The Health Variations Programme and the public health agenda

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Tackling health inequalities

The 1997 election marked a sea change in public health policy. Health inequalities moved from the margins to the centre of government policy. New health strategies were launched in the four constituent nations of the UK around the twin goals of improving population health and narrowing 'the health gap in childhood and throughout life between socio-economic groups'.[1] Reducing health inequalities is an ambitious goal. Over the last three decades, the UK has become both wealthier and healthier, but income and health inequalities have increased.

Tackling these inequalities goes with the grain of public attitudes. Surveys point to widespread concern about the scale of inequality and strong support for government intervention to reduce it[2] (see also article by Paul Dolan and Rebecca Shaw). It is also in line with developments in and beyond Europe, where new health strategies are being developed to deliver reductions in health inequalities.

Achieving these reductions turns on policies which address their underlying determinants. As the government acknowledges, 'the roots of health inequalities run deep' and include 'disadvantage in all its forms - poverty, lack of educational attainment, unemployment, discrimination and social exclusion'.[1,3] Scientific evidence is accorded a central place in the development of policy, vested with the task of identifying the root causes of health inequality and evaluating the effectiveness of interventions to temper their health effects (see articles by Fiona Johnstone and Kate Philip).

Understanding the determinants of health inequality

The Health Variations Programme is designed to contribute to the research base for public health policy. Its major aim is to illuminate the pathways through which socio-economic inequality exerts its influence on health.

The discovery of a single pathway would, of course, simplify the explanatory task and provide a 'clear steer' to the policy and practice communities seeking to reduce health inequalities. However, evidence from the Programme confirms that there are multiple pathways, running from the social structure through living and working conditions to health-related beliefs and behaviours (see articles by Emily Grundy and Gemma Holt, Peter Huxley and Anne Rogers, and Jane Wardle). It suggests, further, that measures of individual socio-economic position, like the Registrar General's classification of occupation, can capture some of the critical pathways. But it is too blunt an indicator to track the many and complex ways in which inequality works - across the lives of individuals and through the structure of communities - to influence health.

The boxes below illustrate how projects in the Programme have deepened our understanding of the determinants of health inequality. They represent a small sample of the themes and findings from the Programme: fuller coverage is provided in the Programme newsletters and Research Findings, in the Programme book[4] and in the publication listings at the end of the newsletter. The first box highlights research on how health inequalities unroll across people's lives while the second box focuses on the complex nature of socio-economic disadvantage and the limitations of the measures used to capture it.

Understanding lifecourse disadvantage

- Disadvantage accumulates over the lifecourse. Disadvantage in early life sets children on educational and employment pathways likely to expose them to further and culminative disadvantage in later life.
- Lifetime disadvantage - from infancy to old age - all make a contribution to the chances of poor health in later life. For some health outcomes, disadvantage at each stage of life makes a contribution to health; for others, early life circumstances appear to be more important.
- Current circumstances matter. Improved circumstances in adulthood can compensate, at least in part, for a disadvantaged start in life while poverty in old age makes a major contribution to poor health in older people.

Understanding socio-economic inequality

- Relying on single measures of socio-economic position, like current occupation, obscures the health effects of related dimensions (like low income and housing).
- These dimensions have separate and different effects on different risk factors and on different health outcomes.
- Conventional indicators of socio-economic position, whether based on occupation, education, tenure or income, inadequately reflect the position of ethnic minority groups.
- When more sensitive indicators are used, socio-economic position makes a major contribution to the relationship between ethnicity and health.
- Over and above the effects of socio-economic disadvantage, both the experience of racial harassment and the perception of discrimination contribute to poor health.

Tackling the determinants of health inequality

The findings highlighted above, like the broader swathe of research on health inequalities, confirm the broad direction of public health policy. It underlines the need for, and the potential of, policies which engage with the 'roots of health inequality' and with 'disadvantage in all its forms'.

Targets have provided an important driver in taking forward these policies. The new public health strategies have been structured around health improvement targets: with targets set to reduce mortality rates from cancer and coronary heart disease, accidents and suicide. In February 2001, the government carried through the commitment made in the NHS Plan to underwrite local health inequality targets with national targets.[1,5] Two health inequality targets have been set to narrow the relative gap between those in the poorest health and the national average, focused on socio-economic inequalities in infant mortality and in area inequalities in life expectancy.

The new inequality targets are path breaking, confirming that public health is now a national endeavour to promote health as an equal opportunity. They have been selected as summary measures of health inequality which require additional 'layers of activities' if the wider determinants are to be addressed and the reductions in inequality achieved.[5] Yet, as currently formulated, the health inequality targets, like the health improvement targets, are oriented (only) to outcomes and not to root causes and underlying disadvantages. Thus, for example, the child health target is framed in terms of a reduction in socio-economic differentials in infant mortality and not in the broader inequalities in life chances and living standards which underlie them.

Thinking beyond health and health inequality outcomes is an important next stage in developing the UK's public health strategy. The Swedish National Health Commission, established by the Swedish government to advise on national goals for public health, has provided a blueprint for such a strategy.[6] The commission is unique in structure and approach: anchored in the policy community and involving politicians and researchers in the target-setting process.

An interim report recommended targets for reductions, not in disease and injury, but in exposure to their social determinants. It suggested that the highest priority should be given to determinants which, on the basis of available evidence, have 'the greatest potential for reducing the overall level *and* the social inequalities in the burden of disease'.[6] These determinants could include, for example, income inequality, housing and relative poverty. As the report argued, targets for determinants make policy linkages - to fiscal and social security policy, to education and employment, to housing and transport - more transparent. They can thus encourage wider ownership of the inequalities agenda by the non-health care sectors which exert leverage on 'disadvantage in all its forms'. In so doing, determinant-oriented targets could help to overcome some of the barriers to implementation identified in Mark Exworthy's project in the Health Variations Programme.[7]

The government has taken an important step towards targeting determinants by setting goals to reduce child poverty by 50% by 2010 and to eradicate it by 2020. It opens the way to the development of a public health strategy which, in line with research evidence, addresses the deep roots as well as the health outcomes of inequality.

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References

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