How much do people care about health inequalities?

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Introduction

Improving population health *and* reducing health inequalities are now the central goals of public health policy in the UK. Many people welcome the emphasis on equity, and would like to see even greater investment in tackling health inequalities. However, tackling inequalities comes at a price, in that it diverts government resources from other potentially beneficial activities.[1] In particular, targeting more NHS funds at the reduction of health inequalities may only be achievable at the expense of some reduction in the *total* health improvement achieved by the NHS. The question, then, for policymakers is: what proportion of the limited resources available should they devote to the reduction in health inequalities as compared to the maximisation of health?[2]

Our study offers evidence on whether ordinary people care about health inequalities, and the extent to which they are prepared to sacrifice the maximization of health gain in order to secure some reductions in inequalities. A key part of the project is to establish whether it is possible to measure people's views on this complex question. This article describes the methods we have developed to do this and some preliminary findings.

What do people understand by a health inequality?

The early, qualitative stage of the study involved in-depth interviews and focus groups.[3] We asked respondents to think about the causes and consequences of health inequalities, using graphical representations of data and open-ended questions. Overall, the information on a range of health inequalities was familiar and well-understood. However, all respondents were surprised by the *magnitude* of the differences in health between social classes *("I'm surprised that there is such a difference. The difference is startling. It's a terrible thing")*. The concept of fairness in health was generally well-understood by respondents, enabling us to test more formal means of eliciting preferences.

Developing methods of eliciting preferences

We developed and piloted a structured questionnaire, which asked respondents to indicate the extent to which they were prepared to sacrifice some element of total health gain in order to secure a health improvement for a particularly disadvantaged group. Health was defined in terms of average life expectancy and rates of limiting long-term illness, as the earlier qualitative research demonstrated public familiarity with these ways of measuring health.

One particular element of the questionnaire (reproduced in Figure 1) asked respondents to choose between two health care programmes. Each programme was designed to reduce mortality in all social classes, but the extent to which they targeted mortality in social class V varied.

Figure 1: Measuring views on health inequalities: the average life expectancy question

As you might know, average life expectancy differs by social class. There are differences between people in social class I (for example, doctors and lawyers) and people in social class V (for example, road-sweepers and cleaners). These two groups are more or less equal in size (they each make up about 7% of the population).

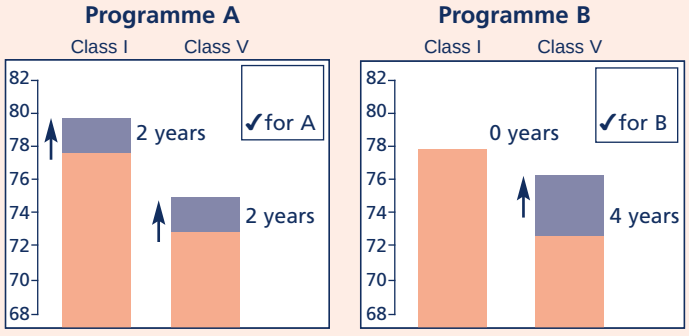
Whilst actual life expectancy varies between individuals, on average, people in social class I live to be 78 and in social class V they live to be 73.

Imagine that you are asked to choose between two programmes which will increase average life expectancy. Both programmes cost the same.

In the two graphs below the pink part shows average life expectancy, and the blue part shows the increase in life expectancy. There is a separate graph for each of the programmes.

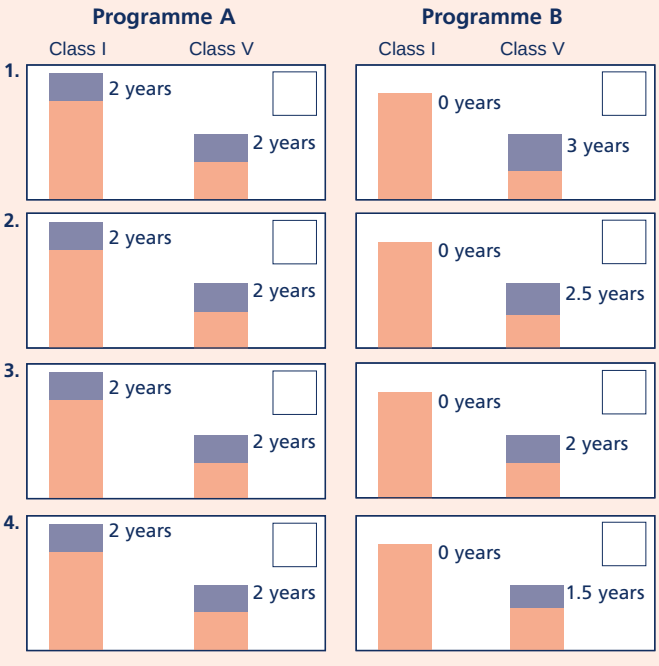
As you can see, Programme A is aimed at both social classes and Programme B is aimed only at social class V .

Please indicate whether you would choose A or B by ticking one box.



It may be that Programme B is less effective than we had first thought. This will mean that the increase in life expectancy is less overall.

For each of the **four** choices below, please tick one box to indicate whether you would still choose B, or whether you would now choose A.



Respondents are asked initially to choose between programme A, which increases the life expectancy of both social groups by 2 years, and Programme B, which increases only the life expectancy of social class V, but does so by 4 years. Those respondents who choose Programme B are then offered a succession of less attractive alternatives, in which the benefit to Social Class V is steadily reduced. The intention is to identify at which point (if any) the improvement in health for the disadvantaged group offered by Programme B becomes unacceptable when viewed alongside the greater overall improvement in health offered by Programme A.

Other respondents were presented with identical questions but related to gender differences, rather than class differences, in health. This enabled us to see whether people's aversion to inequality differs according to the type (rather than magnitude) of inequality. To test further the sensitivity of people's aversion to inequality, other respondents were presented with the same life expectancy and long-term illness differences across groups defined simply as the 'healthiest 20%' and the 'unhealthiest 20%' of the population.

The questionnaire was administered through 130 one-to-one interviews with residents from the York area. While people found the questions challenging, all respondents appeared to understand the questions and the questionnaire was fully completed in all cases. We have subsequently developed a postal survey instrument, based on a simplified version of the questionnaire.[4] The results of the postal survey are still being analysed and are not reported on here.

Some preliminary results

Our preliminary results from the interviews suggest that a majority of respondents are prepared to sacrifice some total health gain in order to reduce the stated inequality.[5] For the majority who are prepared to make such a trade-off, views differed on the point at which the benefits to the less healthy group were not adequate compensation for the loss in benefits overall. The median respondent (the one in the middle of the range) is indifferent between people in social classes I and V living on average to be 80 and 75, respectively, and these groups living to be 78 and 75.5, respectively. This means that people felt that a gain of 6 months to the worse off group could be regarded as equivalent to a gain of 2 years to the better off. This is also the median response when the sub-groups are defined in terms of the healthiest and unhealthiest quintiles of the population. In contrast, when identical data are presented but sub-groups are defined by sex, the median preference is to favour no targeting of men at all. We found a similar picture when the questions were framed in terms of long-term illness rather than life expectancy.[5]

There were no significant differences in attitudes towards tackling health inequalities by education, gender and family responsibilities. For example, those with educational qualifications were no less willing to target social class V than those without qualifications, and women are no less willing to extend the lives of men than are men themselves.

Policy implications

Overall, the results suggest that the majority of people are willing to make trade-offs between efficiency and equity. However, there is a great deal of heterogeneity in responses, and the strength and nature of an individual's preferences are often sensitive to *what* inequalities exist and *where* they exist. The later stages of the project are designed to build on these findings and create a set of tools which policymakers can use to elicit public preferences. The intention is to ensure that the views of the general public can play a central role in informing health inequalities policy.

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