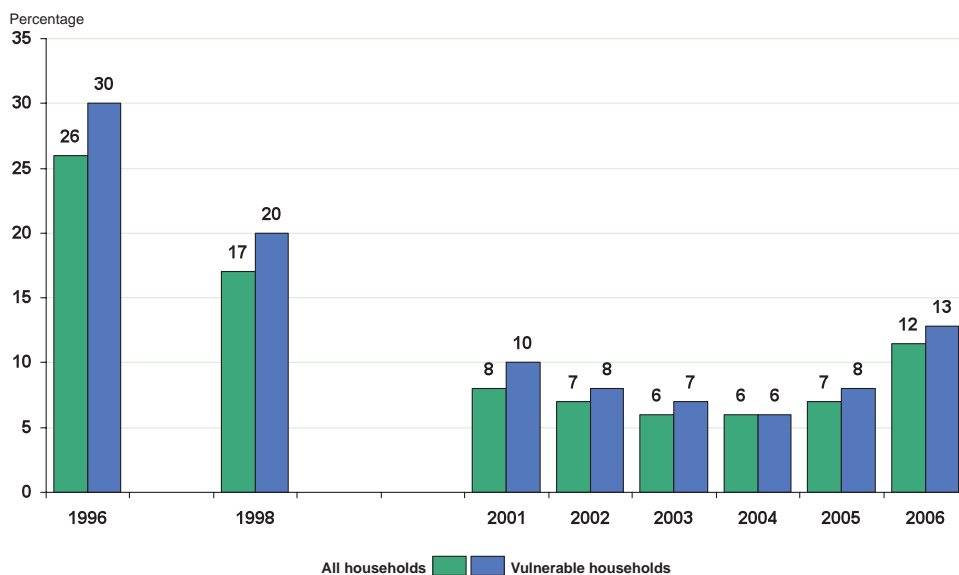
Under the original definition of decent, which used the fitness standard as the statutory minimum and enables comparison over time, 68 per cent of vulnerable households were living in decent homes in 2006 – a considerable improvement on the 43 per cent figure in 1996.

Using this definition, the decade after 1996 saw a reduction across all tenures in the proportion of households living in non-decent homes. The proportion of social sector tenants and private vulnerable households fell by an average of 2.5 percentage points each year, compared to 1.5 percentage points for other (i.e. non-vulnerable) private sector households; this reduced the disparities in housing conditions between poorer and more affluent households. In 2006, 28 per cent of social tenants and 32 per cent of private sector vulnerable households were living in non-decent homes, compared with 24 per cent of non-vulnerable private sector households under this definition of the standard.

Communities and Local Government (2008)

English House Condition Survey 2006 Headline Report – Decent Homes and Decent Places
www.communities.gov.uk/documents/housing/pdf/headlinereport2006.pdf

A.22a: Differential exposures, vulnerabilities and consequences – Material circumstances: Housing conditions
Households in fuel poverty
 England, 1996–2006



Sources: Department for Work and Pensions (2007) *Opportunity for all: Indicators update 2007* (1996–2004 data); Department for Business, Enterprise and Regulatory Reform (2007) *The UK fuel poverty strategy: annual progress report* (2005 data); Department for Environment, Food and Rural Affairs (2008) *The UK Fuel Poverty Strategy: 6th annual progress report* (2006 data).

A household is said to be in fuel poverty if it needs to spend more than 10 per cent of its income on fuel to maintain an adequate level of warmth (usually defined as 21°C for the main living area, and 18°C for other occupied rooms). This broad definition of fuel costs also includes modelled spending on water heating, lights, appliances and cooking.

Between 1996 and 2006, the number of fuel-poor households in England fell from 5.1 million (26.0 per cent of all households) to around 2.4 million (11.5 per cent of all households), a fall of over 2.6 million.

However, in the most recent periods the number of fuel-poor households has increased. The estimate of 2.4 million households in fuel poverty in England in 2006 (of which around 1.9 million were vulnerable) represented a total rise of 0.9 million households since 2005 (and a rise of 0.7 million vulnerable households over the same period). This rise was due to the effect of increasing energy prices.

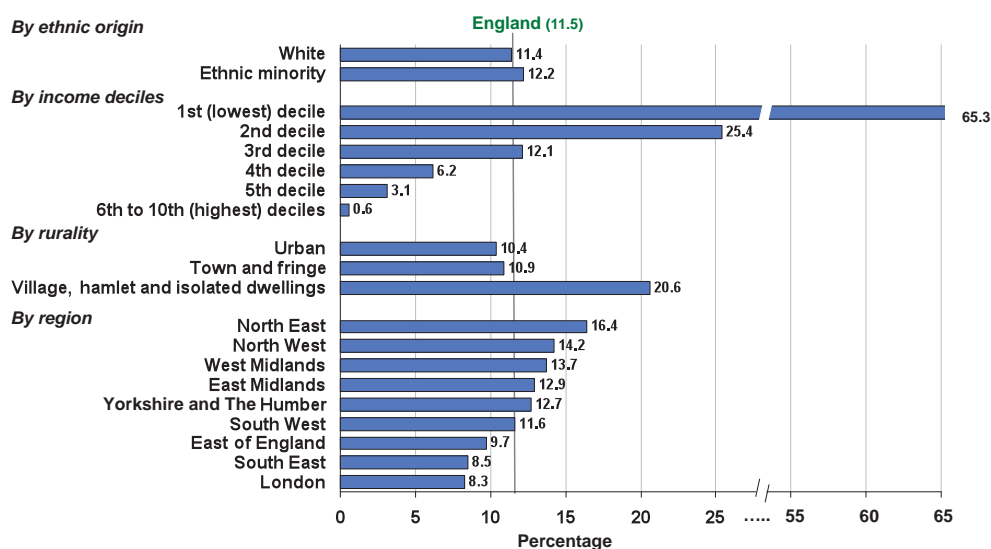
The most influential factor affecting the number of fuel-poor households over the decade from 1996 was rising incomes. The second-largest factor, which partly offset the effect of incomes, was fuel prices. In comparison, aggregate energy efficiencies of dwellings had a relatively small effect, although the impact could be highly significant for those households that benefited from efficiency improvements.

Projections of fuel poverty in England for 2007 showed that energy prices were likely to have pushed a further 0.7 million households into fuel poverty. Projections for 2008 showed a further increase in fuel poverty for England, of around 0.5 million households.

A.22b: Differential exposures, vulnerabilities and consequences – Material circumstances: Housing conditions

Households in fuel poverty (full income definition)

England, 2006



Source: Department for Environment, Food and Rural Affairs (2008) *The UK Fuel Poverty Strategy: 6th annual progress report*.

In England in 2006, the proportion of households in fuel poverty was slightly higher among those where the household reference person was from an ethnic minority than among white households.

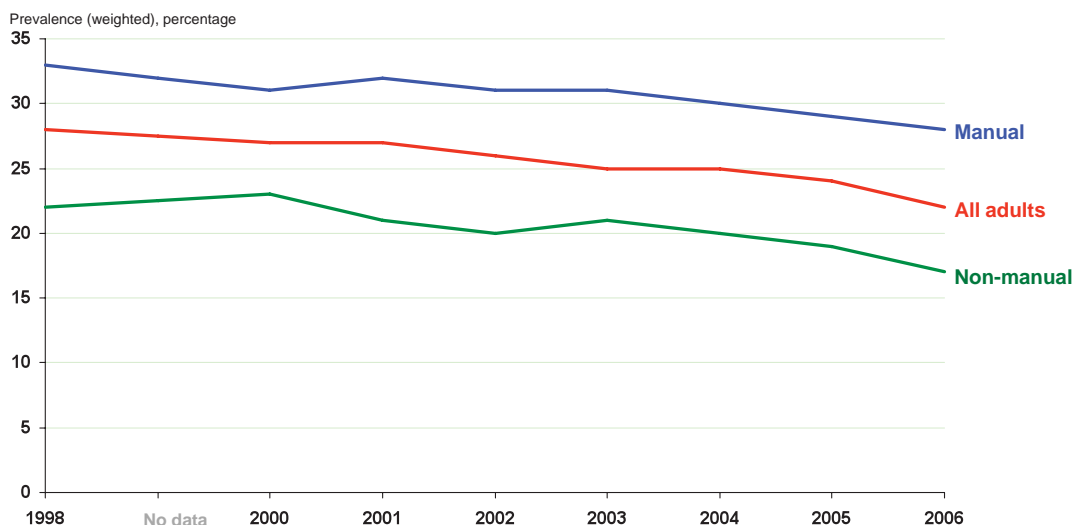
In 2006 almost 70 per cent of households in the lowest income decile (income up to around £8,900) were fuel poor. This group made up over half of all fuel-poor households in total, with over 1.3 million fuel-poor households in the lowest income decile group in England. By contrast, very few households in the highest five income deciles were in fuel poverty – only around 60,000 in total (2 per cent of all fuel-poor households). Taken together, the lowest three income deciles accounted for nearly 90 per cent of all fuel-poor households in England in 2006.

Households in more rural areas were around twice as likely as those in urban areas to be in fuel poverty in 2006.

At regional level in 2006, the highest proportions of households in fuel poverty were in the North East and the North West; the lowest proportions in fuel poverty were in the South East and London.

Department for Environment, Food and Rural Affairs (2008)
The UK Fuel Poverty Strategy: 6th annual progress report
www.berr.gov.uk/whatwedo/energy/fuel-poverty/strategy/index.html

A.23a: Differential exposures, vulnerabilities and consequences – Health-related behaviours and biological factors: Smoking
Smoking prevalence overall and by socio-economic (manual or non-manual) group
 England, 1998–2006



Source: Office for National Statistics (2008) *General Household Survey 2006: Smoking and drinking among adults, 2006* (Table 1.6).

Recent Government public service agreement targets include reducing the prevalence of smoking among routine and manual groups to 26 per cent or less by 2010. Routine and manual groups are part of the National Statistics Socio-economic Classification (NS-SEC), which was introduced in 2001. However, data is presented here for manual and non-manual groups, part of the previous socio-economic classification, as a longer time series is available on this basis. A target was originally set in the 2000 NHS *Cancer Plan* in terms of the previous socio-economic classification: to reduce smoking prevalence among manual groups to 26 per cent by 2010.

Figures from 2001 onward are based on the new NS-SEC, recoded to produce the manual/non-manual split from the old socio-economic classification. Because of the new occupation coding in NS-SEC, the classifications are not exactly the same, and comparisons with previous years should be treated with caution.

The General Household Survey (GHS) has consistently shown striking differences in the prevalence of cigarette smoking in relation to socio-economic group, with smoking being considerably more prevalent among those in manual groups than among those in non-manual groups. In the 1970s and 1980s, the prevalence of cigarette smoking fell more sharply among those in non-manual than in manual groups, so that differences between the groups became proportionately greater. There was little further change in the relative proportions smoking cigarettes during the 1990s.

In England in 2006, 28 per cent of those in manual groups were cigarette smokers, compared with 33 per cent in 1998, confirming progress towards the NHS *Cancer Plan* target. However, since the proportion of those in non-manual groups who were cigarette smokers fell by a similar amount (from 22 per cent in 1998 to 17 per cent in 2006), the differential between non-manual and manual was not reduced.

Caution is advisable when making comparisons over this period: the recreated socio-economic groups may have been affected by the change from head of household to household reference person as the basis for assessing socio-economic group, and by revisions to the way in which occupation is coded.

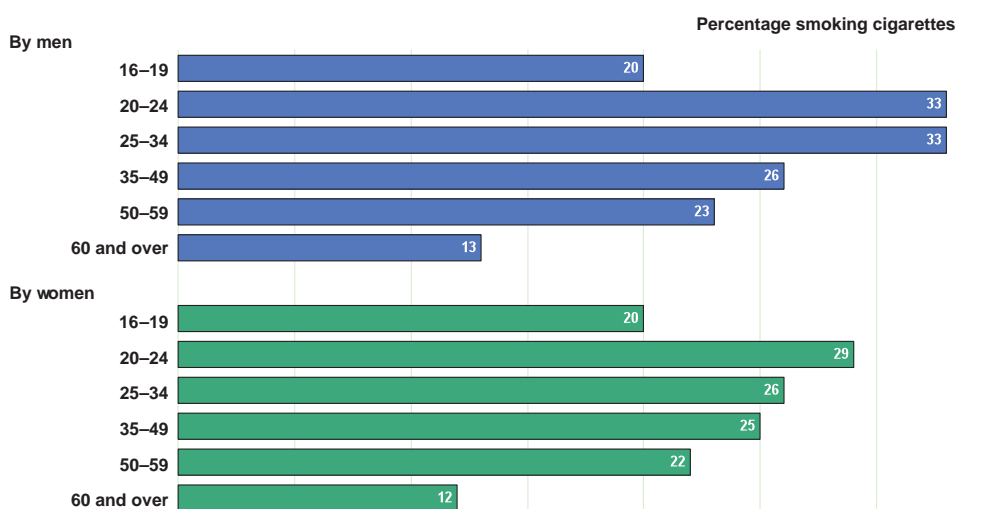
A.23b: Differential exposures, vulnerabilities and consequences – Health-related behaviours and biological factors: Smoking
Adult smoking prevalence by Government Office region
 Great Britain, 2004–06



Note: 'Adult' refers to people aged 16 and over.
 Source: Office for National Statistics (2008) *General Household Survey 2006: Smoking and drinking among adults, 2006* (Table 1.12).

For men, the three regions of England with the highest prevalence were the North East, the North West and Yorkshire and The Humber, where 26–27 per cent of men were cigarette smokers (similar to the level in Scotland, and significantly higher than in all other regions except London). Among women, prevalence in the North East, at 28 per cent, was significantly higher than in every other region of England, and also significantly higher than in Wales and Scotland. The prevalence of cigarette smoking was lowest, at 20 per cent, among women in the West Midlands, the East of England, London and the South East.

A.23c: Differential exposures, vulnerabilities and consequences – Health-related behaviours and biological factors: Smoking
Adult smoking prevalence by gender and age
 Great Britain, 2006



Note: 'Adult' refers to people aged 16 and over.
 Source: Office for National Statistics (2008) *General Household Survey 2006: Smoking and drinking among adults, 2006* (Table 1.14).

Since the early 1990s, the prevalence of cigarette smoking has been higher among those aged 20–24 than in other age groups, but the difference relative to the next age group – those aged 25–34 – has reduced in recent years. Up to the early twenties, more young people are starting to smoke than are giving up. At around 12 per cent in 2006, prevalence continues to be lowest among men and women aged 60 and over. Although they are more likely than younger people to have ever been smokers, they are also much more likely to have given up.

There was a fall in prevalence among those aged 16–19, from 24 per cent in 2005 to 20 per cent in 2006; although marked, this was on the borderline of statistical significance, but the 2006 prevalence was significantly lower than the rate of 31 per cent in 1998.

Throughout the period during which the GHS has been monitoring cigarette smoking, prevalence has been higher among men than among women, and this continues to be the case: in 2006, 23 per cent of men and 21 per cent of women were cigarette smokers.

Office for National Statistics (2008)

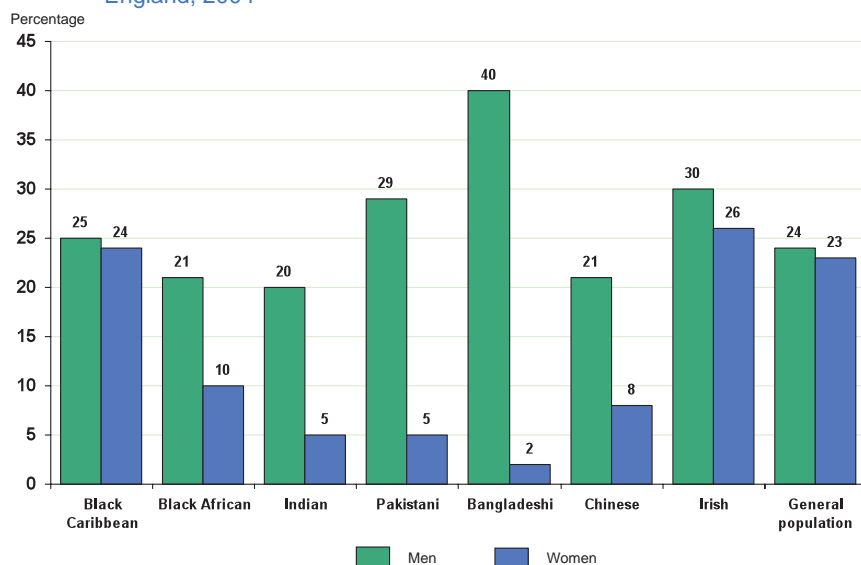
General Household Survey 2006: Smoking and drinking among adults 2006

www.statistics.gov.uk/StatBase/Product.asp?vlnk=5756&Pos=&ColRank=1&Rank=272

A.23d: Differential exposures, vulnerabilities and consequences – Health-related behaviours and biological factors: Smoking

Adult smoking prevalence by ethnicity and gender

England, 2004



Note: 'Adult' refers to people aged 16 and over.
Source: The Information Centre for Health and Social Care (2006) *Health Survey for England 2004: Health of Ethnic Minorities – Full Report*.

Adult smoking prevalence by ethnicity and gender, 1999 and 2004
England

		Black Caribbean	Black African	Indian	Pakistani	Bangladeshi	Chinese	Irish	General population
Men	1999 Observed %	35	n/a	23	26	44	17	39	27
	2004 Observed %	25	21	20	29	40	21	30	24
	2004 Standardised risk ratio	1.02	0.80	0.78	1.08	1.43	0.81	1.30	1
Women	1999 Observed %	25	n/a	6	5	1	9	33	27
	2004 Observed %	24	10	5	5	2	8	26	23
	2004 Standardised risk ratio	1.08	0.34	0.23	0.19	0.11	0.32	1.11	1

Notes: 'Adult' refers to people aged 16 and over.
'Smoking' refers to cigarette smoking.
Black Africans were included in the 2004 survey, but not in the 1999 survey.
'Standardised risk ratio' is the ratio of the age-standardised prevalence in the ethnic group to the age-standardised prevalence in the general population. Risk ratios greater/less than 1 indicate a higher/lower prevalence in the ethnic group than the general population, after taking into account differences in age profile.
Source: The Information Centre for Health and Social Care (2006) *Health Survey for England 2004: Health of Ethnic Minorities – Full Report*.

Data on smoking prevalence by ethnic group was reported in the 2004 Health Survey for England (note that estimates of smoking prevalence in the general population from this survey may differ slightly from estimates from the GHS, presented in Indicator A.23).

In 2004, both Bangladeshi and Irish men were significantly more likely to report current smoking than the general population, after allowing for differences in age profile. Indian men were significantly less likely than men in the general population to report that they were currently smoking cigarettes.

The pattern of cigarette smoking among minority ethnic groups was very different in women. Around one-quarter of Black Caribbean women, Irish women and women in the general population were current cigarette smokers. Among all other minority ethnic groups, prevalence of cigarette smoking was low, ranging from 2 per cent among Bangladeshi women to 10 per cent among Black African women.

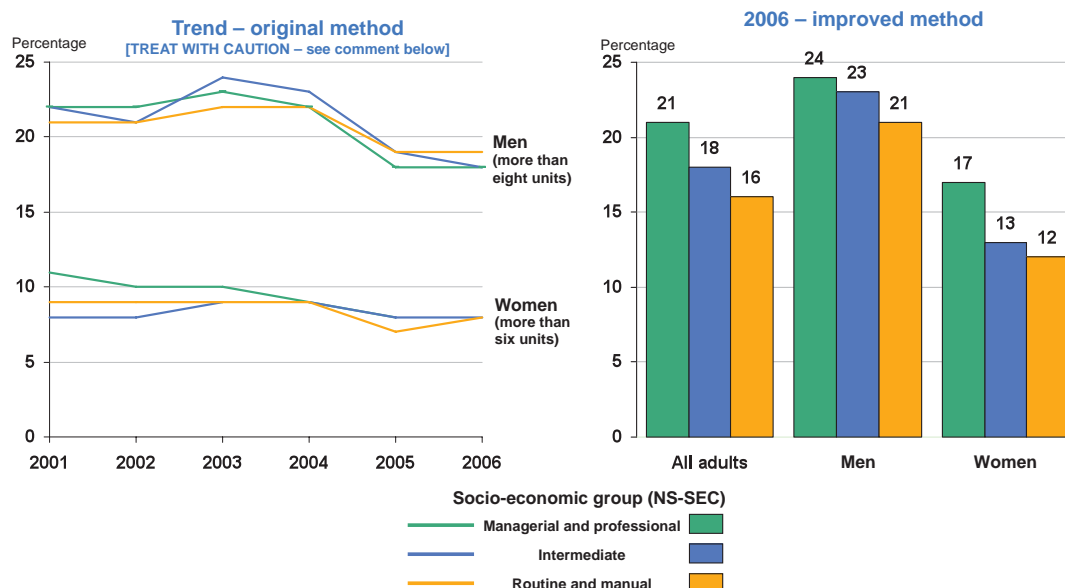
Cigarette smoking prevalence among Black Caribbean men, Irish men and men in the general population decreased significantly between 1999 and 2004. For all other minority ethnic groups, there were no significant differences between the two years. Among Irish women and those in the general population, smoking prevalence was also lower in 2004 than in 1999. There were no significant differences among any of the other ethnic groups.

The Information Centre for Health and Social Care (2006)

Health Survey for England 2004: Health of Ethnic Minorities – Full Report

www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles-related-surveys/health-survey-for-england/health-survey-for-england-2004:-health-of-ethnic-minorities--full-report

A.24a: Differential exposures, vulnerabilities and consequences – Health-related behaviours and biological factors: Alcohol consumption
Excessive alcohol consumption by socio-economic group
 Great Britain, 2001–06



Notes: Figures cover men and women aged 16 and over.
 'Excessive alcohol consumption' indicates that the individual drank more than eight/six units (for men/women respectively) on at least one day in the previous week.
 Source: Office for National Statistics (2008) *General Household Survey 2006: Smoking and drinking among adults, 2006* and previous annual reports from General Household Survey.

Excessive alcohol consumption by socio-economic group, 2001–06

Great Britain

	Percentage (original method)						Percentage (improved method)
	2001	2002	2003	2004	2005	2006	2006
All adults	15	15	16	16	13	13	18
Managerial and professional	16	16	16	15	13	13	21
Intermediate	15	14	16	15	13	12	18
Routine and manual	14	15	15	15	13	13	16
All adult males	21	21	23	22	19	18	23
Managerial and professional	22	22	23	22	18	18	24
Intermediate	22	21	24	23	19	18	23
Routine and manual	21	21	22	22	19	19	21
All adult females	10	10	9	9	8	8	15
Managerial and professional	11	10	10	9	8	8	17
Intermediate	8	8	9	9	8	8	13
Routine and manual	9	9	9	9	7	8	12

Notes: Figures cover men and women aged 16 and over.
 'Excessive alcohol consumption' indicates that the individual drank more than eight/six units (for men/women respectively) on at least one day in the previous week.
 From April 2001 the National Statistics Socio-economic Classification (NS-SEC) was introduced for all official statistics and surveys.
 It has replaced Social Class based on Occupation and Socio-economic Groups (SEG). The individual's socio-economic group is based on their current or last job. Full-time students, persons in inadequately described occupations, persons who have never worked and the long-term unemployed are not shown as separate categories, but are included in the figure for 'All adults'.
 Source: Office for National Statistics (2008) *General Household Survey 2006: Smoking and drinking among adults, 2006* and previous annual reports from General Household Survey.

Improved method for assessing units of alcohol consumed

Estimates of alcohol consumption in surveys are given in standard units derived from assumptions about the alcohol content of different types of drink, combined with information from the respondent about the volume drunk. In recent years, new types of alcoholic drink have been introduced, the alcohol content of some drinks has increased, and alcoholic drinks are now sold in more variable quantities than they used to be. It has therefore become necessary to reconsider the assumptions made in obtaining estimates of alcohol consumption; under the improved methodology, a glass of wine is taken to be two units rather than one. This is of particular importance when comparing by socio-economic group, as those in managerial and professional households (particularly women) are more likely to drink wine – so the improved methodology results in a wider gap between this and the other two groups. Details of the improved methodology are presented in *General Household Survey 2006: Smoking and drinking among adults, 2006*, under 'Updated method of converting volumes drunk to units' (pp 48–52).

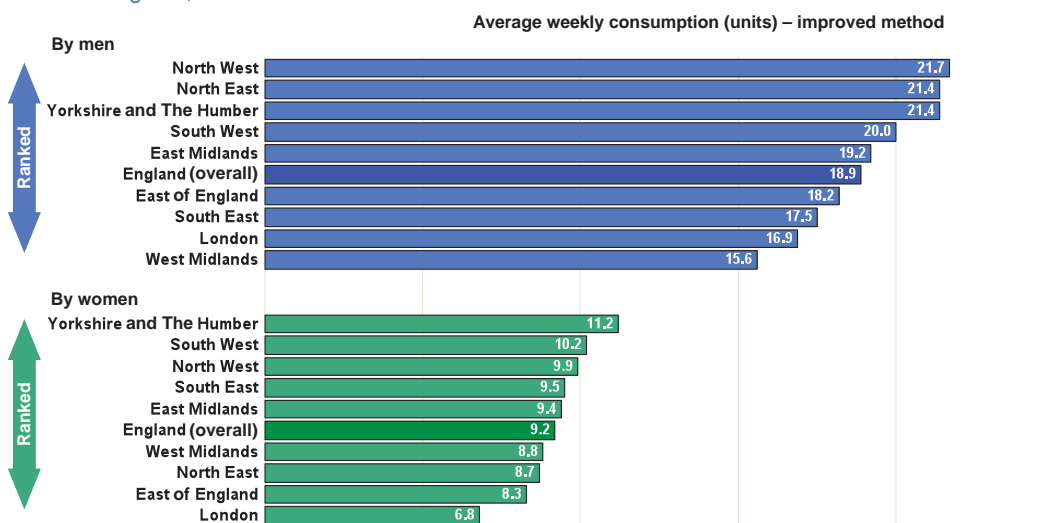
It should be noted that changing the way in which alcohol consumption estimates are derived does not in itself reflect a real change in drinking among the adult population. As data using the improved methodology is available only for 2006, trend data is presented using the original method (but should be treated with caution).

Socio-economic group

Under the improved methodology, variations in the amounts drunk across socio-economic groups were marked, particularly for women. In 2006, women in large employer/higher managerial households were much more likely than those in the routine group to have drunk more than the recommended three units on any one day (47 per cent compared with 23 per cent), and also more likely to have drunk heavily on at least one day in the previous week (19 per cent compared with 11 per cent). The figure and table illustrate the gradient in respect of aggregate socio-economic groupings.

Supplementary information in respect of the frequency of drinking alcohol shows that, in 2006, men and women in large employer/higher managerial households were the most likely to have drunk alcohol in the previous week, while those in households where the reference person was in a semi-routine or routine occupation were the least likely. A similar pattern was apparent in the proportions drinking on five or more days in the previous week. For example, 72 per cent of women in large employer/higher managerial households had drunk alcohol in the last week and 18 per cent had done so on five or more days; among women in households where the reference person was in a routine occupation, these proportions were 42 per cent and 6 per cent respectively.

A.24b: Differential exposures, vulnerabilities and consequences – Health-related behaviours and biological factors: Alcohol consumption
Average adult weekly alcohol consumption by Government Office region
 England, 2006



Note: 'Adult' refers to people aged 16 and over.
 Source: Office for National Statistics (2008) *General Household Survey 2006: Smoking and drinking among adults, 2006* (Table 2.10).

Some differences between men and women were also evident in the variation in consumption across the English regions. Among men, consumption was highest in the three northern regions (North East, North West and Yorkshire and The Humber) and in the South West. The pattern was similar among women, except that consumption was not particularly high in the North East.

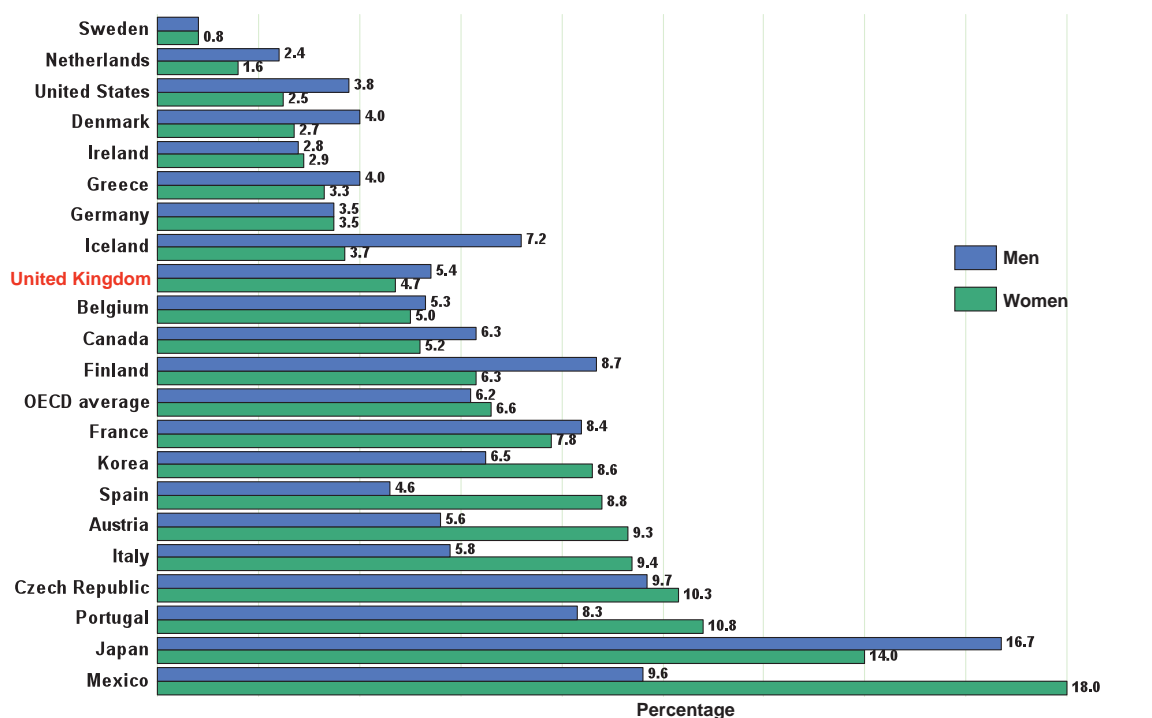
It should be noted that sample sizes in some regions are small and some fluctuation in results from year to year is to be expected. This can affect whether a particular region or country appears to have a high or low consumption level relative to that of other areas, which may not be due to real differences in the population from which the sample is drawn. It is therefore unwise to give undue weight to data for a single year only.

Office for National Statistics (2008)

General Household Survey 2006: Smoking and drinking among adults, 2006

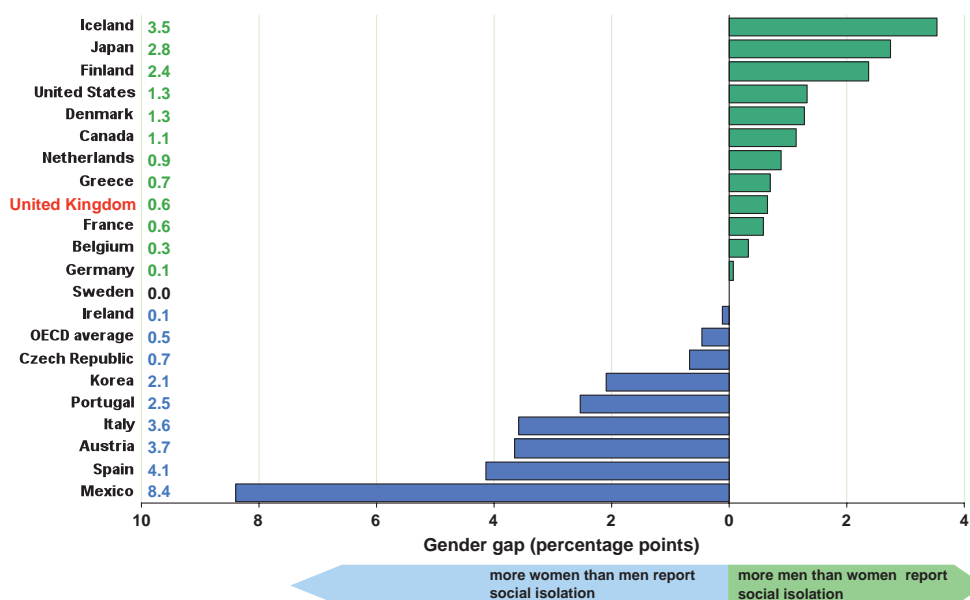
www.statistics.gov.uk/StatBase/Product.asp?vlnk=5756&Pos=&ColRank=1&Rank=272

A.25a: Differential exposures, vulnerabilities and consequences – Social cohesion/social capital: Social isolation
Proportion of population who rarely or never spend time with friends, colleagues or others
 OECD countries, 1999–2002



Note: Ranked on figures for women.
 Source: Organisation for Economic Co-operation and Development (2007) *Women and Men in OECD Countries*, p25 – from *World Values Surveys* data.

A.25b: Differential exposures, vulnerabilities and consequences – Social cohesion/social capital: Social isolation
Proportion of population who rarely or never spend time with friends, colleagues or others – gender gap
 OECD countries, 1999–2002



Source: Organisation for Economic Co-operation and Development (2007) *Women and Men in OECD Countries*, p25 – from *World Values Surveys* data.

Social isolation is characterised by the lack of contact with other people in normal daily living. Social contact occurs in a variety of settings – in the workplace, in social activities and within families – and can be assessed through data measuring the frequency of contacts reported by individuals.

The data shown in the charts is from the *World Values Surveys*, which ask respondents about their contact with other people in their normal daily lives. In the latest wave of surveys (1999–2002), countries supplied information on whether respondents ‘rarely’ or ‘never’ had contact with friends, work colleagues and other acquaintances in places of worship and in sports and cultural associations.

Among the 21 OECD countries for which data was available, the percentages of respondents (all adults regardless of gender) in the ‘never’ or ‘rarely’ categories exceeded 10 per cent in Mexico (where women feel particularly isolated) and Japan (where isolation is a male problem). Total rates of under 4 per cent were reported in Sweden, the Netherlands, the United States, Denmark, Ireland, Greece, Germany and Ireland.

By gender

Figure A.25b indicates that, among the 21 countries for which data was available, social isolation was a greater problem among men in more countries than it was a greater problem among women. However, the gender gaps were not large except in Iceland, Japan and Finland (greater social isolation among men) and in Mexico, Spain and Austria (greater social isolation among women).

By income

In almost all countries, the risk of social isolation was lower for people in the (self-reported) high-income group than for those in the low- and middle-income groups.

By age

Those in the oldest age group (50 and over) were more likely to have infrequent contacts than prime working-age (30–49 years) and young (15–29 years) respondents.

Organisation for Economic Co-operation and Development (2007)

Women and Men in OECD Countries

www.oecd.org/document/39/0,3343,en_21571361_38039199_38168743_1_1_1_1,00.html

www.oecd.org/dataoecd/44/52/37962502.pdf

Organisation for Economic Co-operation and Development (2005)

Society at a Glance: OECD Social Indicators, 2005

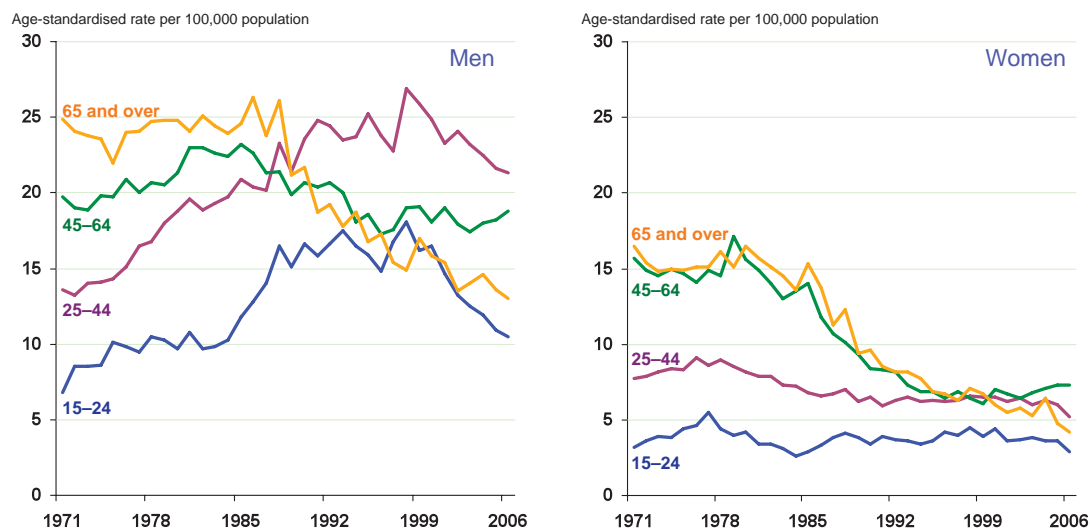
www.oecd.org/document/24/0,3343,en_2649_34637_2671576_1_1_1_1,00.html

Indicator **A.26** shows suicide mortality, and **A.27** shows self-reported life satisfaction.

A.26a: Differential exposures, vulnerabilities and consequences – Psychosocial factors: Negative life events

Suicide mortality rate by gender and age

United Kingdom, 1971–2006



Notes: Data includes deaths with a verdict of undetermined intent (open verdicts). Rates from 2002 are coded to ICD-10. Rates are age-standardised to the European standard population. Source: Office for National Statistics (2008) *Social Trends No 38 – 2008 edition*, Table 7.18 (p103).

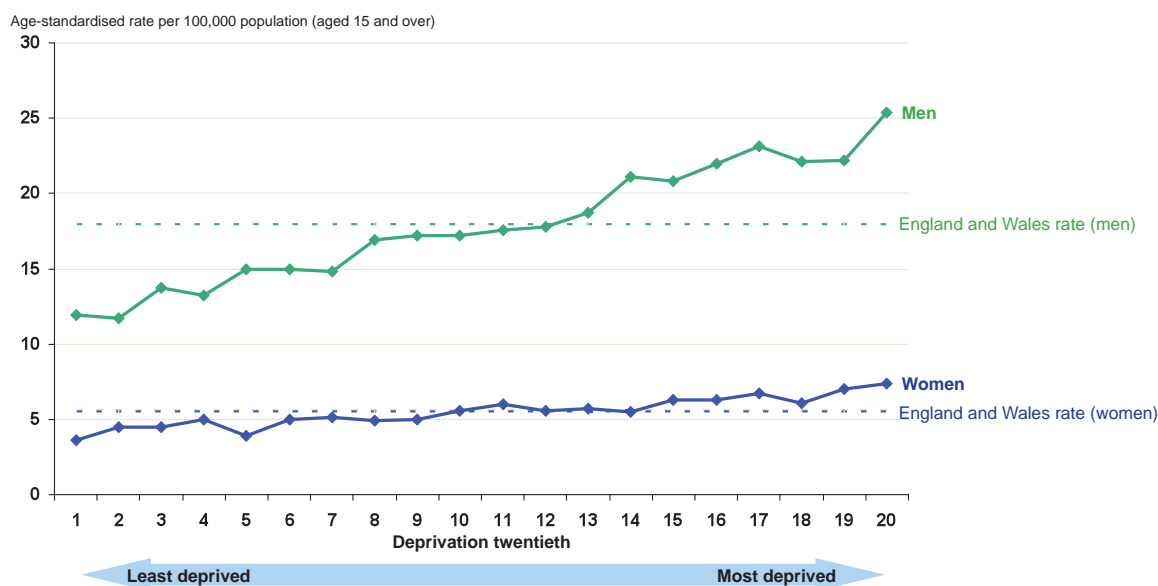
Trends in suicide rates have varied by age group and gender in the UK over the last 35 years. Until 1988, men aged 65 and over had the highest suicide rates. In 1986 the suicide rate among men aged 65 and over peaked at 26.3 per 100,000 population; it then fell, reaching 13.0 per 100,000 in 2006. In contrast, suicide rates among younger men rose over the period – in particular for those aged 25–44, whose suicide rate almost doubled from 13.6 per 100,000 in 1971 to a peak of 26.9 per 100,000 in 1998. It has since declined, but in 2006 remained the highest of all age groups and of both genders, at 21.3 per 100,000.

There is a clear difference in suicide rates between men and women. In 2006, the age-standardised rate for all men aged 15 and over in the UK was 17.4 per 100,000, three times that of women (5.3 per 100,000). Among women aged 45 and over, suicide rates more than halved between 1981 and 2006. For younger women the rates have remained fairly stable since the mid-1980s.

A.26b: Differential exposures, vulnerabilities and consequences – Psychosocial factors: Negative life events

Suicide rates by deprivation twentieth and gender

England and Wales, 1999–2003



Note: Data excludes suicides by people aged under 15. Rates are age-standardised to the European standard population. Source: Office for National Statistics (2006) 'Suicide trends and geographical variations in the United Kingdom, 1991–2004' *Health Service Quarterly* 31, Figure 7 (Autumn 2006).

Analysis by ONS of data for England and Wales over the period 1999–2003 shows that suicide rates are highest in the most deprived areas. For both men and women aged 15 and over, suicide rates among those living in the most deprived areas were double those living in the least deprived – rates of 11.9 and 3.6 per 100,000 for men and women respectively in the least deprived twentieth contrasted with 25.4 and 7.4 in the most deprived twentieth.

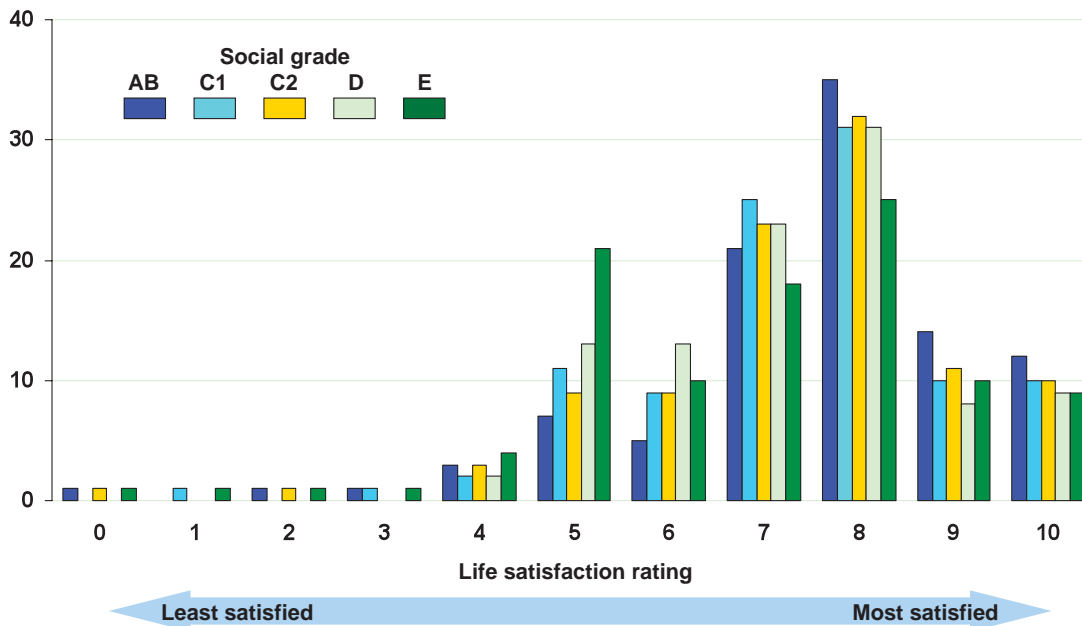
Within the regions of England and Wales, the relationship between suicide and deprivation was still clear, with those living in the most deprived fifth of areas having higher suicide rates than those living in the least deprived fifth.

Office for National Statistics (2006) 'Suicide trends and geographical variations in the United Kingdom, 1991–2004', in *Health Statistics Quarterly* 31 (Autumn 2006)
www.statistics.gov.uk/downloads/theme_health/HSQ31.pdf

Indicator **A.25** shows the proportion of population who rarely or never spend time with friends; **A.27** shows self-reported life satisfaction.

A.27a: Differential exposures, vulnerabilities and consequences – Psychosocial factors: Subjective wellbeing
Self-reported life satisfaction by social grade
 England, 2007

Percentage of people reporting overall life satisfaction ratings, on a scale from 0 to 10



Note: Social grade is a classification based on occupation developed from the *National Readership Survey*. Examples of occupation on each grade include:
 AB : (A) Doctor, solicitor, accountant, (B) teacher, nurse, police officer
 C1 : Junior manager, student, clerical worker
 C2 : Foreman, plumber, bricklayers
 D : Manual workers, shop workers, apprentices
 E : Casual labourers, state pensioners, unemployed. Grades A and B have been combined owing to their very similar distributions.
 Source: Defra (2007), statistical release 'New statistics on life satisfaction shed light on wellbeing'.

In 2007, approximately three-quarters (73 per cent) of people in England rated their satisfaction with life as 7 or more out of 10, according to preliminary results from the 2007 *Survey of behaviours and attitudes* carried out by the Department for Environment, Food and Rural Affairs (Defra).

Large differences in satisfaction with life in general, and with selected aspects of life,⁹¹ were found between occupational groups and between age groups.

Fewer people than average in unskilled jobs, on a state pension or unemployed were satisfied with all the selected aspects of life except for feeling part of a community. More older people than average were satisfied with their future financial security and feeling part of a community; more younger people than average were satisfied with their health.

Those in unskilled jobs, on a state pension or unemployed were more likely than average to have regularly experienced negative feelings such as depression, feeling unsafe and feeling lonely in the previous two weeks. Those in skilled jobs such as doctors, solicitors and teachers were more likely than average to have regularly felt happy, energised or engaged with what they were doing in the previous two weeks.

The satisfaction rating became more informative when looked at by socio-demographic variables such as 'social grading', which is determined by occupation. For the combined social grades of A and B (comprised of, for example, doctors, solicitors, accountants, teachers, nurses and police officers), making up 23 per cent of the population, the average rating was 7.6. For group E (e.g. casual labourers, state pensioners and unemployed people), making up 15 per cent of the population, the average rating was 6.7.

⁹¹ Relationships, accommodation, standard of living, local area, day-to-day activities, health, leisure, control, achievement of goals, future financial security and community. From Defra statistical release 233/07, 27/7/07.

In both group D (manual workers, shop workers, apprentices etc, making up 15 per cent of the population) and group E, the proportions rating themselves as 5 (which could be interpreted as neither satisfied nor dissatisfied) were higher than in other groups, and the proportions rating themselves as around 7 or 8 (broadly interpreted as satisfied) were lower than in other groups.

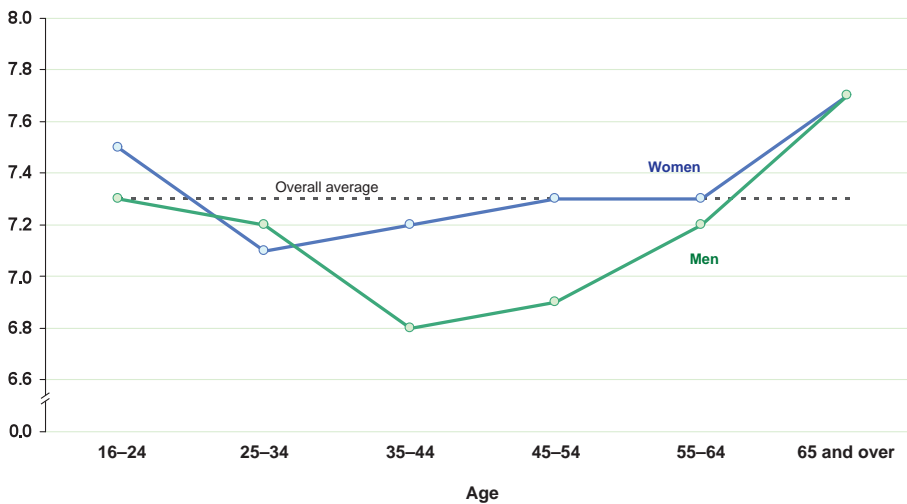
Social grades C1 (junior manager, student, clerical worker) and C2 (foreman, plumber, bricklayer) together make up 47 per cent of the population, and in showing similar characteristics they strongly affect and reflect the overall averages for life satisfaction.

Research suggests that average overall life satisfaction changes little over time in developed countries. However, at present there is no clear consensus about why this is the case.

Defra (2007) statistical release ‘New statistics on life satisfaction shed light on wellbeing’
www.nds.coi.gov.uk/imagelibrary/detail.asp?MediaDetailsID=211483

A.27b: Differential exposures, vulnerabilities and consequences – Psychosocial factors: Subjective wellbeing
Self-reported life satisfaction by gender and age
England, 2007

Average life satisfaction rating (out of 10)



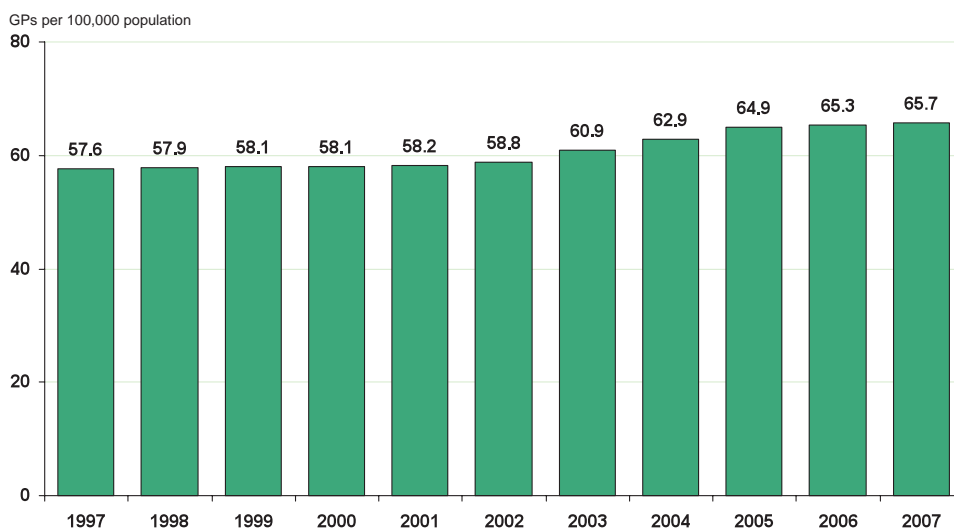
Source: Defra (2007) statistical release ‘2007 Survey of Public Attitudes and Behaviours Toward the Environment’.

Defra’s 2007 survey found that the average ‘satisfaction with life’ rating was 7.3, with variations by age and gender. The most satisfied groups were those who were 65 and over, with both men and women in this age group reporting average ratings of around 7.7. Satisfaction with life was lowest among middle-aged men, with an average rating of 6.8 for men aged 35–44.

Defra (2007) statistical release ‘2007 Survey of Public Attitudes and Behaviours Toward the Environment’
www.defra.gov.uk/environment/statistics/pubatt/download/pubattsum2007.pdf

Indicator **A.25** shows the proportion of the population who rarely or never spend time with friends, **A.26** shows suicide mortality, and **A.30** to **A.39** cover health outcomes.

A.28a: Differential exposures, vulnerabilities and consequences – Health system: Availability (access to services)
Number of GPs per 100,000 population
 England, 1997–2007



Notes: Figures exclude GP registrars and GP retainers, and are based on a count of GP contracts; note that some doctors may have more than one contract. Data is as at 1 October from 1997 to 1999 and 30 September from 2000 to 2007. Source: The Information Centre for Health and Social Care (2008) *General and Personal Medical Services, England, 1997–2007*.

Between 1997 and 2007 the number of NHS general medical practitioners (excluding GP registrars and GP retainers) rose by 19 per cent, from 28,046 to 33,364. This represents an increase from 57.6 to 65.7 GPs per 100,000 population.

The rate of increase in the number of GPs has slowed in the last two years (2006 and 2007).

The Information Centre for Health and Social Care (2008)
General and Personal Medical Services, England 1997–2007
www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-staff-numbers/nhs-staff-1997--2007-general-practice

A.28b: Differential exposures, vulnerabilities and consequences – Health system: Availability (access to services)
Number of GPs per 100,000 weighted population, * by area deprivation
 England, September 2005



Notes: Figures exclude GP retainers and registrars. *The GP-relevant population was constrained to ONS population estimates (based on GP lists in the ADS2004 reconciled to 2003-based ONS population projections for 2005), weighted for age and to reflect need for GP consultations. Age and need weightings were based on the method used for the 2006/07 PCT revenue allocations for primary medical services. Area deprivation was measured by the Index of Multiple Deprivation 2004, PCT summary (average score) (produced by the Healthcare Commission for PCT boundaries pre-October 2006 reorganisation). Source: Department of Health (2008) *Tackling Health Inequalities: 2007 Status Report on the Programme for Action*. Based on data from the Census of General and Personal Medical Services (The Information Centre for Health and Social Care).

The analysis by area deprivation presented in the chart above is based on full-time equivalent (FTE) GPs per 100,000 weighted population (weighted for age and to reflect need for GP consultations), for primary care trusts (PCTs) prior to the reorganisation of October 2006. (Note that Figure A.28a is based on headcount rather than FTE GPs, and on unweighted populations.)

Although the number of FTE GPs per 100,000 weighted population has increased over recent years, inequalities persist between more and less deprived areas. In September 2005, the most deprived fifth of PCTs had the fewest FTE GPs per 100,000 while the least deprived fifth of PCTs had the most FTE GPs per 100,000.

Although some deprived PCTs have a relatively high number of FTE GPs per 100,000 weighted population, at September 2005 more than three-quarters of PCTs in the most deprived fifth (46 out of 61) had GP levels below the England average level and nearly two-thirds of PCTs in this fifth (37 out of 61) were more than 10 per cent below the England average level.

Department of Health (2008)

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

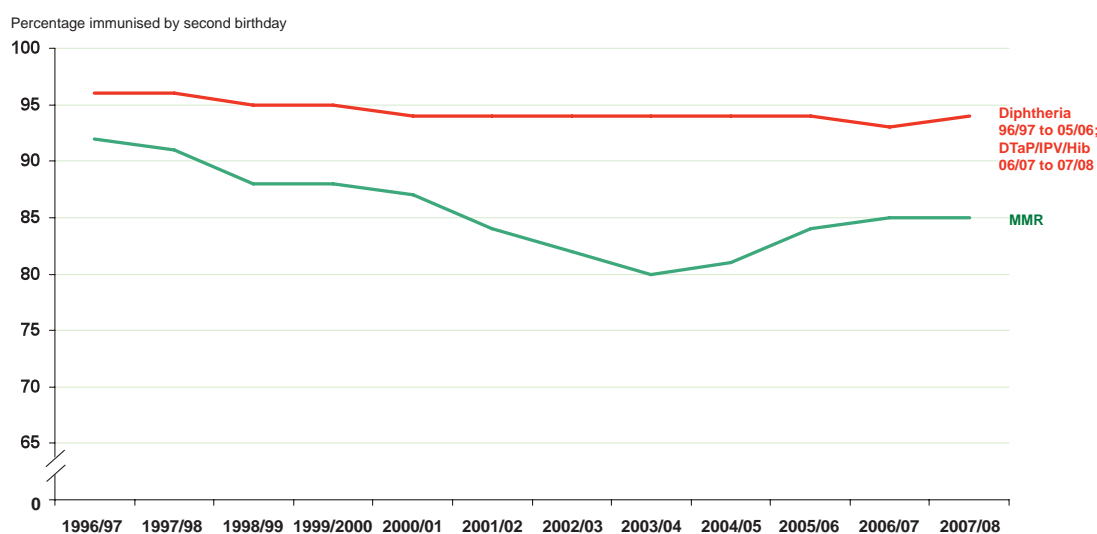
www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH_083471

Indicator **A.8** shows government expenditure on health as a percentage of GDP.

A.29: Differential exposures, vulnerabilities and consequences – Health system: Contact (access to services)

Childhood immunisation rates

England, 1996/97–2007/08



Note: For the period 1996/97–2005/06 the rates for the three immunisations diphtheria, tetanus and polio are virtually identical as they are generally administered at the same time: for convenience the rates for diphtheria are shown.
Source: The Information Centre for Health and Social Care (2008) *NHS Immunisation Statistics, England 2007–08*.

Childhood immunisation rates, 1996/97–2007/08

England		percentages							
Year of second birthday	Diphtheria, Tetanus, Polio, Pertussis Hib (DTaP/IPV/Hib)	Diphtheria	Tetanus	Polio	Pertussis (Whooping Cough)	Haemophilus Influenzae b (Hib)	Measles, Mumps, Rubella (MMR)	MenC	
1996/97	–	96	96	96	94	95	92	–	
1997/98	–	96	96	96	94	95	91	–	
1998/99	–	95	95	95	94	95	88	–	
1999/2000	–	95	95	95	94	94	88	–	
2000/01	–	94	95	94	94	94	87	–	
2001/02	–	94	94	94	93	93	84	85	
2002/03	–	94	94	93	93	93	82	92	
2003/04	–	94	94	94	93	93	80	93	
2004/05	–	94	94	93	93	93	81	93	
2005/06	–	94	94	94	94	94	84	93	
2006/07	93	–	–	–	–	–	85	93	
2007/08	94	–	–	–	–	–	85	93	

Notes: Figures show percentages of children immunised by their second birthday. Nine PCTs were unable to submit data in 2005/06 owing to problems relating to the implementation of a new child health system. Seven PCTs were unable to provide reliable annual data in 2006/07 owing to ongoing problems relating to the implementation of a new child health system. In 2007/08 six PCTs did not provide any data, while a further seven had some missing data for the five-year cohort, owing to ongoing problems relating to the implementation of a new child health system. One further PCT was unable to provide data owing to a major problem with its child health computer system.

Immunisation is one of the most important public health initiatives of the last 60 years. It has improved the quality and chance of life for many, both in the UK and internationally. Participation by everyone in this programme is crucial, as every child who dies without immunisation from one of the targeted diseases represents a death that could have been prevented.

The UK’s immunisation programme has had a major impact on preventing illnesses and deaths from a range of diseases that previously presented considerable risk to the population.

After falling to 80 per cent in 2003/04, uptake of the measles, mumps and rubella (MMR) vaccine by children reaching their second birthday increased steadily to 85 per cent in 2006/07 and remained at 85 per cent in 2007/08. For children reaching their second birthday, uptake of vaccines against diphtheria, tetanus, polio, pertussis, Haemophilus influenzae type b (DTaP/IPV/Hib) and meningitis C remained between 93 per cent and 94 per cent over the last five years to 2007/08.

At a regional level, all 10 strategic health authorities (SHAs) with the exception of London (where reported coverage is incomplete) reported uptake rates of DTap/IPV/Hib above 90 per cent in 2007/08 and 7 had rates of 95 per cent or above. For MMR, all SHAs reported coverage below 90 per cent, but London was the only SHA to record uptake of less than 80 per cent.

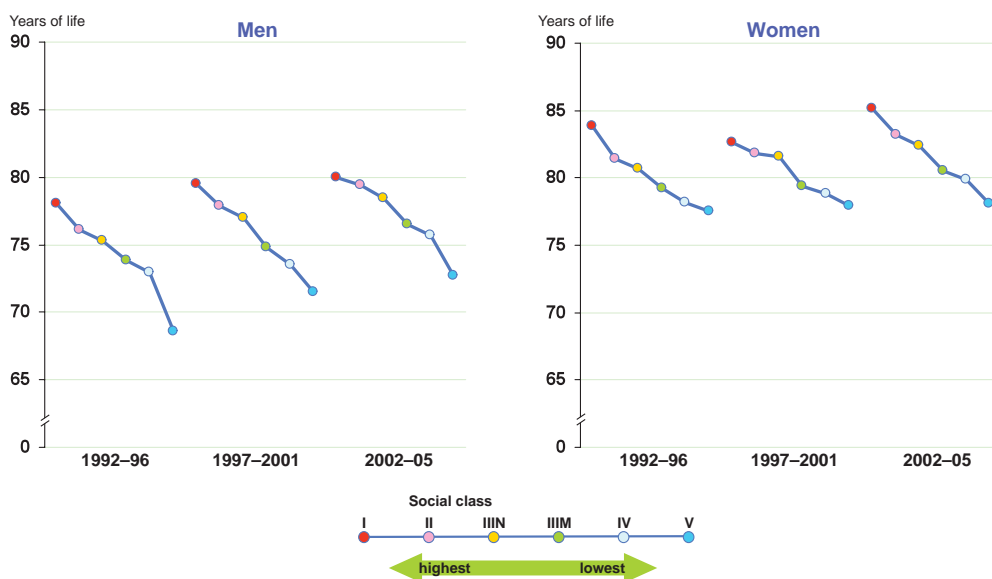
The Information Centre for Health and Social Care (2008)
NHS Immunisation Statistics, England 2007–08
www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/immunisation

MMR and deprivation

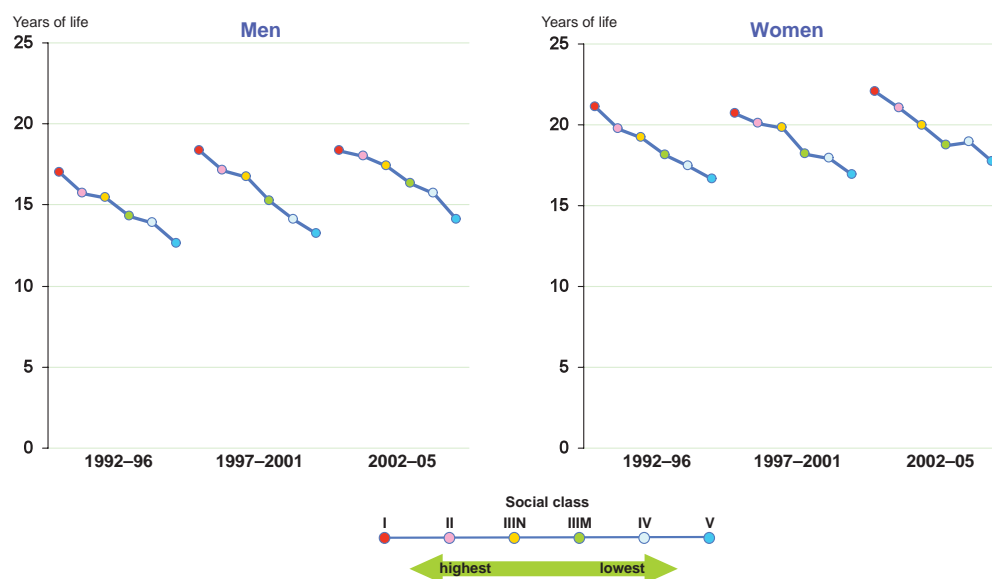
By examining the Index of Multiple Deprivation (IMD) score for each PCT, the North West Public Health Observatory identified a relationship between the deprivation of the PCT and the percentage of children immunised with the MMR vaccine. Studies have revealed that those not vaccinated, or not fully up to date with their vaccination schedule, are more likely to live in disadvantaged areas and less likely to use primary care services. Within the North West (and probably elsewhere) there is a negative correlation between the IMD Score (2004) and the percentage of children immunised with MMR, indicating that the more deprived areas have lower protection against measles, mumps and rubella. Sixty-one per cent of the variation rate is explained by deprivation.

North West Public Health Observatory (2006)
NWPHO Monthly, August 2006 A: Health Protection – Childhood Immunisation
www.nwph.net/nwpho/Publications/NWPHO%20Monthly_2006-09a.pdf

A.30a: Differential outcomes in health – Mortality: Life expectancy at birth and 65
Life expectancy at birth by social class
 England and Wales, 1992–2005



A.30b: Differential outcomes in health – Mortality: Life expectancy at birth and 65
Life expectancy at age 65 by social class
 England and Wales, 1992–2005



Note: Registrar General's Social Class (RGSC) based on occupation
 Non-manual Manual
 I Professional III M Skilled manual
 II Managerial and technical/intermediate IV Partly skilled
 III N Skilled non-manual V Unskilled
 Source: Office for National Statistics (2007) news release 'Variations persist in life expectancy by social class'.

Life expectancy at birth and at age 65 by social class, 1972–2005

England and Wales

Men								Women							
Social class	1972–76	1977–81	1982–86	1987–91	1992–96	1997–2001	2002–2005	Social class	1972–76	1977–81	1982–86	1987–91	1992–96	1997–2001	2002–2005
At birth								At birth							
I	71.9	74.4	75.1	76.2	78.0	79.5	80.0	I	79.0	80.1	80.7	81.1	83.8	82.6	85.1
II	71.9	72.6	74.1	75.0	76.1	77.9	79.4	II	77.1	78.3	78.8	80.7	81.4	81.8	83.2
IIIN	69.5	71.1	72.5	74.4	75.3	77.0	78.4	IIIN	78.3	78.2	79.0	80.0	80.7	81.6	82.4
IIIM	70.0	70.0	71.7	72.7	73.8	74.8	76.5	IIIM	75.2	76.3	77.3	77.9	79.2	79.4	80.5
IV	68.3	69.0	71.0	70.8	72.9	73.5	75.7	IV	75.3	75.9	77.5	77.4	78.2	78.8	79.9
V	66.5	67.4	67.7	68.7	68.6	71.5	72.7	V	74.2	75.6	75.9	76.6	77.5	77.9	78.1
unclassified	57.5	62.7	65.5	66.7	68.8	71.5	73.8	unclassified	70.1	73.0	73.0	74.0	75.0	77.5	77.9
All men	69.3	70.1	71.7	72.6	73.9	75.3	77.0	All women	75.3	76.5	77.4	78.3	79.3	80.0	81.1
Non-manual	71.2	72.3	73.7	75.0	76.1	77.9	79.2	Non-manual	77.7	78.4	79.0	80.4	81.3	81.8	82.9
Manual	69.1	69.4	71.0	71.7	73.0	74.1	75.9	Manual	75.2	76.0	77.2	77.5	78.5	79.0	80.0
<i>Difference</i>	2.1	2.9	2.7	3.3	3.2	3.8	3.3	<i>Difference</i>	2.5	2.4	1.9	2.9	2.8	2.8	2.9
At age 65								At age 65							
I	14.0	15.5	15.5	15.8	17.0	18.3	18.3	I	19.1	20.0	18.9	19.0	21.1	20.7	22.0
II	13.3	14.2	14.5	15.0	15.7	17.1	18.0	II	17.2	17.8	18.2	19.2	19.7	20.1	21.0
IIIN	12.6	13.3	13.6	14.3	15.4	16.7	17.4	IIIN	17.9	17.7	18.2	18.7	19.2	19.8	19.9
IIIM	12.2	12.5	13.1	13.6	14.3	15.2	16.3	IIIM	16.4	16.9	16.9	17.2	18.1	18.2	18.7
IV	12.2	12.1	12.7	12.8	13.9	14.1	15.7	IV	16.9	16.8	17.5	17.3	17.4	17.9	18.9
V	11.6	11.8	11.6	12.0	12.6	13.2	14.1	V	16.6	16.4	16.2	16.4	16.6	16.9	17.7
unclassified	10.8	9.8	10.9	11.1	12.0	13.7	15.1	unclassified	15.5	15.8	15.6	15.8	16.0	17.1	17.6
All men	12.3	12.6	13.1	13.7	14.5	15.5	16.6	All women	16.3	16.7	17.0	17.5	18.1	18.6	19.4
Non-manual	13.1	14.0	14.3	14.9	15.8	17.1	17.9	Non-manual	17.5	17.9	18.2	18.9	19.5	20.0	20.5
Manual	12.1	12.3	12.7	13.2	14.0	14.7	15.9	Manual	16.6	16.8	17.0	17.1	17.6	17.9	18.6
<i>Difference</i>	1.0	1.7	1.6	1.7	1.8	2.4	2.0	<i>Difference</i>	0.9	1.1	1.2	1.8	2.0	2.1	1.9

Source: Office for National Statistics (2007) news release 'Variations persist in life expectancy by social class'.

The National Statistics Socio-Economic Classification (NS-SEC) replaced the Registrar General’s Social Class (RGSC) as the official socio-economic classification at the 2001 Census. However, RGSC has been used for this analysis of life expectancy by social class to enable review of long-term trends.

Variations in life expectancy among social classes persist. While life expectancy has risen for all social classes over the last 30 years, people in professional occupations (Social Class I) have the longest expectation of life, followed by managerial and technical occupations (Social Class II) and so on. People in unskilled manual occupations (Social Class V) have the shortest expectation of life.

Taking the period of analysis as a whole, from 1972–76 to 2002–05:

- both men and women classified to non-manual occupations had a greater increase in life expectancy at birth and at age 65 than those classified to manual occupations
- for men, there was an increase in life expectancy at birth of 8.0 years over the period of analysis for those classified to non-manual occupations, compared with 6.8 years for those classified as manual
- for women, these figures were 5.2 years and 4.8 years respectively.

In contrast, between 1997–2001 and 2002–05:

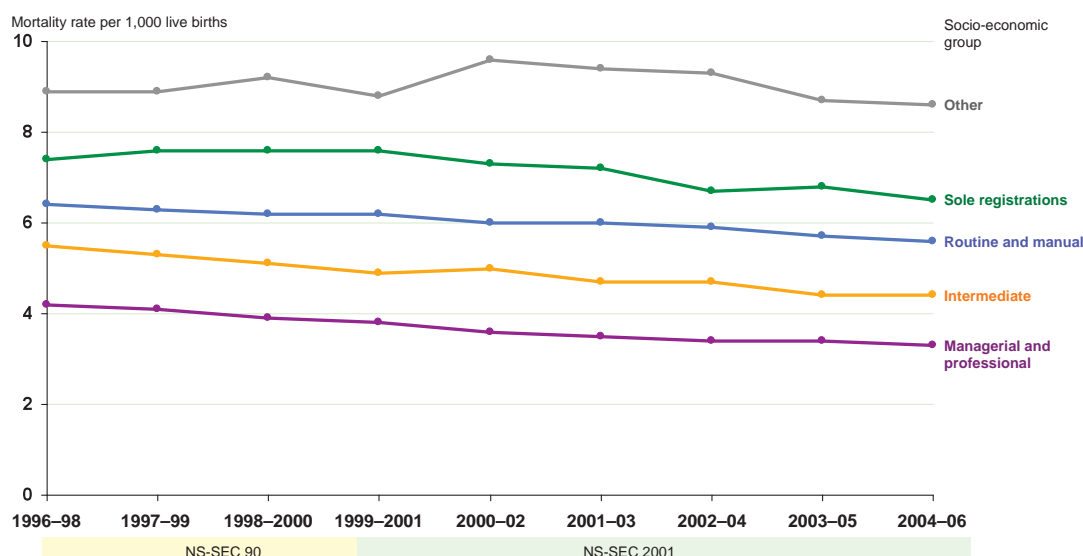
- life expectancy for men, at birth and at age 65, increased more for manual than non-manual groups
- among women, estimates of life expectancy increased by a similar amount for those classified to non-manual and manual occupations.

Care should be taken in interpreting the figures. Some degree of variation is to be expected as a result of sampling, and the results for the latest period – while interesting – are not conclusive evidence of an underlying change in the pattern of inequalities.

Office for National Statistics (2007)

Trends in ONS Longitudinal Study estimates of life expectancy, by social class 1972–2005
www.statistics.gov.uk/StatBase/Product.asp?vlnk=8460&Pos=2&ColRank=1&Rank=272

A.31a: Differential outcomes in health – Mortality: Infant mortality ratio
Infant mortality rate by socio-economic group
 England and Wales, 1996–2006



Note: Figures are three-year average rates using NS-SEC 90 for 1994–2001, and NS-SEC 2001 for 2001 onwards.
 Source: Department of Health (2008) *Tackling Health Inequalities: 2007 Status Report on the Programme for Action* – based on ONS data.

Infant mortality rate by socio-economic group, 1994–2006

England and Wales

Analytical classes	NS-SEC 90					NS-SEC 2001					
	1994–96	1995–97	1996–98	1997–99	1998–2000	1999–2001	2000–02	2001–03	2002–04	2003–05	2004–06
Three-class version											
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
Intermediate	5.2	5.4	5.5	5.3	5.1	4.9	5.0	4.7	4.7	4.4	4.4
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 registrations)	5.9	5.8	5.7	5.6	5.4	5.3	5.2	5.0	4.9	4.8	4.8
Sole registrations	7.9	7.5	7.4	7.6	7.6	7.6	7.3	7.2	6.7	6.8	6.5

Notes: Figures are three-year average rates of infant deaths per 1,000 live births using NS-SEC 90 for 1994–2001 and NS-SEC 2001 for 2001 onwards.
 Figures for live births are a 10 per cent sample coded for father's occupation.
 'Other' refers to students, never worked, long-term unemployed, occupation inadequately described or not classifiable for other reasons.
 'Inside marriage/joint registrations' refers to infants born inside marriage or outside marriage jointly registered by both parents.
 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.
 'Sole registrations' are births registered by the mother alone. They are not included in 'All (inside marriage/joint registrations)'.
 Source: Department of Health (2008) *Tackling Health Inequalities: 2007 Status Report on the Programme for Action* – based on ONS data.

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

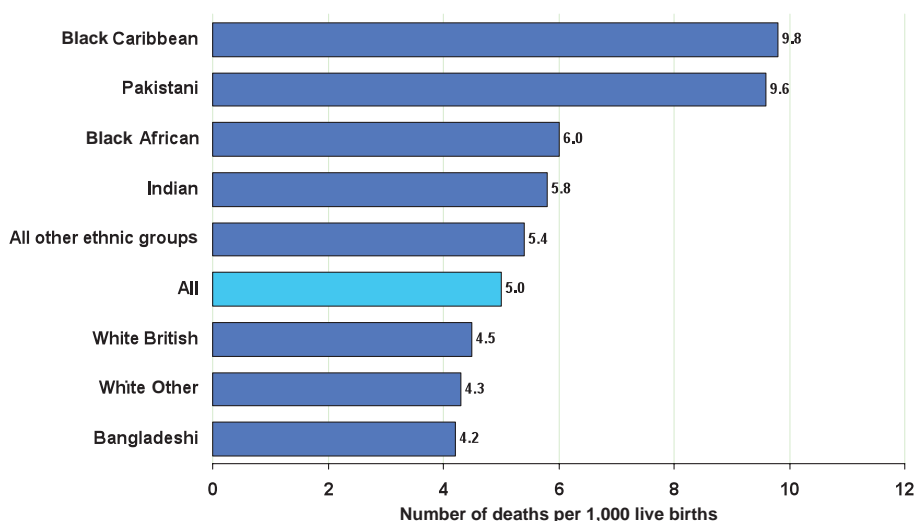
Latest data for 2004–06 shows a further slight narrowing in the gap between the routine and manual group and the population as a whole, compared with 2002–04 and 2003–05. Over the period since 1997–99, the gap widened, although there were year-on-year fluctuations in intervening years.

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

Department of Health (2008)

Tackling Health Inequalities: 2007 Status Report on the Programme for Action
www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH_083471

A.31b: Differential outcomes in health – Mortality: Infant mortality ratio
Infant mortality rate by ethnic group
England and Wales, babies born in 2005



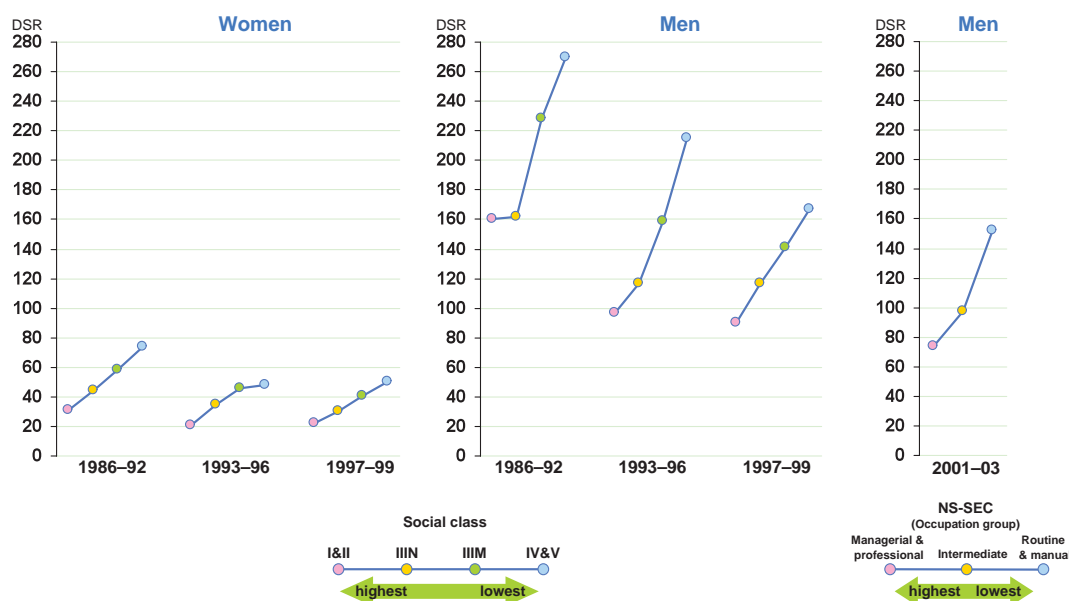
Notes: 'All other ethnic groups' covers Chinese, Other Asian, Other Black, Other, and all Mixed groups.
The 'All' figure includes birth and death registration records not linked to an NHS Numbers for Babies record.
Source: Office for National Statistics (2008) news release 'Large differences in infant mortality by ethnic group'.

There are large differences in the infant mortality rates of different ethnic groups in England and Wales. Asian and Black ethnic groups accounted for over 11 per cent of live births in England and Wales in 2005, and 17 per cent of infant deaths. For babies born in 2005, babies in the Pakistani and Black Caribbean groups had particularly high infant mortality rates, of 9.6 and 9.8 deaths per 1,000 live births respectively – more than double the rate in the White British group of 4.5 deaths per 1,000 live births.

Mortality in the Pakistani group was high throughout the first year of life. Mortality in the Black Caribbean group was especially high in the first month of life. Half of all infant deaths in the Pakistani group were due to congenital anomalies, compared with only a quarter of deaths in the White British group. In the Black Caribbean group, 67 per cent of the infant deaths were due to conditions arising from low birthweight and premature birth. Only 44 per cent of the deaths in the White British group were due to these conditions.

This data has been compiled from a linkage of routine birth and death registration records for all live births in England and Wales in 2005 with NHS Numbers for Babies (NN4B) records, which include information on ethnic group. Stillbirths are not included in these figures.

Office for National Statistics (2008) news release 'Large differences in infant mortality by ethnic group'
www.statistics.gov.uk/StatBase/Product.asp?vlnk=151111&Pos=3&ColRank=1&Rank=272

A.32a: Differential outcomes in health: Mortality: Cardiovascular**Ischaemic heart disease mortality rate by social class and socio-economic group**Aged 35–64 years by social class (1986–1999) or aged 25–64 (by NS-SEC (2001–03))
England and Wales

Note: 'DSR' is directly age-standardised death rate.

Source: Social class (1986–99) – 'Trends in social class differences in mortality by cause, 1986–2000' in *Health Statistics Quarterly* 20 (Winter 2003).NS-SEC (2001–03) – 'Social inequalities in male mortality for selected causes of death by the NS-SEC, England and Wales, 2001–03' in *Health Statistics Quarterly* 38 (Summer 2008).

Ischaemic heart disease (IHD), which makes the single largest contribution to overall male mortality, accounted for 31 per cent of all male deaths in 1997–99. Although there were marked falls in deaths from IHD in all social classes, the rate of improvement varied significantly between social classes. The greatest percentage fall was in Social Classes I&II, particularly between 1986–92 and 1993–96 when a 40 per cent fall was sustained.

The pattern of improvement over time in Social Classes IV&V was different from that in the other classes. While the reduction in IHD deaths in Social Classes I&II, IIIN and IIIM took place mainly before 1996, the fall in Social Classes IV&V was slower but continued at the same rate throughout the period to 1999. Despite these differences in the rate of change, the gradient between social classes remained present throughout and widened over the period. The ratio of mortality rates between Social Classes IV&V and I&II rose from 1.69 in 1986–92 to 2.22 in 1993–96, then fell back to 1.86 in 1997–99.

Between 1986–92 and 1997–99, IHD mortality in women showed similar falls of around 30 per cent in all social classes. Social class gradients persisted throughout the period, although the difference between Social Classes I&II and IV&V marginally failed to achieve statistical significance in 1997–99. The ratio of mortality rates between Social Classes IV&V and I&II fell slightly from 2.38 to 2.27.

Office for National Statistics (2003) 'Trends in social class differences in mortality by cause, 1986 to 2000', in *Health Statistics Quarterly* 20 (Winter 2003)

www.statistics.gov.uk/downloads/theme_health/HSQ20.pdf

Subsequent analysis of data for 2001–03 by NS-SEC in respect of males aged 25–64 found that the 'routine' class had a rate of death from IHD 2.9 times higher than the 'higher managerial and professional' class. Analyses by RGSC for the period 1991–93 in men aged 20–64 also showed a mortality rate from IHD in Social Class V 2.9 times higher than in Social Class I.

The gap in mortality between the most advantaged and most disadvantaged classes has therefore remained similar in magnitude. This is despite the more disadvantaged socio-economic position of RGSC Social Class V occupations compared with those occupations designated to the NS-SEC routine

class, the smaller population size of the former class, and its more homogeneous make-up. The lack of change in the magnitude of the relative gap between the most and least advantaged classes, whether measured by RGSC in 1991–93 or by NS-SEC in 2001–03, is suggestive of several, potentially counterbalancing explanations brought about by the change in the occupational profile and population sizes of classes at the extremes of the social position scale between 1991–93 and 2001–03.

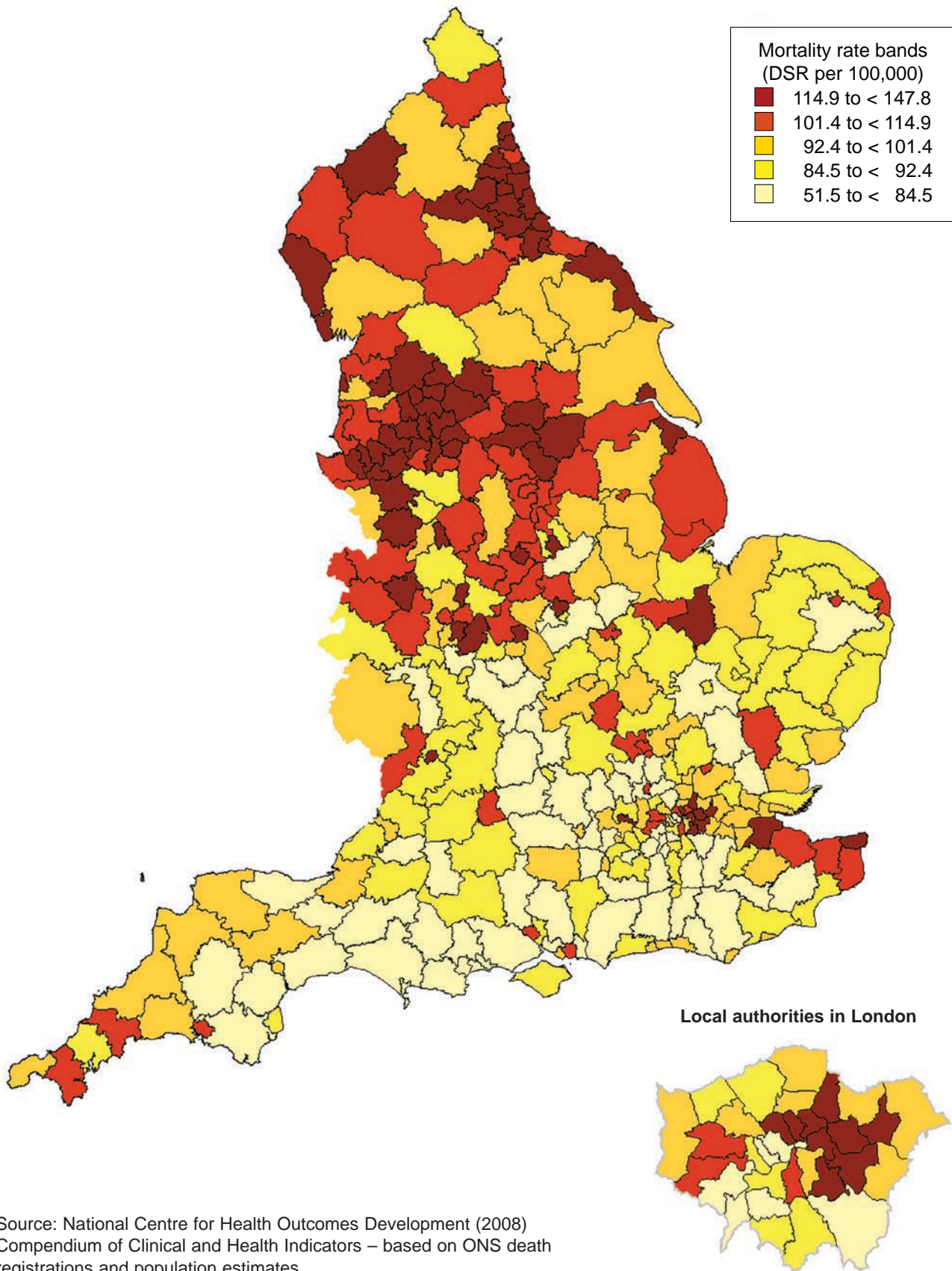
For example, although the composition of the routine class is relatively less disadvantaged than RGSC Social Class V, this is likely to be compensated for by the relatively more advantaged composition of the higher managerial and professional class compared with RGSC Social Class I. The persistence of sizeable differences in rates calculated for larger (and hence more reliable) population groupings suggests that a higher proportion of the England and Wales population had clearly distinct risks of death from this cause than previously observed using RGSC.

Office for National Statistics (2008) ‘Social inequalities in male mortality for selected causes of death by the NS-SEC, England and Wales, 2001–03’, in *Health Statistics Quarterly* 38 (Summer 2008)
www.statistics.gov.uk/downloads/theme_health/HSQ38_Final_WEB_file.pdf

A.32b: Differential outcomes in health – Mortality: Cardiovascular

Coronary heart disease mortality rate by local authority area

All ages, Local authorities (single tier and district) in England, 2004–06



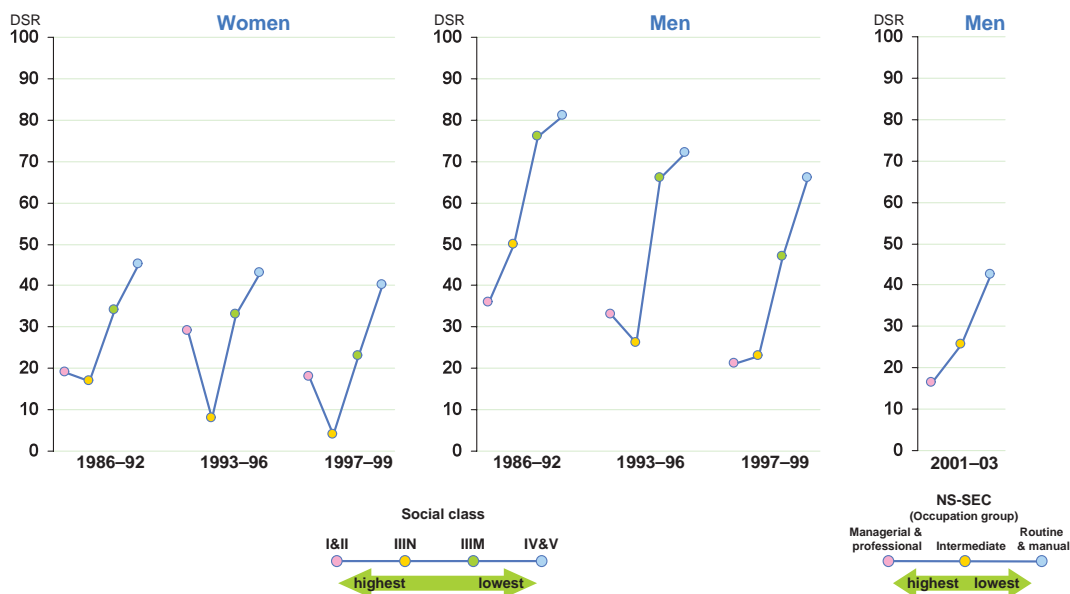
There is a north–south divide in mortality from coronary heart disease, with local authorities in the north of England generally having higher mortality rates than those in the south. Mortality rates from coronary heart disease are also higher in inner-city areas (as seen, for example, in London).

A.33: Differential outcomes in health – Mortality: Cancer

Lung cancer mortality rate by social class and socio-economic group

Aged 35–64 years by social class (1986–99) or aged 25–64 by NS-SEC (2001–03)

England and Wales



Note: 'DSR' is directly age-standardised death rate.
 Source: Social class (1986–99) – 'Trends in social class differences in mortality by cause, 1986–2000' in *Health Statistics Quarterly* 20 (Winter 2003).
 NS-SEC (2001–03) – 'Social inequalities in male mortality for selected causes of death by the NS-SEC, England and Wales, 2001–03' in *Health Statistics Quarterly* 38 (Summer 2008).

Mortality from lung cancer declined for men in all social classes from 1986–92 to 1997–99, but not at the same rate. There was a large fall of 42 per cent in Social Classes I&II, more than twice the percentage decrease in Social Classes IV&V. The ratio of mortality rates between the lowest and highest classes rose from 2.25 to 3.14 over the period.

Lung cancer is the third most common cause of death in women, after breast cancer and IHD. The largest fall in rates between 1986–92 and 1997–99 was 75 per cent in Social Class IIIN, while Social Classes I&II fell by only 7 per cent. Mortality in Social Classes IV&V remained substantially higher than in all other social classes throughout the period. Despite the minimal improvement in Social Classes I&II, the mortality rate of Social Classes IV&V was more than double that of the highest social classes at both the beginning and the end of the period.

Office for National Statistics (2003) 'Trends in social class differences in mortality by cause, 1986 to 2000', in *Health Statistics Quarterly* 20 (Winter 2003)
www.statistics.gov.uk/downloads/theme_health/HSQ20.pdf

Lung cancer deaths in men aged 25–64 have been declining in all social groups for the past 25 years, predominantly because of a lowering in smoking prevalence during the same period. Analysis of data for 2001–03 by NS-SEC in respect of males aged 25–64 found that the trend in deaths over time demonstrates a contraction in the ratio between RGSC Social Class V and I in 1991–93 compared with the 'routine' class and the 'higher managerial and professional' class in 2001–03, from 4.8 to 3.7. However, this fall is unlikely to be attributable to a corresponding change in cigarette smoking between manual and non-manual workers during the 1990s, as General Household Survey data has demonstrated constancy of prevalence rates in this period. A more likely explanation for the decline in the ratio of death rates is the influence of changes in the composition of the routine class to include approximately 10 per cent of men who would formally have been assigned to RGSC Social Class IV.

The lower supervisory, technical, semi-routine and routine classes had higher rates of death from lung cancer than that for all men, whereas the other classes had lower rates. The raised rates of death in classes regulated by a labour contract compared with all men is likely to arise from the fact that these classes are predominantly drawn from the former manual RGSC social classes, and therefore have higher current and historical cigarette smoking prevalence.

The lower managerial, professional and intermediate classes had very similar rates of death, but both had lower mortality than the ‘small employers, own account workers’. A possible mechanism for the lower mortality of the intermediate class over the small employers, own account workers from lung cancer is class composition: a proportion of men in the latter class would be classified to a manual RGSC social class whereas the former class is composed exclusively of men who would be classified to a non-manual RGSC social class, causing the prevalence of current and historic cigarette smoking in the small employers, own account workers class to be relatively higher.

Office for National Statistics (2008)

‘Social inequalities in male mortality for selected causes of death by the NS-SEC, England and Wales, 2001–03’, in *Health Statistics Quarterly* 38 (Summer 2008)
www.statistics.gov.uk/downloads/theme_health/HSQ38_Final_WEB_file.pdf

A.34: Differential outcomes in health – Mortality: Cardiovascular
Cerebrovascular disease mortality rate by social class and socio-economic group
 Aged 35–64 years by social class (1986–99) or aged 25–64 by NS-SEC (2001–03)
 England and Wales



Note: 'DSR' is directly age-standardised death rate.
 Source: Social class (1986–99) – 'Trends in social class differences in mortality by cause, 1986–2000' in *Health Statistics Quarterly* 20 (Winter 2003).
 NS-SEC (2001–03) – 'Social inequalities in male mortality for selected causes of death by the NS-SEC, England and Wales, 2001–03' in *Health Statistics Quarterly* 38 (Summer 2008).

Mortality rates from cerebrovascular disease for men fell in all social classes between 1986–92 and 1997–99. The rate of improvement varied markedly between social classes, with a steep decline of 56 per cent in Social Classes I&II causing a clear widening in the social class gradient in males. Social class IIIN also showed a decline of more than half. In contrast, mortality in Social Classes IV&V men increased by 16 per cent between 1986–92 and 1993–96, before falling sufficiently to result in a decrease of 18 per cent over the period as a whole. The ratio between the lowest and highest social classes increased from 1.34 to 2.67, with the rate in Social Classes IV&V at the end of the period still higher than that in Social Classes I&II at the beginning.

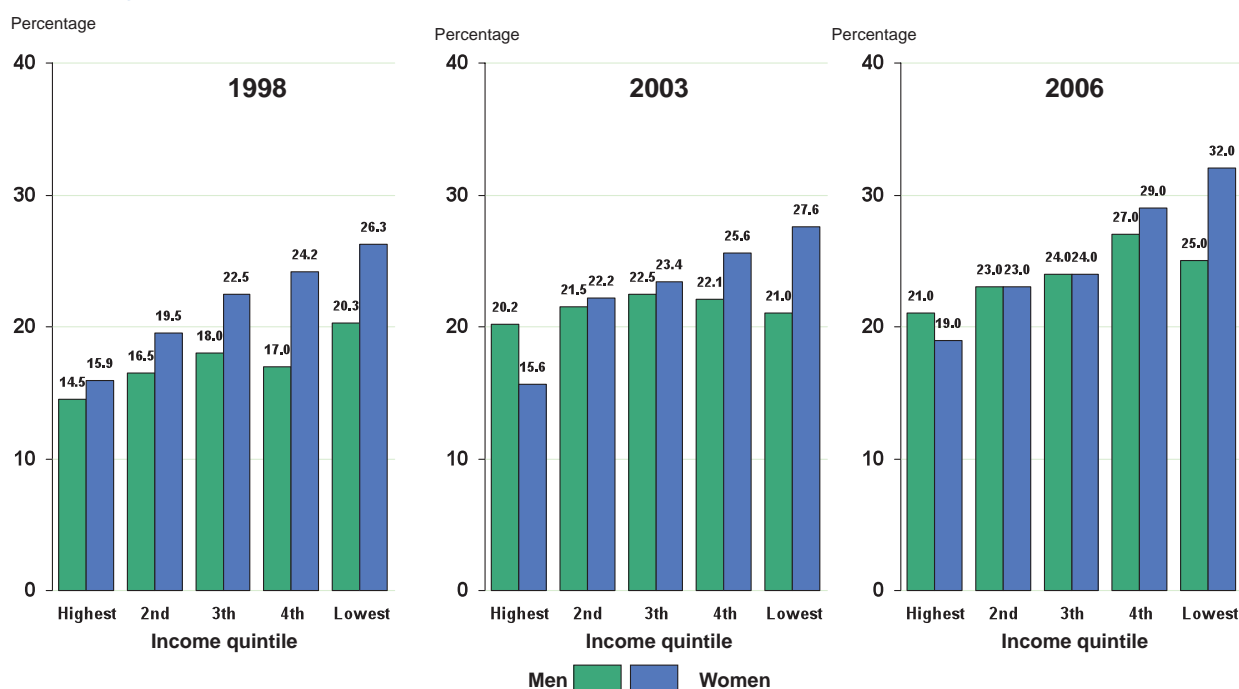
Patterns of female mortality from cerebrovascular disease were mixed. Taking the period as a whole, there were large falls in Social Classes IIIN and IV&V of 58 per cent and 41 per cent respectively, and smaller increases in Social Classes I&II and IIIM. These contrasting trends reduced a ratio of 2.36 between Social Classes IV&V and I&II in 1986–92 to a non-significant 1.06 in 1997–99.

Office for National Statistics (2008) 'Trends in social class differences in mortality by cause, 1986 to 2000', in *Health Statistics Quarterly* 20 (Winter 2003)
www.statistics.gov.uk/downloads/theme_health/HSQ20.pdf

More recent analysis of data for 2001–03 by NS-SEC in respect of males aged 25–64 found that the routine class had a rate of death from cerebrovascular diseases 2.9 times higher than the higher managerial and professional class. Analyses by RGSC for the period 1991–93 in men aged 20–64 showed a mortality rate from cerebrovascular diseases in Social Class V 3.2 times higher than in professionals in Social Class I. The gap in mortality between the most advantaged and most disadvantaged classes has remained similar in magnitude. (See discussion under indicator A.32 for possible explanations for this.)

Office for National Statistics (2008) 'Social inequalities in male mortality for selected causes of death by the NS-SEC, England and Wales, 2001–03', in *Health Statistics Quarterly* 38 (Summer 2008)
www.statistics.gov.uk/downloads/theme_health/HSQ38_Final_WEB_file.pdf

A.35: Differential outcomes in health – Morbidity: Prevalence of obesity in adults
Prevalence of obesity in adults by gender and income quintile
 England, 1998, 2003 and 2006



Notes: 'Obesity' is defined as having a body mass index (BMI) of 30 or more. Figures cover people aged 16 and over with both valid height and weight measurements. Data standardised for age distribution. Source: Department of Health (1999) *Health Survey for England 1998* (Table 3.45); Department of Health (2004) *Health Survey for England 2003* (Table 6.8); The Information Centre for Health and Social Care (2008) *Health Survey for England 2006* (Table 5.4).

In the earlier years of the Health Survey for England (the early 1990s), the prevalence of obesity was higher among women than men. Prevalence has increased in both sexes, but more rapidly among men, so that in recent years there has been little difference between the sexes in obesity prevalence. Taking obesity and overweight together, prevalence has continued to be higher among men than women.

Review of trends 1998 to 2003

Among men in 2003, the proportion who were obese was not related to equivalised household income. The 1998 *Health Survey for England*, however, showed the proportion increasing as household income decreased. There has been an increase over time in obesity prevalence among men, and this change in pattern by household income quintile suggests that the increase has occurred mainly in the higher income quintiles.

As in 1998, the proportion of men who were either overweight or obese in 2003 followed a different pattern from the proportion who were obese, being lower in the lowest income quintile (59.4 per cent) than in other income quintiles (over 65 per cent). After age standardisation the difference remained, but was reduced.

Among women, a different picture emerged. As in 1998, the proportion who were obese in 2003 increased as household income decreased: of women in the highest income quintile, 15.4 per cent were obese, but of those in the lowest income quintile 28.1 per cent were obese. (These figures are not standardised for age – the chart shows the age-standardised figures.) The proportion of women who were either overweight or obese was also lower in the highest income quintile (47 per cent) than in the other four income quintiles (ranging from 54 per cent to 61 per cent).

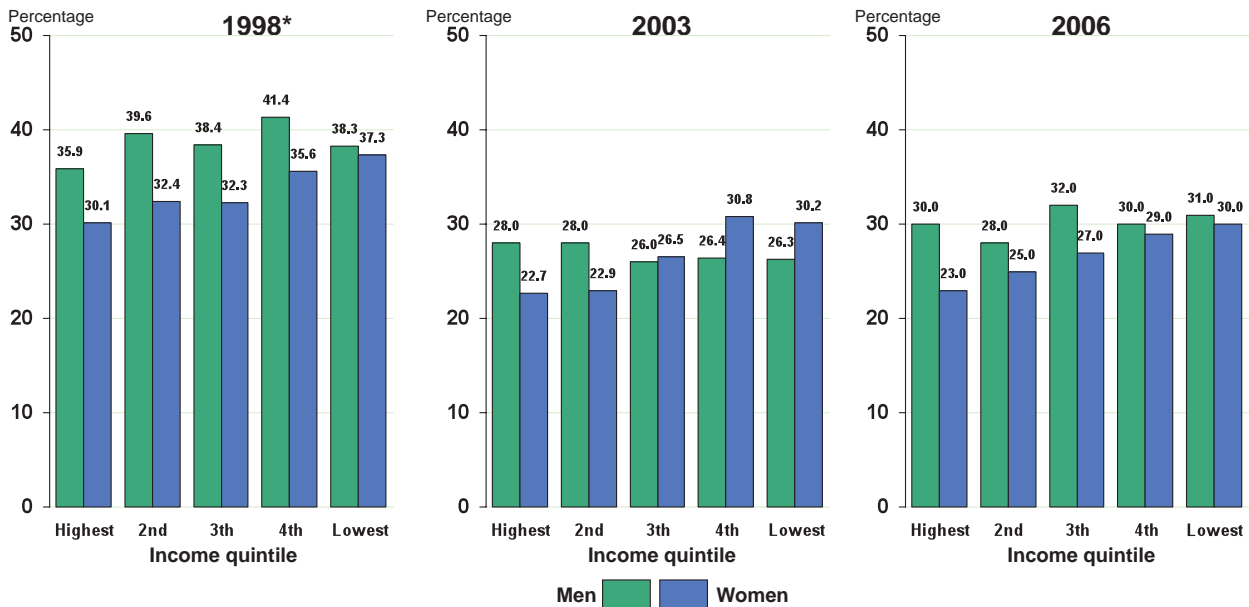
Department of Health (2004)
Health Survey for England 2003, Volume 2: Risk factors for cardiovascular disease
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_4098712

Update to 2006

In 2006, the age-standardised prevalence of obesity was inversely related to quintile of equivalised household income among women, i.e. prevalence of obesity rose as income fell. This measure was not related to income among men. However, the prevalence of overweight in men was generally positively related to income, with prevalence of overweight generally higher among men with higher incomes.

The Information Centre for Health and Social Care (2008)
Health Survey for England 2006,
Volume 1: Cardiovascular disease and risk factors in adults
www.ic.nhs.uk/pubs/hse06cvdandriskfactors

A.36: Differential outcomes in health – Morbidity: Prevalence of hypertension in adults
Prevalence of hypertension in adults by income quintile
 England, 1998, 2003 and 2006



Notes: Hypertension is defined as having systolic blood pressure of 140mmHg or over or diastolic blood pressure of 90mmHg or over, or taking medication prescribed for high blood pressure. For this analysis, adults are people aged 16 and over with valid blood pressure measurements. Data has been standardised for age distribution.
 *In 1998 measurements were taken using the Dinamap machine. In 2003 and 2006 the Omron machine was used. Data presented for 1998 is not comparable with data for 2003 or 2006. See the *Health Survey for England* for more details.
 Source: Department of Health (1999) *Health Survey for England 1998* (Table 3.62); Department of Health (2004) *Health Survey for England 2003* (Table 7.11); The Information Centre of Health and Social Care (2008) *Health Survey for England 2006* (Table 3.4).

As the Dinamap machine was used for taking measurements in 1998 and the Omron machine was used for 2003 and 2006, results should not be compared over the full time period presented. The focus of this set of charts should be on the gradients apparent in the years under review rather than the underlying trends over time. There was a consistency of relationship between equalised household income and prevalence of hypertension across the three years illustrated.

Compared with 2003, the proportion of those in the general population in 2006 with high blood pressure (treated or untreated) decreased for both sexes (from 32 to 31 per cent among men and from 30 to 28 per cent among women). Comparisons with years before 2003 are more difficult. It appears that, after a period of stability in men and a slight increase in the overall proportion with high blood pressure in women between 1998 and 2001, there was a gradual downward trend.

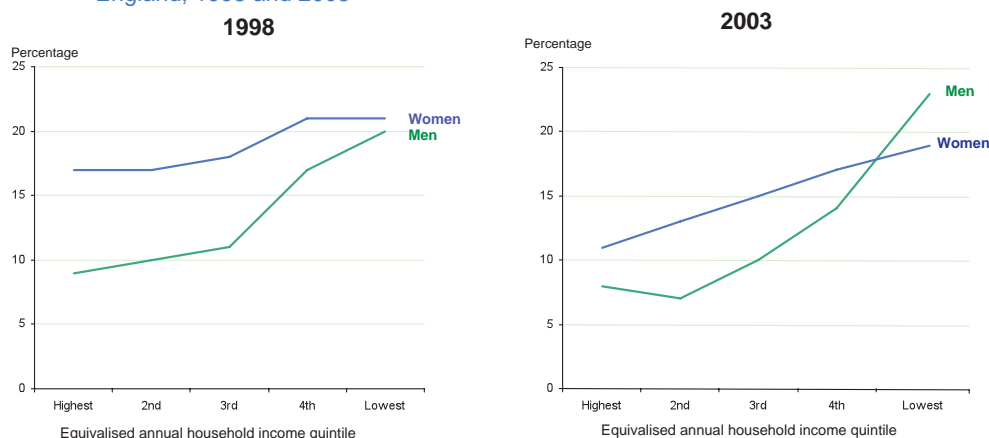
In 1998, the prevalence of high blood pressure among women increased as income decreased – from 30.1 per cent in the highest income quintile to 37.3 per cent in the lowest income quintile.

In 2003, the prevalence of high blood pressure among women again increased as equalised household income decreased. There was no clear-cut relationship among men.

In 2006, the prevalence of hypertension varied significantly between the highest and bottom two equalised income quintiles among women but not among men. Again the pattern was for higher prevalence of high blood pressure among women from lower-income households.

Department of Health (1999, 2004) *Health Survey for England 1998 and 2003*
 The Information Centre for Health and Social Care (2008) *Health Survey for England 2006*
www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/HealthSurveyForEngland/index.htm
www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles-related-surveys/health-survey-for-england

A.37: Differential outcomes in health – Morbidity: Prevalence of major depression among adults
Prevalence of mental ill health by household income
 England, 1998 and 2003



Notes: Figures show the proportion of men and women with high GHQ12 score (age-standardised). Figures are for adults aged 16 and over.
 Source: Department of Health (1999) *Health Survey for England 1998* (Table 6.27); Department of Health (2004) *Health Survey for England 2003* (Table 10.23).

The General Health Questionnaire (GHQ12) was designed to detect possible psychiatric morbidity in the general population. The questionnaire is based on 12 questions about general level of happiness, depression, anxiety and sleep disturbance over the past four weeks. A score is constructed from the responses. In Health Survey reports, a score of 4 or more is used as a threshold to identify informants with a possible psychiatric disorder, and is referred to as a ‘high GHQ12 score’.

In 1998, among men, there was a marked inverse relationship between high GHQ12 and equivalised household income: the lower the income, the higher the proportion with a high GHQ12 score. The age-standardised proportion of men scoring 4 or more increased from 9 per cent in the highest income quintile to 20 per cent in the lowest income quintile.

A similar but weaker relationship was found among women: the age-standardised proportion scoring 4 or more increased from 17 per cent in the lowest income quintile to 21 per cent in each of the two highest quintiles.

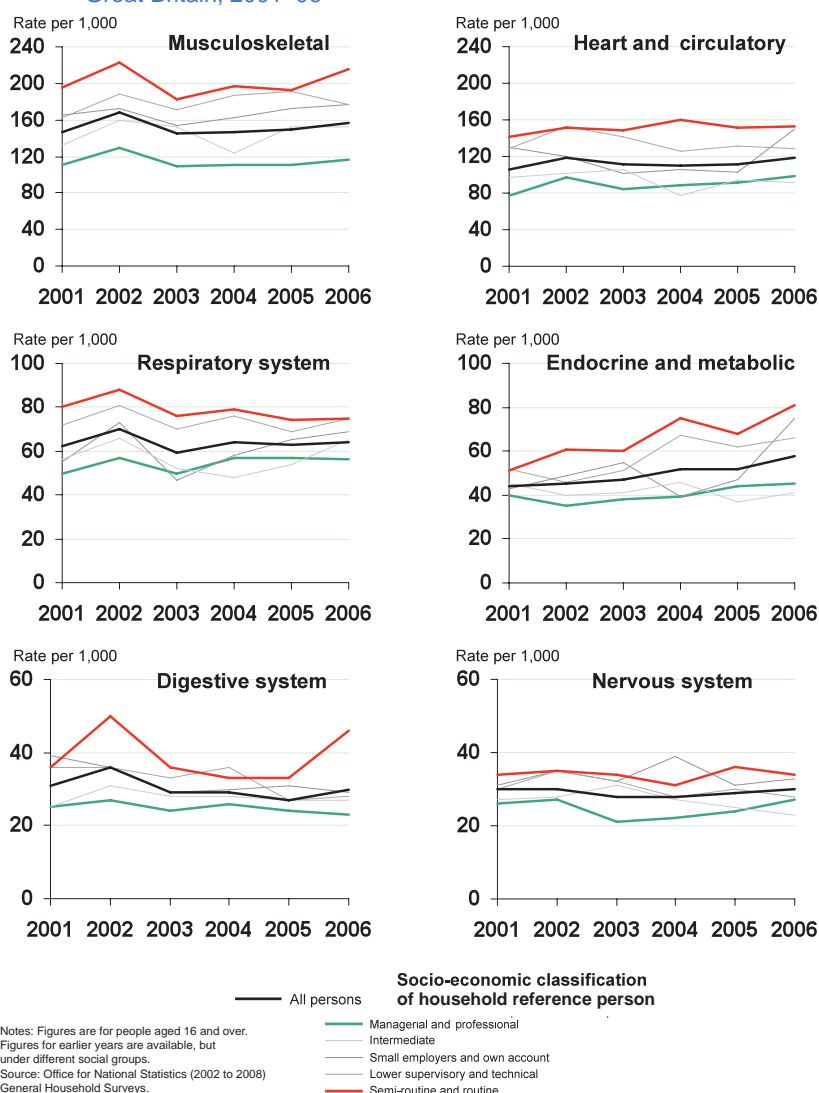
In 2003, for self-reported psychosocial health, the prevalence of high GHQ scores increased as equivalised household income decreased, from 8 per cent of men and 13 per cent of women in the highest income quintile to 20 per cent of men and 19 per cent of women in the lowest equivalised income quintile. After age standardisation – as illustrated in the chart above – the effect of equivalised household income was more marked.

Department of Health (1999, 2004) *Health Survey for England 1998 and 2003*
www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/HealthSurveyForEngland/index.htm

A.38: Differential outcomes in health – Disability

Prevalence of limiting long-standing illness by socio-economic group

Great Britain, 2001–06



On average, respondents whose household reference person was in the managerial and professional group had the lowest incidence of long-standing conditions. Respondents whose household reference person was in the semi-routine and routine group were the most likely to report a limiting long-standing illness.

Of those with a long-standing illness, respondents whose household reference person was in the managerial and professional group reported the lowest average number of conditions (1.47). Respondents whose household reference person was in the semi-routine and routine group, meanwhile, reported the highest average (1.74).

Rate per 1,000 reporting long-standing condition, by socio-economic group of household reference person

People aged 16 and over

Condition group	Managerial and professional						Intermediate					
	2001	2002	2003	2004	2005	2006	2001	2002	2003	2004	2005	2006
XIII Musculoskeletal system	111	130	109	110	111	117	165	173	154	162	172	177
VII Heart and circulatory system	77	97	85	89	92	99	130	120	102	106	103	150
VIII Respiratory system	50	57	50	57	57	56	55	73	47	58	65	69
III Endocrine and metabolic	40	35	38	39	44	45	43	49	55	39	47	75
IX Digestive system	25	27	24	26	24	23	39	36	29	30	31	29
VI Nervous system	26	27	21	22	24	27	31	35	32	39	31	33
Average number of condition groups reported by those with a long-standing illness	1.41	1.42	1.40	1.45	1.47	1.47	1.49	1.54	1.55	1.32	1.55	1.68

Condition group	Small employers and own account workers						Lower supervisory and technical					
	2001	2002	2003	2004	2005	2006	2001	2002	2003	2004	2005	2006
XIII Musculoskeletal system	132	160	153	123	152	152	162	188	171	187	191	177
VII Heart and circulatory system	97	101	106	77	95	91	128	153	142	126	131	129
VIII Respiratory system	56	66	52	48	54	65	72	81	70	76	69	75
III Endocrine and metabolic	45	40	41	46	37	41	52	46	51	67	62	66
IX Digestive system	25	31	28	28	27	27	36	36	33	36	27	28
VI Nervous system	27	28	31	27	25	23	30	35	32	28	30	28
Average number of condition groups reported by those with a long-standing illness	1.45	1.54	1.49	1.42	1.50	1.59	1.57	1.54	1.62	1.63	1.62	1.67

Condition group	Semi-routine and routine						Total					
	2001	2002	2003	2004	2005	2006	2001	2002	2003	2004	2005	2006
XIII Musculoskeletal system	195	223	183	197	193	215	146	168	145	147	149	156
VII Heart and circulatory system	141	152	148	160	151	153	106	119	111	110	111	118
VIII Respiratory system	80	88	76	79	74	75	62	70	59	64	63	64
III Endocrine and metabolic	51	61	60	75	68	81	44	45	47	52	52	58
IX Digestive system	36	50	36	33	33	46	31	36	29	29	27	30
VI Nervous system	34	35	34	31	36	34	30	30	28	28	29	30
Average number of condition groups reported by those with a long-standing illness	1.62	1.63	1.62	1.70	1.68	1.74	1.51	1.53	1.52	1.54	1.57	1.54

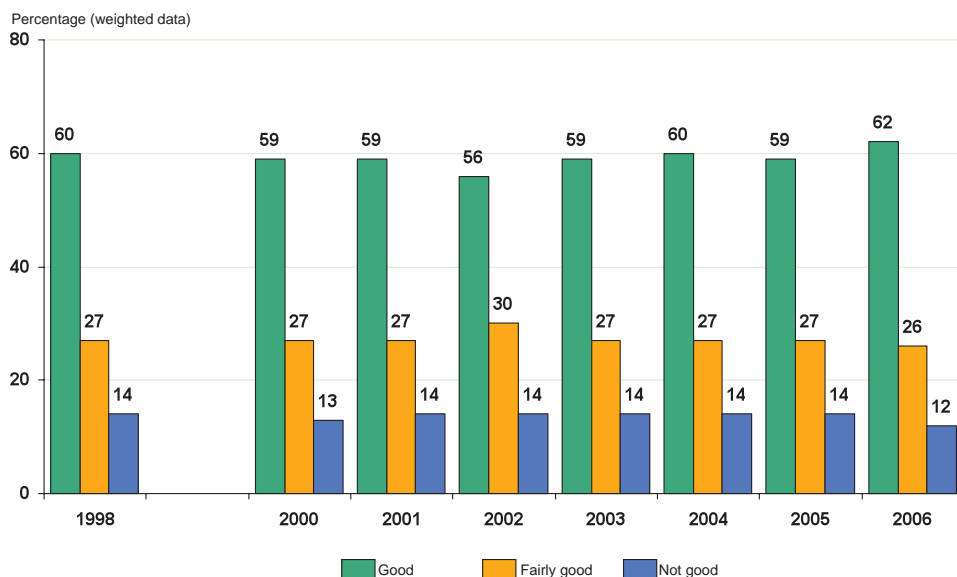
Note: Data for where the household reference person was a full-time student, had an inadequately described occupation, had never worked or was long-term unemployed is included in the total category for all groups.
Source: Office for National Statistics (2002 to 2008) General Household Surveys.

Office for National Statistics (2002 to 2008) General Household Surveys
www.statistics.gov.uk/StatBase/Product.asp?vlnk=5756

A.39a: Differential outcomes in health – Health status

Self-reported health status

Great Britain, 1998–2006

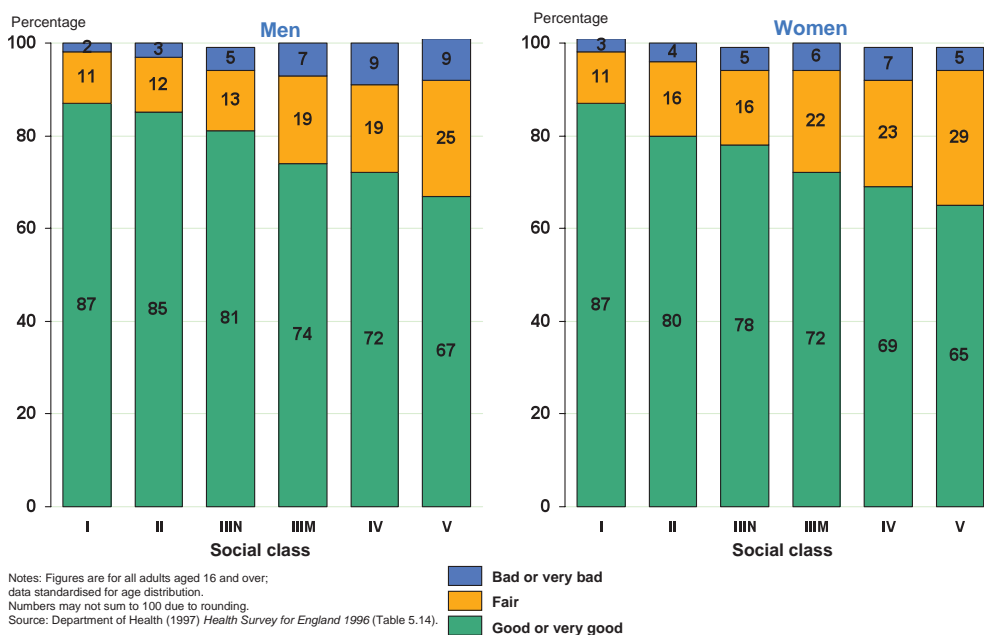


Notes: Figures are for people aged 16 and over.
Source: Office for National Statistics (2008) *General Household Survey 2006* (Table 7.1).

A.39b: Differential outcomes in health: Health status

Adults' self-assessed general health by social class and gender

England, 1996



Self-reported health status is based on the survey respondent's own assessment of their health. Therefore, a change in reported prevalence of good health may reflect changes in the expectations people have about their health, as well as changes in the actual prevalence of good health.

Data for Great Britain from the GHS showed that, in 2006, 62 per cent of adults said they had good health, 26 per cent reported they had fairly good health and 12 per cent said their health was not good. Levels of self-assessed general health have remained largely unchanged since weighted data was introduced in the GHS in 1998.

According to data for England from the *Health Survey for England*, in 1996 self-assessed general health of adults showed a clear relationship with the social class of the head of the household. The age-standardised proportion of adults reporting 'good' or 'very good' health was highest among those whose head of household was in Social Classes I&II – for example, 87 per cent of men and women in Social Class I reported good health, compared with 67 per cent of men and 65 per cent of women in Social Class V. (Data for recent years on an equivalent basis is not available.)

Department of Health (1998) *Health Survey for England 1996*
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_4002768

Annex: Recommendations from the Acheson inquiry

General Recommendations

1. We RECOMMEND that as part of health impact assessment, all policies likely to have a direct or indirect effect on health should be evaluated in terms of their impact on health inequalities, and should be formulated in such a way that by favouring the less well off they will, wherever possible, reduce such inequalities.
 - 1.1 We recommend establishing mechanisms to monitor inequalities in health and to evaluate the effectiveness of measures taken to reduce them.
 - 1.2 We recommend a review of data needs to improve the capacity to monitor inequalities in health and their determinants at a national and local level.
2. We RECOMMEND a high priority is given to policies aimed at improving health and reducing health inequalities in women of child-bearing age, expectant mothers and young children.

Poverty, Income, Tax and Benefits

3. We RECOMMEND policies which will further reduce income inequalities, and improve the living standards of households in receipt of social security benefits. Specifically:
 - 3.1 We recommend further reductions in poverty in women of child-bearing age, expectant mothers, young children and older people should be made by increasing benefits in cash or kind to them.
 - 3.2 We recommend uprating of benefits and pensions according to principles which protect and, where possible, improve the standard of living of those who depend on them and which narrow the gap between their standard of living and average living standards.
 - 3.3 We recommend measures to increase the uptake of benefits in entitled groups.

Education

4. We RECOMMEND the provision of additional resources for schools serving children from less well off groups to enhance their educational achievement. The Revenue Support Grant formula and other funding mechanisms should be more strongly weighted to reflect need and socioeconomic disadvantage.
5. We RECOMMEND the further development of high quality pre-school education so that it meets, in particular, the needs of disadvantaged families. We also recommend that the benefits of pre-school education to disadvantaged families be evaluated and, if necessary, additional resources are made available to support further development.

6. We RECOMMEND the further development of ‘health promoting schools’, initially focused on, but not limited to, disadvantaged communities.
7. We RECOMMEND further measures to improve the nutrition provided at school, including: the promotion of school food policies; the development of budgeting and cooking skills; the preservation of free school meals entitlement; the provision of free school fruit; and the restriction of less healthy food.

Employment

8. We RECOMMEND policies which improve the opportunities for work and which ameliorate the health consequences of unemployment. Specifically:
 - 8.1 We recommend further steps to increase employment opportunities.
 - 8.2 We recommend further investment in high quality training for young and long-term unemployed people.
9. We RECOMMEND policies to improve the quality of jobs, and reduce psychosocial work hazards. Specifically:
 - 9.1 We recommend employers, unions and relevant agencies take further measures to improve health through good management practices which lead to an increased level of control, variety and appropriate use of skills in the workforce.
 - 9.2 We recommend assessing the impact of employment policies on health and inequalities in health.

Housing and Environment

10. We RECOMMEND policies which improve the availability of social housing for the less well off within a framework of environmental improvement, planning and design which takes into account social networks, and access to goods and services.
11. We RECOMMEND policies which improve housing provision and access to health care for both officially and unofficially homeless people.
12. We RECOMMEND policies which aim to improve the quality of housing. Specifically:
 - 12.1 We recommend policies to improve insulation and heating systems in new and existing buildings in order to reduce further the prevalence of fuel poverty.
 - 12.2 We recommend amending housing and licensing conditions and housing regulations on space and amenity to reduce accidents in the home, including measures to promote the installation of smoke detectors in existing homes.
13. We RECOMMEND the development of policies to reduce the fear of crime and violence, and to create a safe environment for people to live in.

Mobility, Transport and Pollution

14. We RECOMMEND the further development of a high quality public transport system which is integrated with other forms of transport and is affordable to the user.
15. We RECOMMEND further measures to encourage walking and cycling as forms of transport and to ensure the safe separation of pedestrians and cyclists from motor vehicles.
16. We RECOMMEND further steps to reduce the usage of motor cars to cut the mortality and morbidity associated with motor vehicle emissions.
17. We RECOMMEND further measures to reduce traffic speed, by environmental design and modification of roads, lower speed limits in built up areas, and stricter enforcement of speed limits.
18. We RECOMMEND concessionary fares should be available to pensioners and disadvantaged groups throughout the country, and that local schemes should emulate high quality schemes, such as those of London and the West Midlands.

Nutrition and the Common Agricultural Policy

19. We RECOMMEND a comprehensive review of the Common Agricultural Policy (CAP)'s impact on health and inequalities in health.
 - 19.1 We recommend strengthening the CAP Surplus Food Scheme to improve the nutritional position of the less well off.
20. We RECOMMEND policies which will increase the availability and accessibility of foodstuffs to supply an adequate and affordable diet. Specifically:
 - 20.1 We recommend the further development of policies which will ensure adequate retail provision of food to those who are disadvantaged.
 - 20.2 We recommend policies which reduce the sodium content of processed foods, particularly bread and cereals, and which do not incur additional cost to the consumer.

Mothers, Children and Families

21. We RECOMMEND policies which reduce poverty in families with children by promoting the material support of parents; by removing barriers to work for parents who wish to combine work with parenting; and by enabling those who wish to devote full-time to parenting to do so. Specifically:
 - 21.1 We recommend an integrated policy for the provision of affordable, high quality day care and pre-school education with extra resources for disadvantaged communities (see also: recommendation 5).
22. We RECOMMEND policies which improve the health and nutrition of women of child-bearing age and their children with priority given to the elimination of food poverty and the prevention and reduction of obesity. Specifically:
 - 22.1 We recommend policies which increase the prevalence of breast feeding.
 - 22.2 We recommend the fluoridation of the water supply.

- 22.3 We recommend the further development of programmes to help women to give up smoking before or during pregnancy, and which are focused on the less well off.
- 23. We RECOMMEND policies that promote the social and emotional support for parents and children. Specifically:
 - 23.1 We recommend the further development of the role and capacity of health visitors to provide social and emotional support to expectant parents, and parents with young children.
 - 23.2 We recommend local authorities identify and address the physical and psychological health needs of looked-after children.

Young People and Adults of Working Age

- 24. We RECOMMEND measures to prevent suicide among young people, especially among young men and seriously mentally ill people.
- 25. We RECOMMEND policies which promote sexual health in young people and reduce unwanted teenage pregnancy, including access to appropriate contraceptive services.
- 26. We RECOMMEND policies which promote the adoption of healthier lifestyles, particularly in respect of factors which show a strong social gradient in prevalence or consequences. Specifically:
 - 26.1 We recommend policies which promote moderate intensity exercise including: further provision of cycling and walking routes to school, and other environmental modifications aimed at the safe separation of pedestrians and cyclists from motor vehicles; and safer opportunities for leisure.
 - 26.2 We recommend policies to reduce tobacco smoking including: restricting smoking in public places; abolishing tobacco advertising and promotion; and community, mass media and educational initiatives.
 - 26.3 We recommend increases in the real price of tobacco to discourage young people from becoming habitual smokers and to encourage adult smokers to quit. These increases should be introduced in tandem with policies to improve the living standards of low income households and policies to help smokers in these households become and remain ex-smokers.
 - 26.4 We recommend making nicotine replacement therapy available on prescription.
 - 26.5 We recommend policies which reduce alcohol-related ill health, accidents and violence, including measures which at least maintain the real cost of alcohol.

Older People

- 27. We RECOMMEND policies which will promote the material well being of older people (see recommendation 3).
- 28. We RECOMMEND the quality of homes in which older people live be improved (see recommendation 12).
- 29. We RECOMMEND policies which will promote the maintenance of mobility, independence, and social contacts (see recommendations 13, 14 and 18).
- 30. We RECOMMEND the further development of health and social services for older people, so that these services are accessible and distributed according to need (see recommendation 1.2).

Ethnicity

31. We RECOMMEND that the needs of minority ethnic groups are specifically considered in the development and implementation of policies aimed at reducing socioeconomic inequalities (see recommendations 3, 8, 10 and 12–18).
32. We RECOMMEND the further development of services which are sensitive to the needs of minority ethnic people and which promote greater awareness of their health risks.
33. We RECOMMEND the needs of minority ethnic groups are specifically considered in needs assessment, resource allocation, health care planning and provision (see recommendation 1.2).

Gender

34. We RECOMMEND policies which reduce the excess mortality from accidents and suicide in young men (see recommendations 8, 11, 15–17, 24 and 26.5).
35. We RECOMMEND policies which reduce psychosocial ill health in young women in disadvantaged circumstances, particularly those caring for young children (see recommendations 3, 10, 14, 21–23 and 25).
36. We RECOMMEND policies which reduce disability and ameliorate its consequences in older women, particularly those living alone (see recommendations 3, 13, 14, 18, 28 and 30).

The National Health Service

37. We RECOMMEND that providing equitable access to effective care in relation to need should be a governing principle of all policies in the NHS. Priority should be given to the achievement of equity in the planning, implementation and delivery of services at every level of the NHS. Specifically:
 - 37.1 We recommend extending the focus of clinical governance to give equal prominence to equity of access to effective health care.
 - 37.2 We recommend extending the remit of the National Institute for Clinical Excellence to include equity of access to effective health care.
 - 37.3 We recommend developing the National Service Frameworks to address inequities in access to effective primary care.
 - 37.4 We recommend that performance management in relation to the national performance management framework is focused on achieving more equitable access, provision and targeting of effective services in relation to need in both primary and hospital sectors.
 - 37.5 We recommend that the Department of Health and NHS Executive set out their responsibilities for furthering the principle of equity of access to effective health and social care, and that health authorities, working with Primary Care Groups and providers on local clinical governance, agree priorities and objectives for reducing inequities in access to effective care. These should form part of the Health Improvement Programme.
38. We RECOMMEND giving priority to the achievement of a more equitable allocation of NHS resources. This will require adjustments to the ways in which resources are allocated and the speed with which resource allocation targets are met. Specifically:

- 38.1 We recommend reviewing the 'pace of change' policy to enable health authorities that are furthest from their capitation targets to move more quickly to their actual targets.
- 38.2 We recommend extending the principle of needs-based weighting to non-cash limited General Medical Services (GMS) resources. The size and effectiveness of deprivation payments in meeting the needs and improving the health outcomes amongst the most disadvantaged populations, including ethnic minorities should be assessed.
- 38.3 We recommend reviewing the size and effectiveness of the Hospital and Community Health Services (HCHS) formula and deprivation payments in influencing the health care outcomes of the most disadvantaged populations, and to consider alternative methods of focusing resources for health promotion and public health care to reduce health inequalities.
- 38.4 We recommend establishing a review of the relationship of private practice to the NHS with particular reference to access to effective treatments, resource allocation and availability of staff.
39. We RECOMMEND Directors of Public Health, working on behalf of health and local authorities, produce an equity profile for the population they serve, and undertake a triennial audit of progress towards achieving objectives to reduce inequalities in health.
- 39.1 We recommend there should be a duty of partnership between the NHS Executive and regional government to ensure that effective local partnerships are established between health, local authorities and other agencies and that joint programmes to address health inequalities are in place and monitored.



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