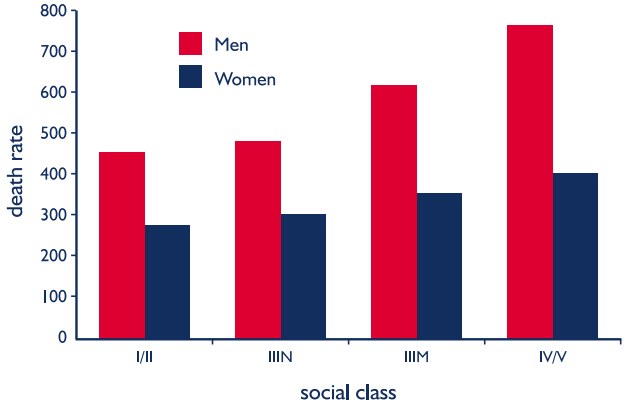
Reports from the Programme conference Introduction

Hilary Graham

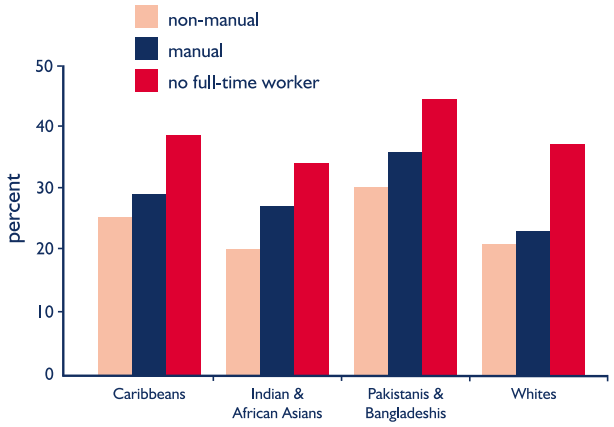
Health is a basic liberty, fundamental to participation in the society to which one belongs.[1] It is a liberty which is unequally distributed. Those on the higher rungs of the socio-economic ladder are more likely to survive in good health; those on lower rungs are more likely to succumb to disease and premature death. In the UK, the socio-economic gradients in health and mortality are evident for both men and women and across ethnic groups (Figures 1 & 2).[2,3] The evidence also points to widening health inequalities, as deaths from the major diseases like heart disease and cancer fall more rapidly in higher than lower socio-economic groups.

Figure 1: Age standardised death rates per 100,000 people by social class, men and women aged 35-64, England and Wales, 1986-92



Note: Women are classified by partner's occupational details or, if absent, by their own
Source: Harding et al 1997 [2]

Figure 2: Reported fair or poor health by social class



Source: Nazroo, 1997 [3]

Inequalities between individuals are matched by inequalities between places, with premature deaths concentrated in poor areas. These spatial inequalities in health are also increasing, as poorer areas lose out in the general improvement in health. Research conducted under the Health Variations Programme demonstrates that these geographical inequalities 'now stand at their highest ever recorded'.[4]

These trends have emerged against a backdrop of increasing national prosperity - and increasing social polarisation. Economic growth has been achieved at the cost of a rapid decline in the manual jobs which were the backbone of working class communities. It has been accompanied, too, by a tax and benefit system which has failed to protect the living standards of poorer households. The result has been a sharp rise in poverty and income inequality, together with a spatial concentration of social disadvantage and economic decline. Table 1 captures this spatial patterning of disadvantage among children in London and the associated concentrations of poor health.[5,6]

As the government acknowledges, tackling health inequalities requires policies which address these broader social inequalities. Such policies turn on an understanding of the processes and pathways which link them. A single pathway would, of course, simplify the explanatory task and provide a clear steer for policy. However, the evidence points to multiple chains of risk, running from the broader social structure through living and working conditions to health-related habits like diet and cigarette smoking. Methodological advances are enabling researchers to track how these chains of risk run across people's lives and through factors operating at individual, household and area level. Researchers in the Health Variations Programme have been working to extend and deepen these important lines of enquiry.

The Programme conference in June provided an opportunity to present findings to those vested with the task of taking forward the new public health strategies, both in and beyond the UK.

Table 1:
Child need and child health: examples from London boroughs 1997

BOROUGH	% CHILDREN IN OVERCROWDED ACCOMMODATION	% CHILDREN IN FAMILIES ON INCOME SUPPORT	INFANT MORTALITY (PER 1000 LIVE BIRTHS)	CHILDHOOD MORTALITY (PER 100,000)
Hackney	33	40	11	18
Harrow	12	14	4	11
Richmond -on-Thames	6	9	5	10
Tower Hamlets	54	43	6	32

Source: Health of Londoners Project, 19995, London Research Centre, 2000 [6]

The conference was organised around a series of linked presentations, drawing on qualitative and quantitative projects in the Programme.

The presentations drew on findings from:-

- research which has tracked how risks, and their health-damaging consequences, accumulate across the lifecourse. Drawing on longitudinal data, projects have demonstrated that disadvantage in infancy, adolescence and early adulthood all make a contribution to poor health in adulthood. Other projects have focused on how people understand the legacy of the past and the way these understandings affect current health beliefs and health behaviours (see presentations by Chris Power and Kate Hunt);

- projects which are examining the influence of areas and places. These confirm that area and regional inequalities in health reflect the different socio-economic composition of areas of low and high mortality. But these projects suggest that areas also have an effect. Economic decline, poor local services and low social cohesion are among the factors identified by researchers in the Health Variations Programme (see presentations by Heather Joshi and Carol Thomas);

- a third set of projects are concerned with the intersections between ethnicity, gender and socio-economic status. Research has explored, for example, how employment opportunities and housing careers can be disrupted by migration and constrained by racism. It has examined, too, how different dimensions of socio-economic inequality - like employment conditions and material living standards - have different roles to play in the socio-economic patterning of women's health (see presentations by George Davey Smith and Mel Bartley).

- As a final example, the Programme conference presented findings concerned with the impact of policy, at national and international level. Drawing on a project undertaken in collaboration with Swedish researchers, Margaret Whitehead presented a framework through which to map the health inequalities impact of policies (see presentation by Margaret Whitehead).

Tackling health inequalities requires, of course, more than an understanding of their causes. But it is an essential first stage for a public health strategy committed to ensuring that health is a basic liberty for all.

References

1. Sen, A. (1999) *Development as Freedom,* Oxford: Oxford University Press.
2. Harding, S., Bethune, A., Maxwell, R. and Brown, J. (1997) 'Mortality trends using the longitudinal study' in Drever, F. and Whitehead, M. (eds.) *Health Inequalities,* Series DS No. 15, London: the Stationery Office.
3. Nazroo, J. (1997) *The Health of Britain's Ethnic Minorities: Findings from a National Survey,* London: Policy Studies Institute.
4. Dorling, D., Shaw, M. & Brimblecombe, N. (2000) 'Housing wealth and community health: exploring the role of migration' in Graham, H. (ed.) *Understanding Health Inequalities,* Buckingham: Open University Press (forthcoming).
5. Health of Londoners Project (1999) *Child Health in London,* London: East London and the City Health Authority.
6. London Research Centre (2000) *Getting the Benefit: a Study of Social Security Receipt in London,* London: London Research Centre.