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POLICY BRIEF

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Evidence supporting a cross-government strategy to address health inequalities

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Summary

The pandemic compounded pre-existing health inequalities. Life expectancy has stalled since 2011 and the difference between rich and poor has widened. The UK embarked on the first international example of a cross-government strategy on health inequalities in the 2000s but evidence to date has been mixed.

By reviewing all the research to date and undertaking a new analysis, we found that the strategy was successful in closing the gap in life expectancy and infant mortality. More could have been done for mental health and healthy life expectancy. There is clear evidence that cross-government action on health inequalities can be effective.

Is a cross government strategy needed?

Health inequalities are a major barrier to our communities enjoying health, well-being and economic productivity. Inequalities are not a recent occurrence but reflect historic trends that have posed challenges to governments for decades.[1]

Between 2003 and 2018 in England, socioeconomic inequality was attributable to one death every ten minutes, accounting for 35.5% of premature deaths.[2] Health inequalities cost the UK £31-33 billion a year in lost productivity and £20-32 billion a year in lost tax revenue and higher benefit payments.[3] If health in 'left behind' neighbourhoods were brought up to the country's average, an extra £29.8 billion would be added to the country's economy each year.[4]

Between 1999-2010, across England, the UK government undertook the first international cross-government strategy to reduce health inequalities. Two key government reports, "Reducing health inequalities: an action report" and 'Tackling health inequalities: a Program for Action" set out the plan of action and targets.[5,6]

The strategy included 'down-stream' actions, such as increased NHS funding or the establishment of NICE, and more 'upstream', such as a national minimum wage, the new deal for employment and school, housing and transport funding.

What did we do?

To date, the success of the strategy has been unclear.[7,8] Additionally, there is insufficient information as to changes in inequalities in individual medical conditions and risk factors. In response to this, our team undertook two pieces of work with overlapping aims – first, a complete review of all published evidence and second a new analysis using Global Burden of Disease data, paying closer attention to the changes in individual medical conditions and risk factors which could have driven the overall changes.[9]

Full details of the research can be found here:

- Review of previous research examining strategy
- New analysis using Global Burden of Disease data

What did we find?

Review of previous research

- Our review found that with the addition of later studies, absolute health inequalities of life expectancy , mortality and infant mortality narrowed.[7,8,10-12] Benefits were not confined to targeted areas- life expectancy increased in areas at all ranges of deprivation, from the most to the least deprived.[8] There was a lack of change or worsening of inequalities in mental health, health-related quality of life and long-term conditions.[13-15] Health inequalities narrowed more consistently when measured between geographical areas rather than between individuals.

New analysis of Global Burden of disease data

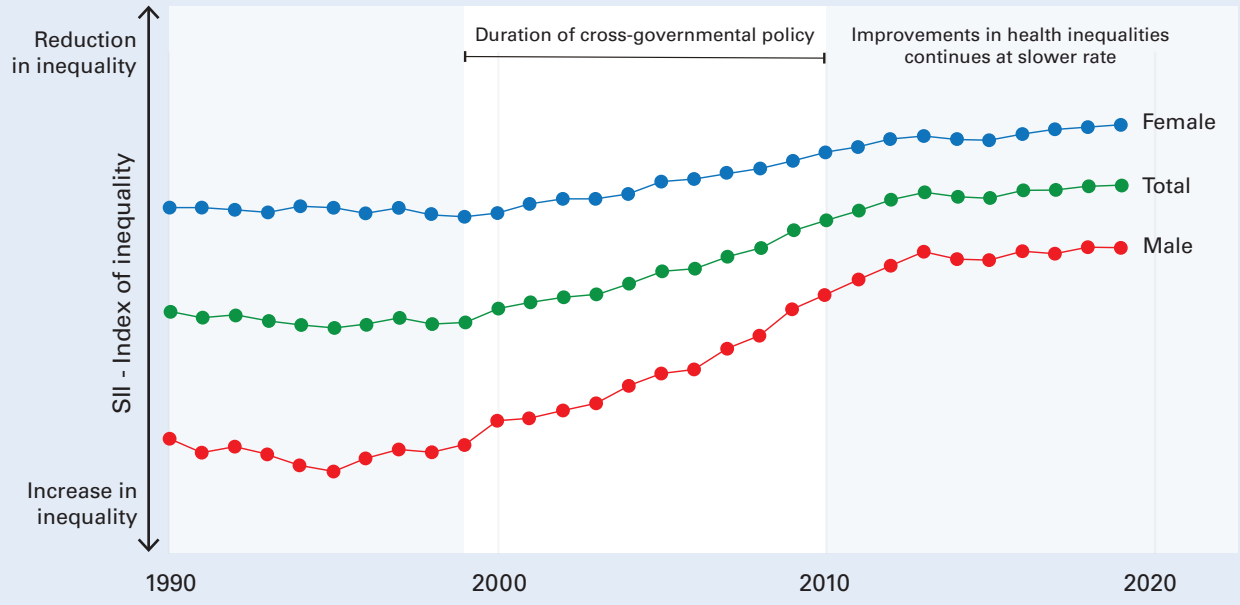
- We found that inequalities reduced throughout the strategy period compared to before and after it (see Figure 1). Absolute inequalities were generally greater in males than in females, however, trends in inequalities over time mirrored a similar pattern across both sexes.
- There were significant reductions in inequalities in three individual conditions (ischemic heart disease, lung cancer and lower respiratory infections) and four risk factors (smoking, blood pressure, dietary risks and high cholesterol).
- However, inequalities remained relatively unchanged for diabetes, pancreatic cancer, colorectal cancer, prostate cancer, drug use, physical activity, self-harm and neonatal preterm birth.

What does this mean?

One major criticism of health inequalities research is that there has been too much effort put into describing the problem, rather than finding solutions. This research provides strong evidence that cross-government action can be successful in not just reducing health inequalities, but improving health for all.

This research begins to explain which conditions and risk factors drove these changes. Previous research found that inequality reductions were driven in part by increasing NHS funding in more deprived areas.[10] Regressive changes in local government funding are one factor that have directly increased health inequalities since the end of the strategy.[16] An increased role of local government may also obtain better results: recent evidence found that devolution in Greater Manchester improved life expectancy, with the benefits most apparent in areas with the highest income deprivation and lowest life expectancy.[17]

Figure 1: Change in Slope Index of Inequality (SII) for all-cause Years of Life Lost in 150 regions in England



Recommendations

1. Develop a new cross-government strategy aimed specifically to tackle health inequalities through a range of upstream and downstream policies.

2. This strategy should pay greater focus on inequalities in conditions such as mental health, health-related quality of life and long-term conditions.

3. The target of this strategy should be clear and easily measurable. Target dates should be relative to the aim itself, with attention paid to the potential latency period between actions and outcomes.

4. We need to build the evidence base of what works alongside a new national strategy.

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