



Strategic Review of Health Inequalities in England post-2010

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Closing the gap in a generation

Health equity through action on the social determinants of health



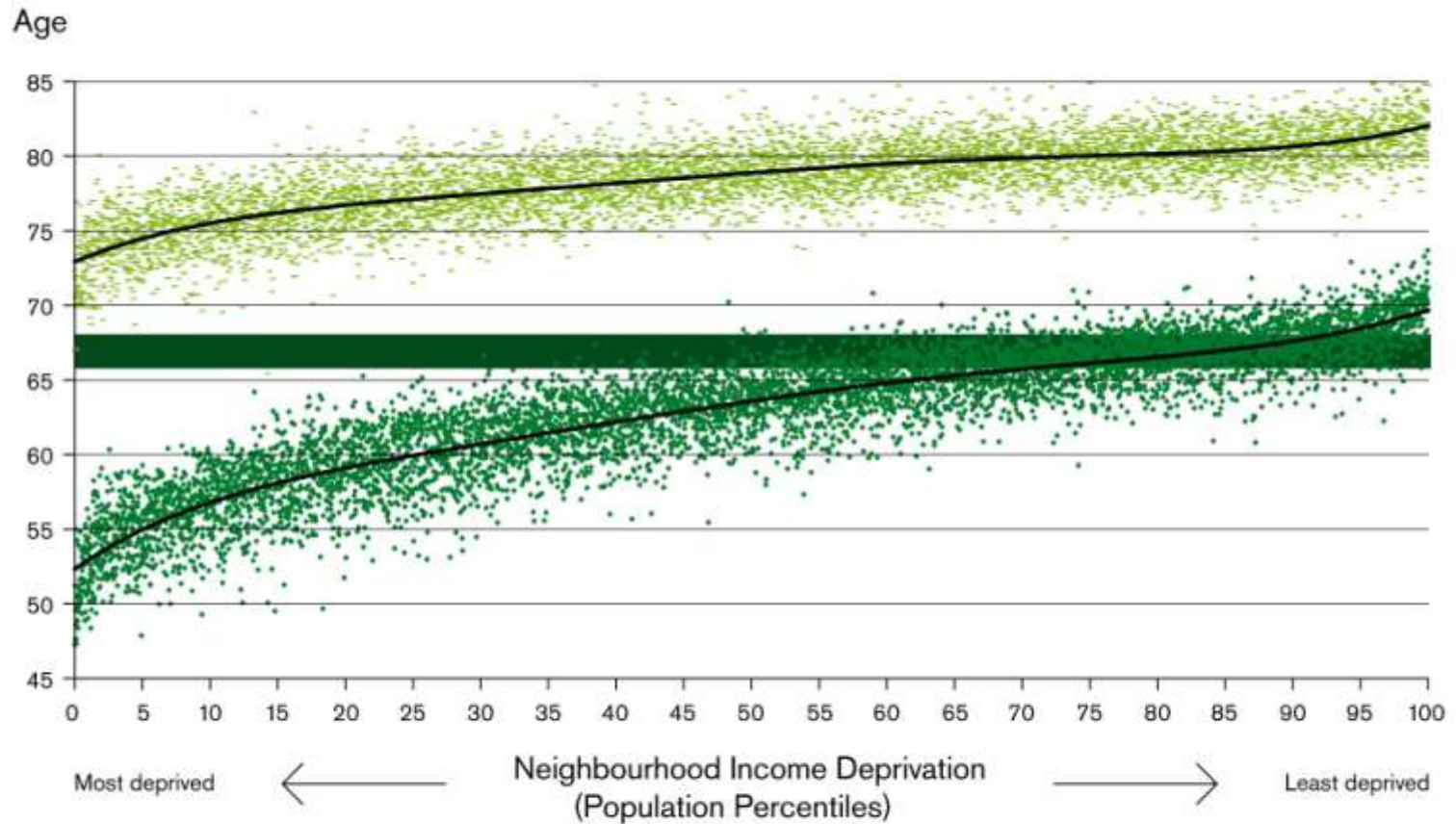
The CSDH – closing the gap in a generation



The Marmot Review – Fair Society Healthy Lives

European Review of Health Inequalities and the Health Divide

Life expectancy and disability-free life expectancy at birth by neighbourhood income deprivation, 1999-2003



- Life expectancy
- DFLE
- Pension age increase 2026–2046

Source: Office for National Statistics⁵

Key themes

Reducing health inequalities is a matter of fairness and social justice

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

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

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

Beyond economic growth to well-being



Cost of Inaction

- In England, dying prematurely each year as a result of health inequalities, between 1.3 and 2.5 million extra years of life.
- **Cost of doing nothing**
- Action taken to reduce health inequalities will benefit society in many ways. It will have economic benefits in reducing losses from illness associated with health inequalities. Each year in England these account for:
 - **productivity losses of £31-33B**
 - **reduced tax revenue and higher welfare payments of £20-32B and**
 - **increased treatment costs well in excess of £5B.**

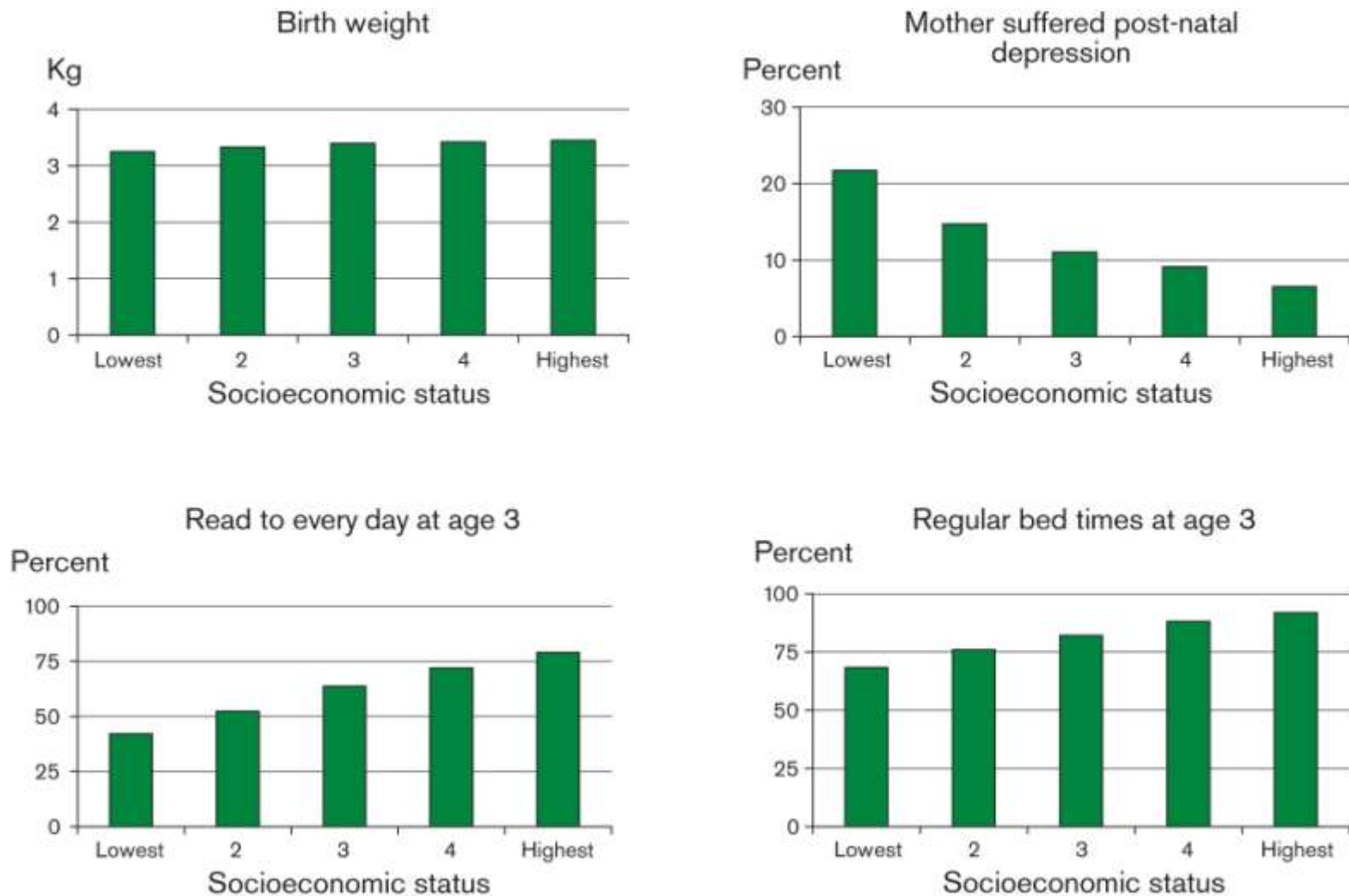


- Describe health inequalities
- Describe and analyse key social determinants
- Assess evidence and propose actions and interventions
- Metrics and targets and Departmental responsibility

Marmot Review: 6 Policy Objectives

- A. Give every child the best start in life**
- B. Enable all children, young people and adults to maximise their capabilities and have control over their lives**
- C. Create fair employment and good work for all**
- D. Ensure healthy standard of living for all**
- E. Create and develop healthy and sustainable places and communities**
- F. Strengthen the role and impact of ill health prevention**

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



Source: Department for Children, Schools and Families⁹³

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

Average position
in distribution

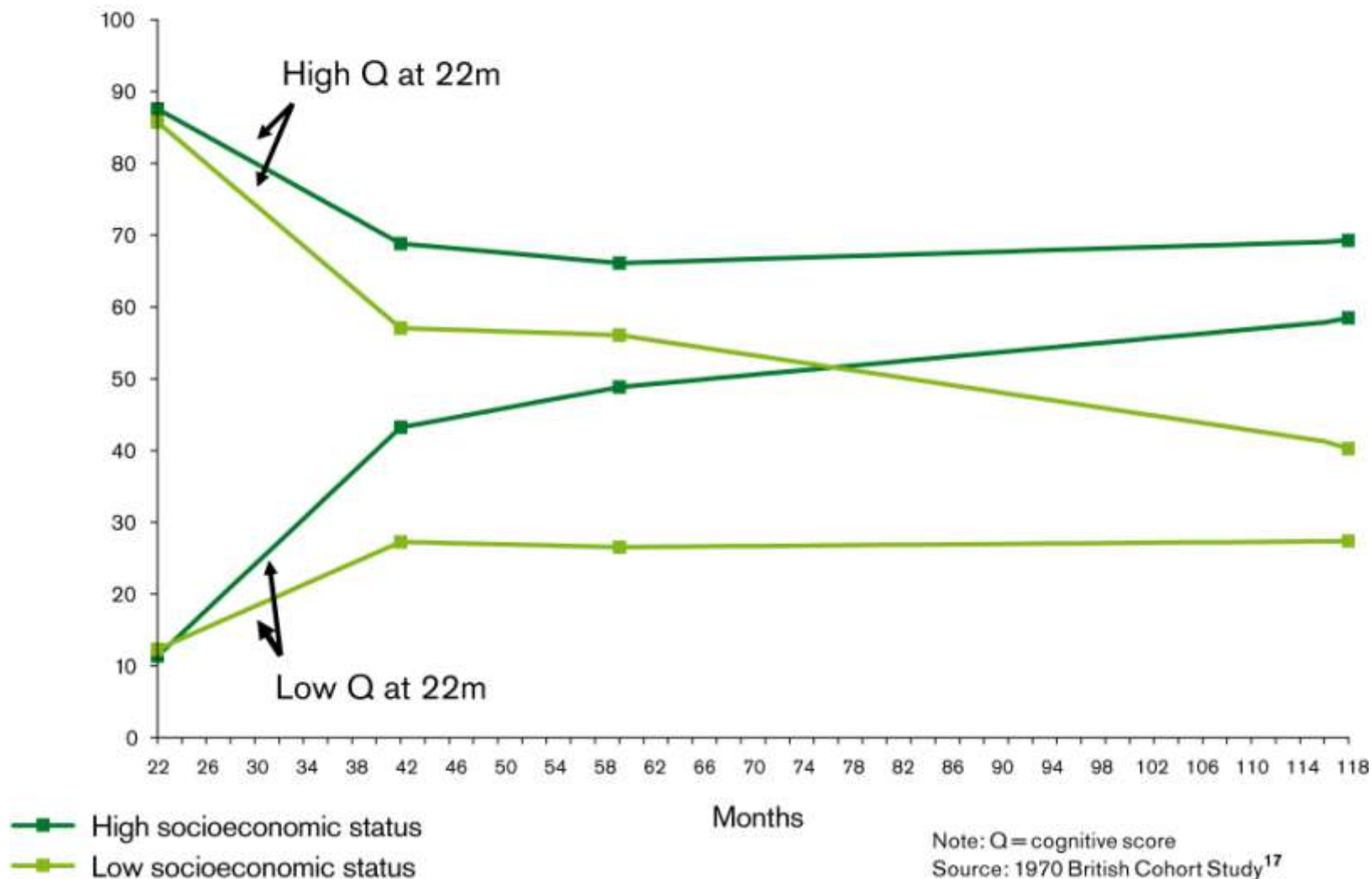
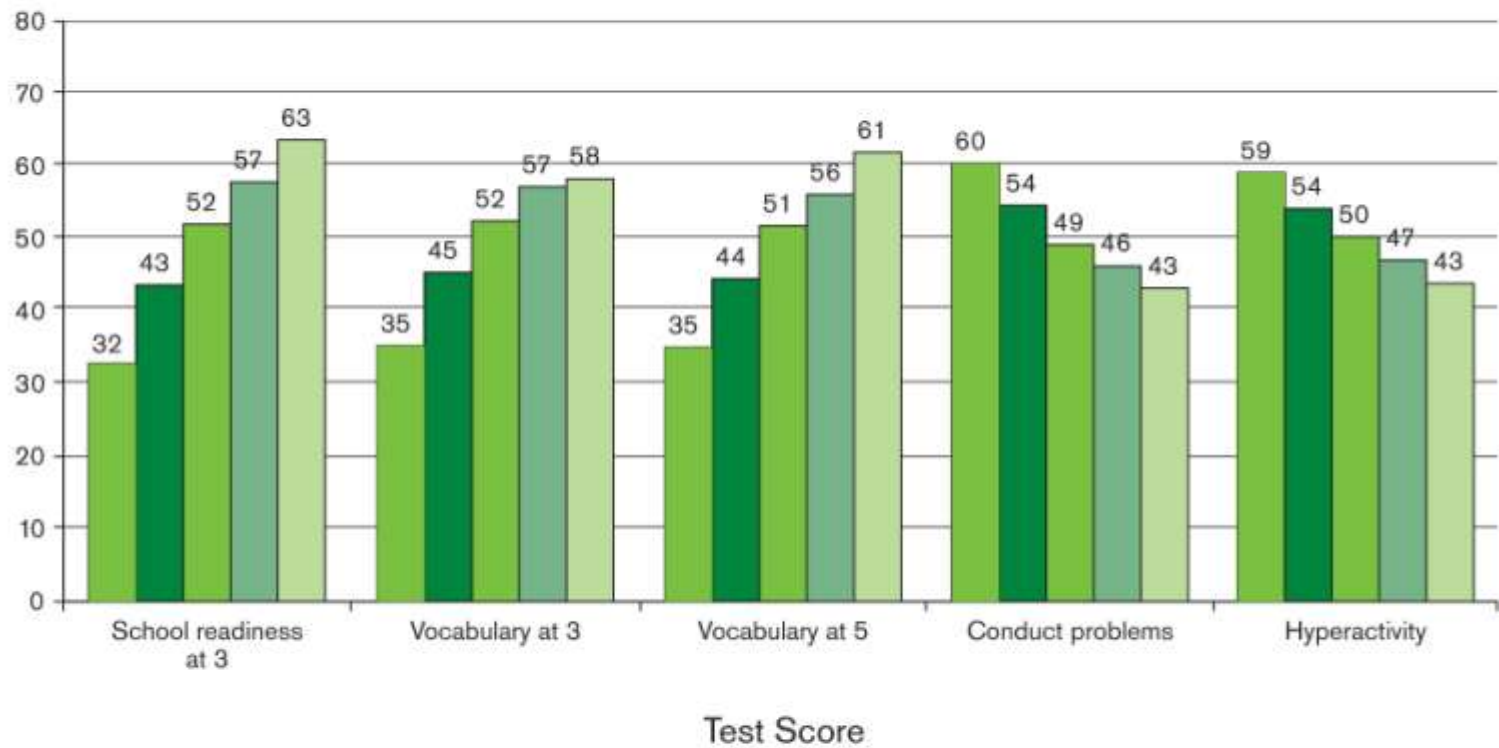


Figure 2.22 Indicators of school readiness by parental income group, 2008

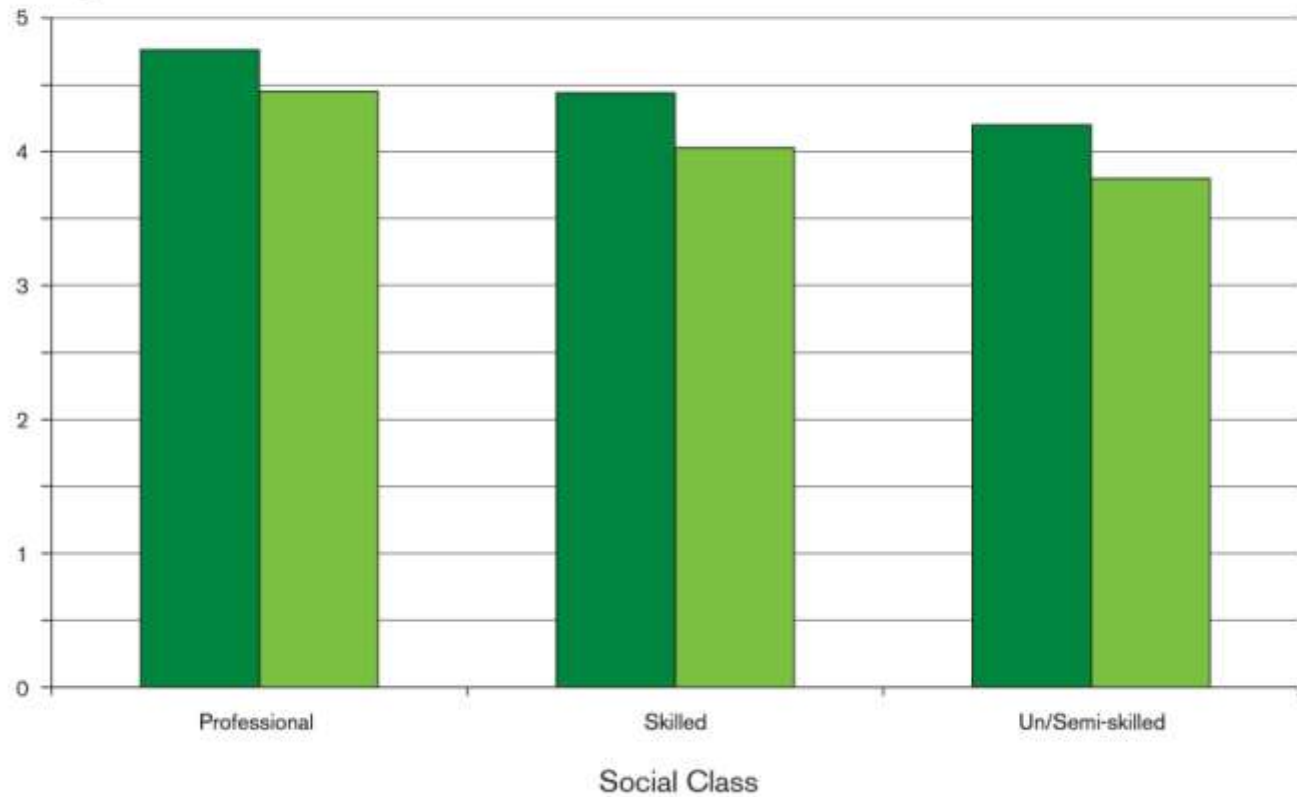
Average percentile score



- Income Q1
- Income Q2
- Income Q3
- Income Q4
- Income Q5

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

Mean Year 6
reading level

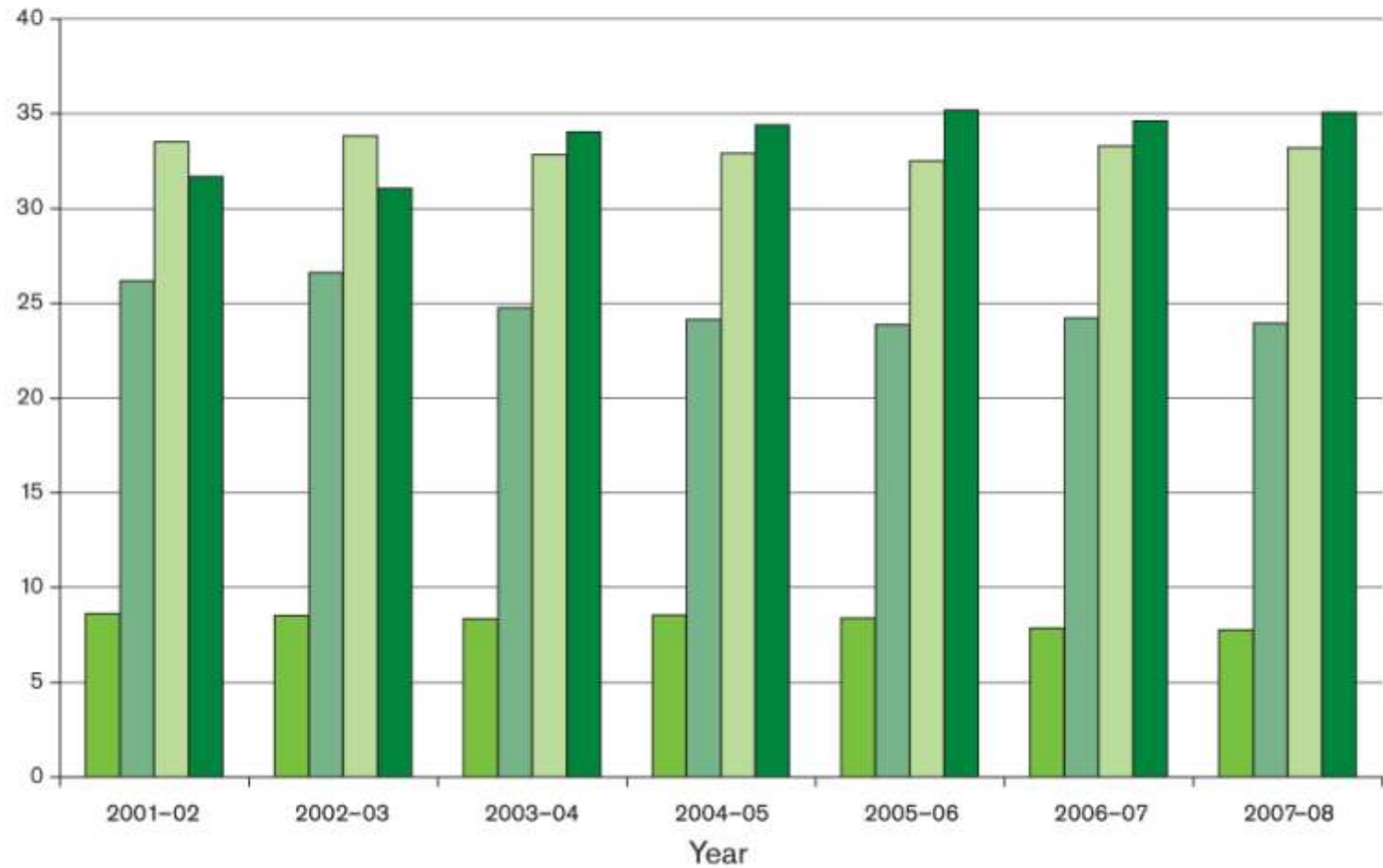


■ Preschool
■ No Preschool

Source: Department for Children, Schools and Families, Effective Provision of Pre-School Education Project³⁰⁰

Figure 4.1 Education expenditure by age group, 2001–8

Percent



Under fives Secondary
Primary Post 16

Source: Department for Children, Schools and Families²⁶³

Policy Objective A

Recommendations

- Increase proportion of expenditure allocated to early years
- Support families (pre and post natal, parenting, parental leave, transition points)
- Quality early years and outreach



- Gradient very important but,
- there are particular groups faring particularly poorly

- Particular groups are at a higher risk of having a low income, which makes them more prone to mental health problems.
- Some have significantly reduced employment opportunities, including disabled adults, those with caring responsibilities, lone parents and young people.
- Particular groups are more likely to rely on state benefits.
 - Disabled people
 - Take-up varies according to ethnic group:
 - Bangladeshis have particularly low levels of benefit receipt alongside the highest levels of poverty
 - Low take-up among Gypsies and Irish travellers
 - Many minority ethnic groups are only eligible for means-tested benefits as their shorter working histories mean they have made fewer NI contributions
- BME groups in London were 1.3 times more likely to be injured as pedestrians and car occupants on the city's roads than those in white ethnic groups



Figure 2.24 Percentage of pupils achieving 5 or more A*–C grades at GCSE or equivalent by gender, free school meal eligibility and ethnic group, 2008/9

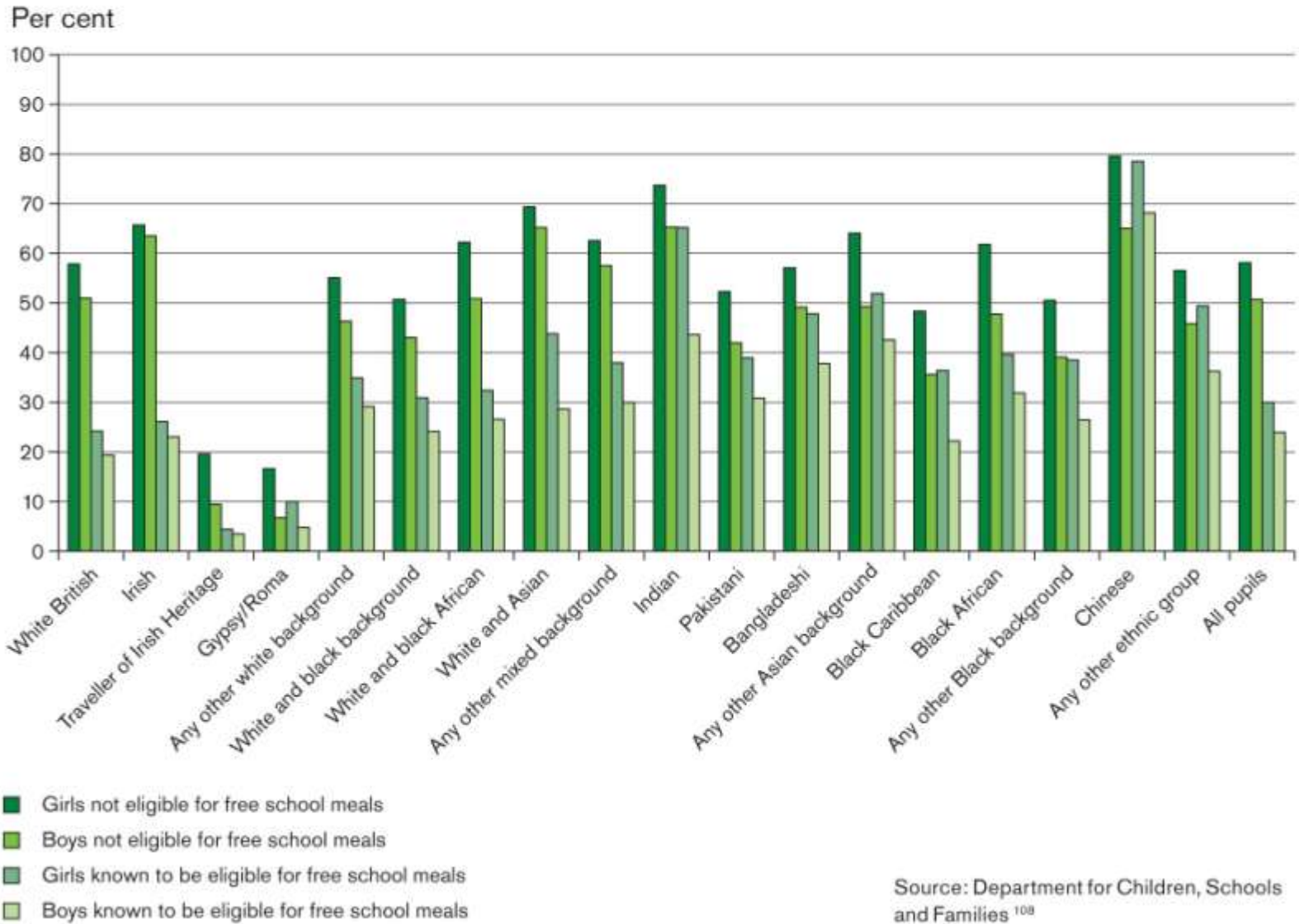
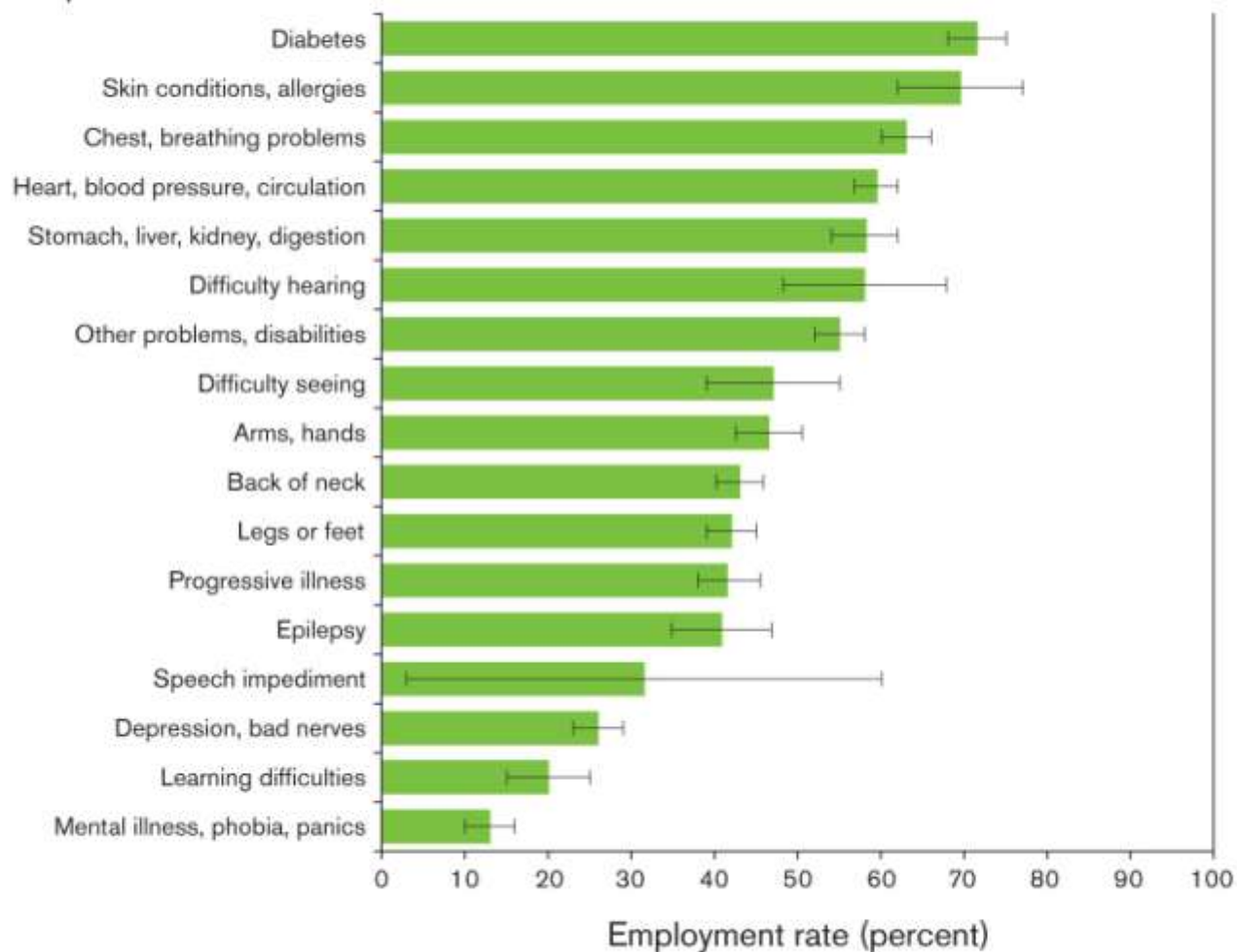


Figure 2.30 Employment rates among working age adults by type of disability, 2008

Type of impairment



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

Source: Office of Disability Issues, based on Labour Force Survey¹³²

Future work

- Healthy Lives, Healthy Places
- Local implementation – 22 areas
- London
- European Review



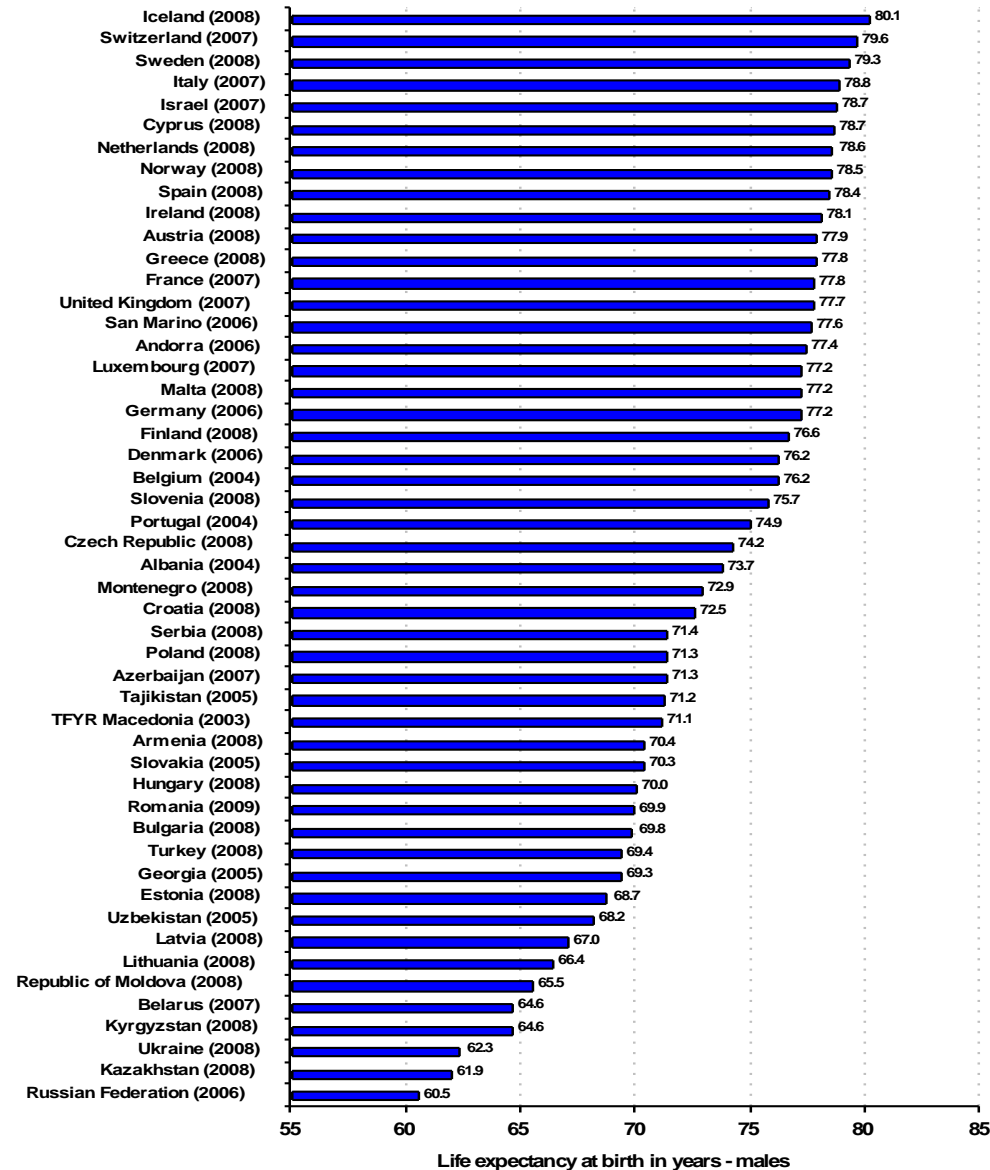
European Review on Social Determinants and the Health Divide: July 2010 – Sept 2012

Aims

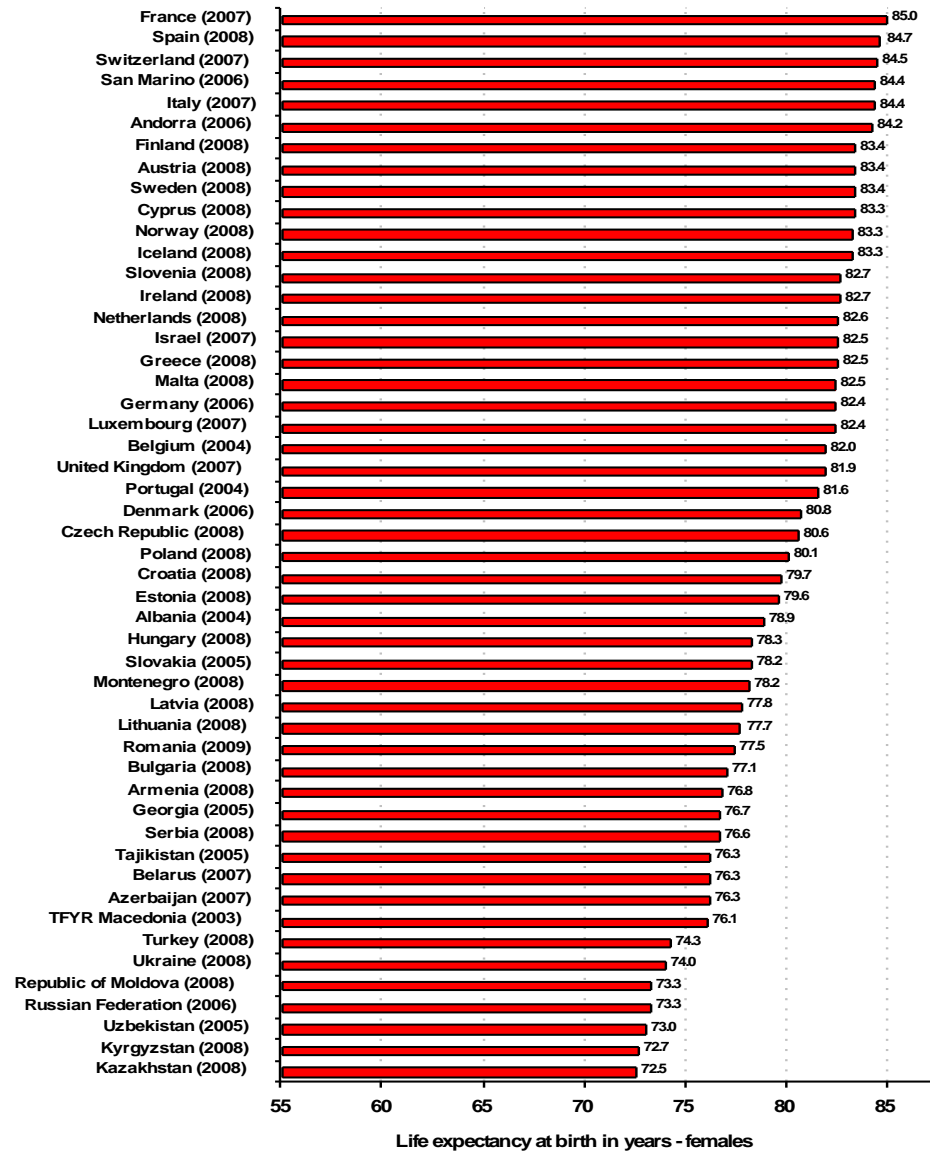
- Identify key policy areas in the European Region likely to be most effective in addressing social determinants of health and in reducing health inequities
- Provide scientific evidence and input into the development of the European Health Policy (Health 2020)

Health inequalities between countries: the health divide in Europe







Male life expectancy at birth

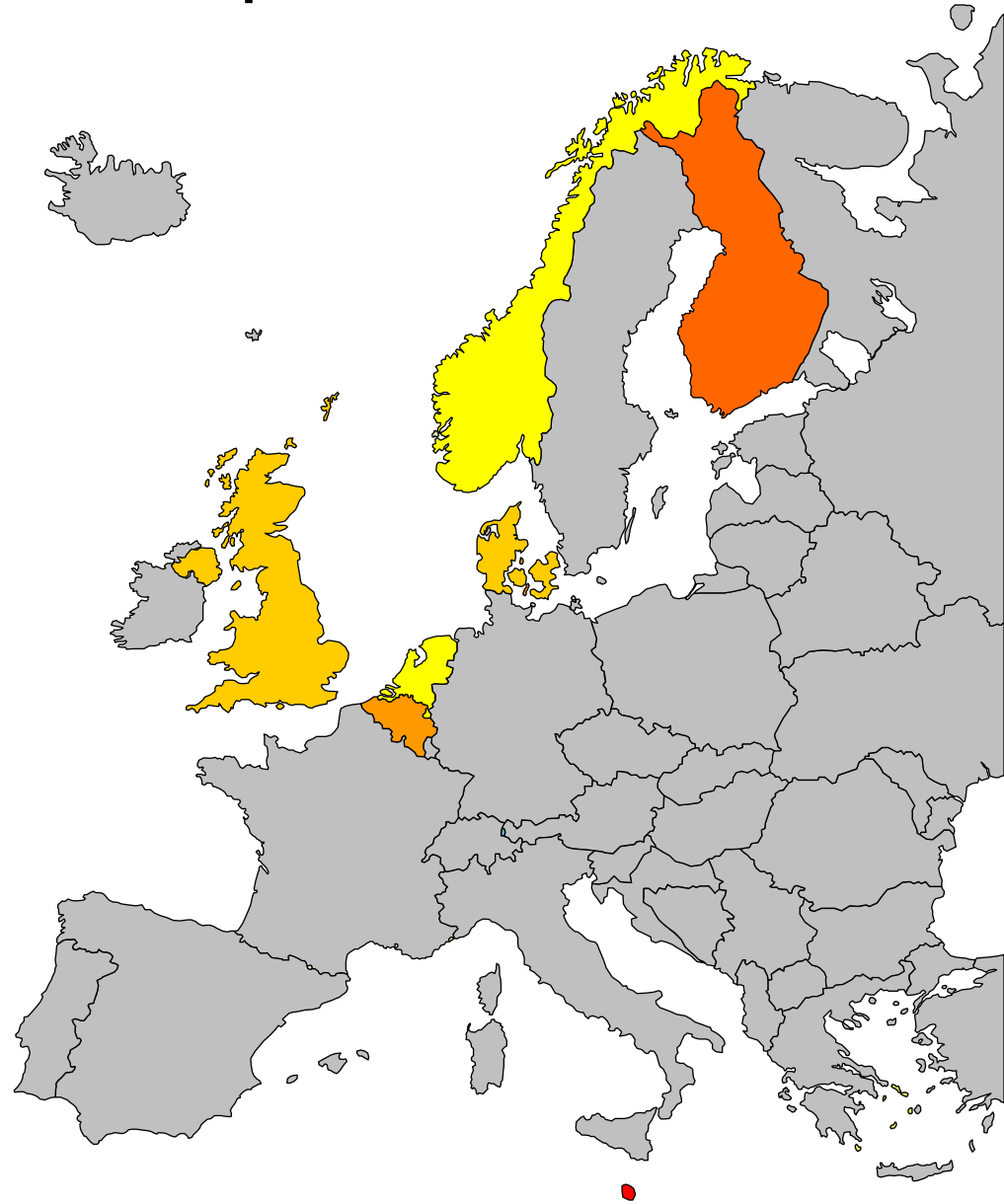


Female life expectancy at birth










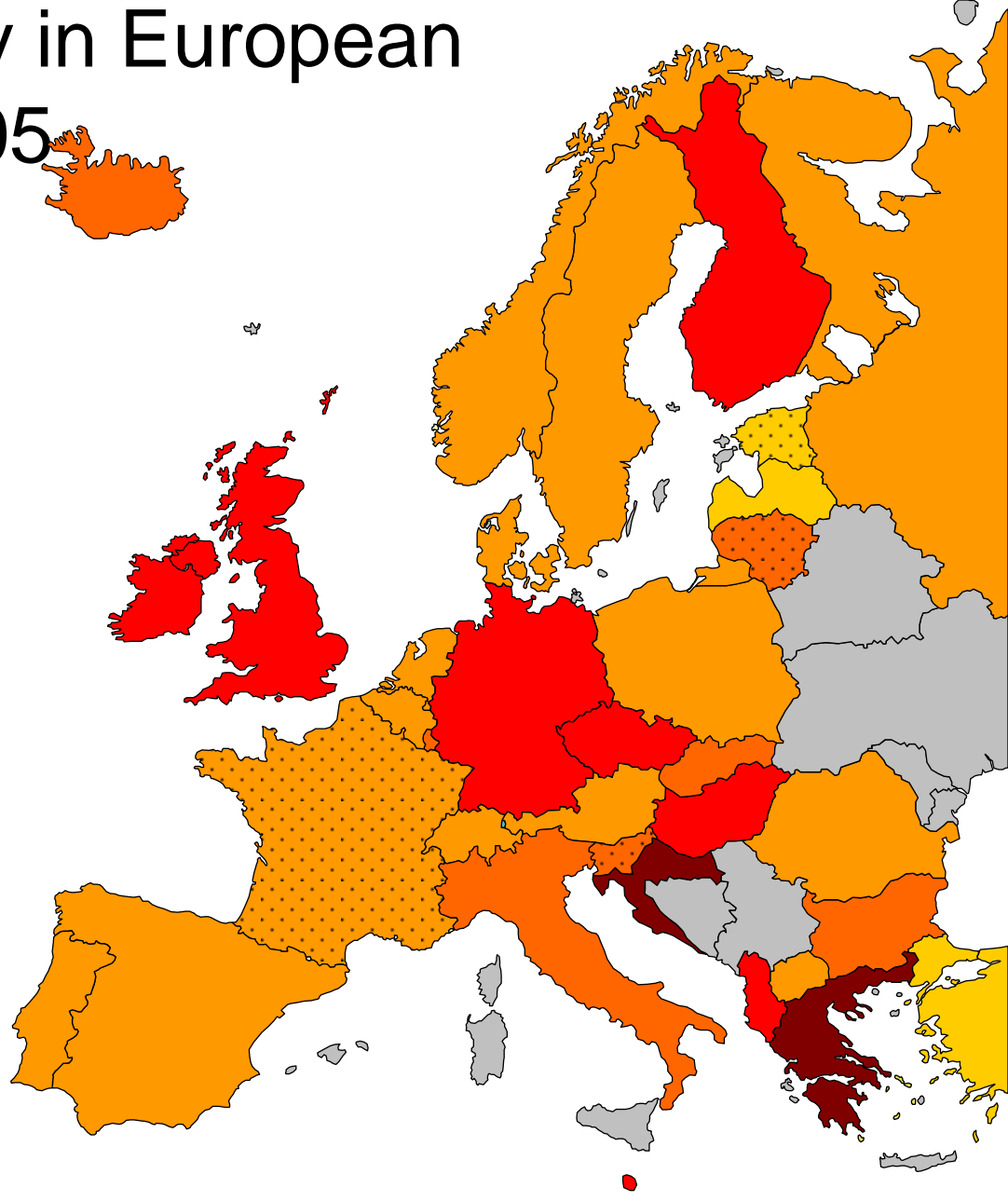
Prevalence of Obesity in European Adult Males 1980-84

% Obesity	
	< 5 %
	5-9.9%
	10-14.9%
	15-19.9%
	20-24.9%
	≥ 25%



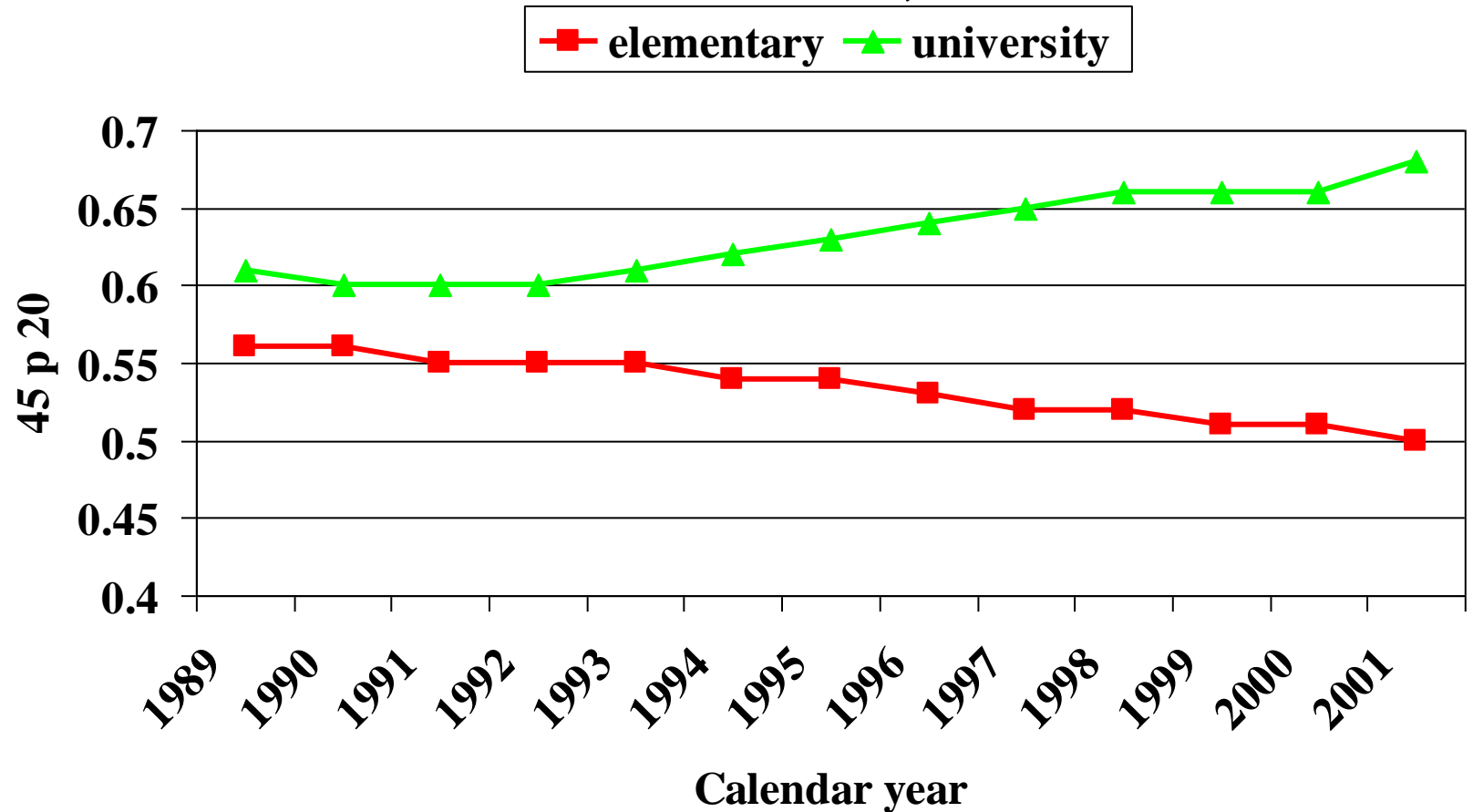
Prevalence of Obesity in European Adult Males 2000-2005

% Obesity	
	< 5 %
	5-9.9%
	10-14.9%
	15-19.9%
	20-24.9%
	≥ 25%
	Self Reported data



- Health inequalities within countries: the social gradient in health

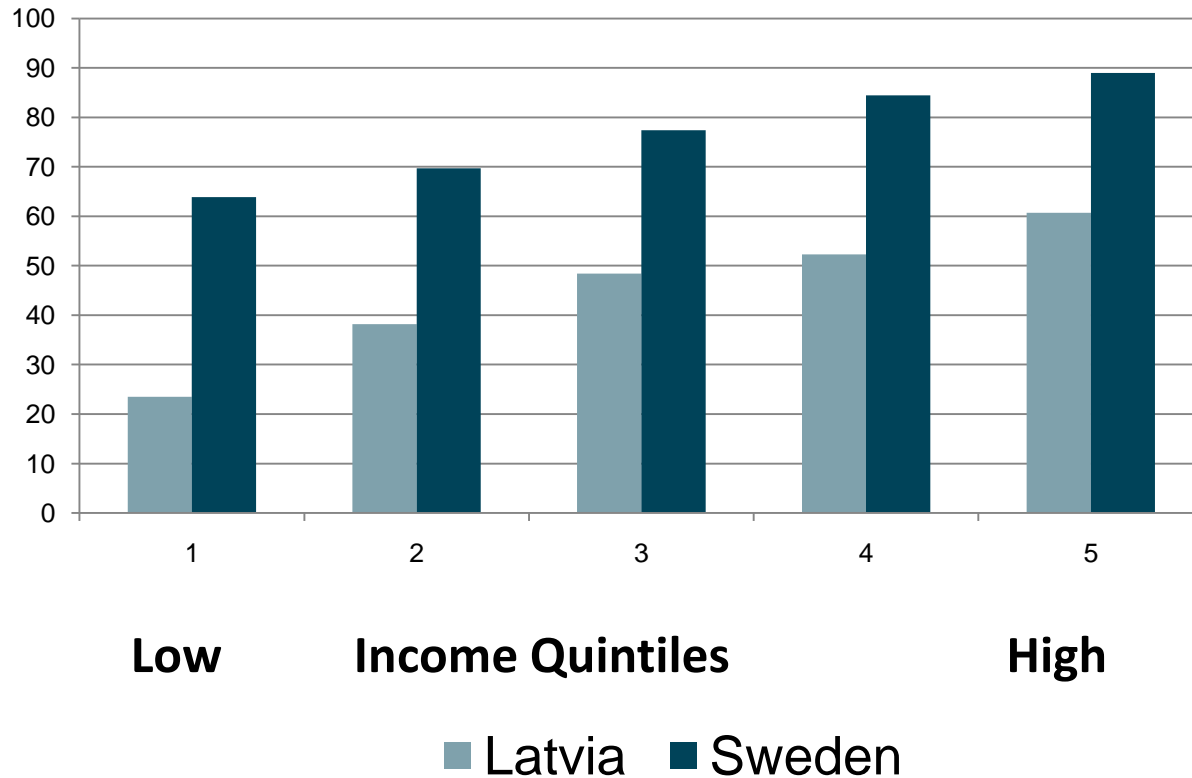
The widening trend in mortality by education in Russia, 1989-2001



45 p20 = probability of living to 65 yrs when aged 20 yrs

Self reported good health by income quintiles: Latvia and Sweden

Percentage in good/
very good health



Phase 1 objectives and report

- a) Assess the evidence underpinning:
- the divergence in health and its social determinants across the European Region
 - the social gradients within European countries, and
 - the health disadvantage associated with poverty and vulnerable population groups.

Phase 2 objectives

- a) Investigate gaps in knowledge
- b) Identify priority policy areas and potentially effective interventions across the diverse countries in Europe
- c) Indicate the working arrangements needed with national and international stakeholders
- d) Take account of the diverse processes and mechanisms across Europe
- e) Produce a framework for targets and indicators.

- Interim report – September 2010
- Consultation report – April 2011
- September 2011 – report
- September 2012 – final report

www.marmotreview.org