Overview

The Department of Health has published the third and final status report on progress made against the national health inequalities strategy, Tackling Inequalities: A Programme for Action, which was published in 2003. The progress report notes that there has been a further slight narrowing of the infant mortality gap, little change in the gap in male life expectancy and a widening of the gap in female life expectancy. There has been long-term progress in reducing child poverty and narrowing inequalities in housing quality, educational attainment and uptake of flu vaccinations. Child road accidents and teenage conceptions, cancer and circulatory heart disease gaps are narrowing in absolute terms and there has been a general decline in smoking prevalence but no narrowing of the gap.

The report concludes that to narrow the health inequalities gap by at least 10% by 2010 is still a "challenging" target. It also makes clear that:

“Active partnership with local government and other organisations in delivering this agenda is the best hope for effective local action on a broad front to narrow the gap”.

Briefing in full

Tackling Inequalities: A programme for action – final report

The Department of Health (DH) has published the third and final status report on progress made against the national health inequalities strategy, Tackling Inequalities: A Programme for Action, which was published in 2003.

Background

The Programme for Action was originally a three-year plan to meet the national targets for reducing health inequalities and to tackle their underlying causes. The overall targets were to reduce inequalities in health outcomes by 10% as measured by both infant mortality and life expectancy by 2010.

The focus of the Programme was the “Spearhead Group” of 70 local authority areas in the bottom fifth nationally for health outcomes. Other local authority areas are also expected to address health inequalities in their targets and, more recently, in their Local Are Agreements. The Programme for Action was continued beyond 2006, pending revision, and Alan Johnson announced a revised strategy in September 2007.
Progress on the Programme

The progress report notes that there has been a further slight narrowing of the infant mortality gap, little change in the gap in male life expectance and a widening of the gap in female life expectancy. The report also states that:

- there has been long-term progress in reducing child poverty and narrowing inequalities in housing quality, educational attainment and uptake of flu vaccinations
- child road accidents and teenage conceptions, cancer and circulatory heart disease gaps are narrowing in absolute terms (but not in relative terms)
- there has been a general decline in smoking prevalence but no narrowing of the gap.

The report concludes that to narrow the health inequalities gap by at least 10% by 2010 presents a challenge. It also makes clear that:

“Active partnership with local government and other organisations in delivering this agenda is the best hope for effective local action on a broad front to narrow the gap”.

Summary of progress against national indicators

Because the targets are based on long-term outcomes, the DH has developed a set of indicators which it believes are a means to assess progress towards the ultimate target. Progress against these indicators is outlined below.

The major killers – There have been improvements in cancer and circulatory disease death rates from 1995–97 (including for the most disadvantaged areas), with a narrowing of inequalities in absolute terms for both. There has been no significant change in relative terms for cancer, but there has been a widening in inequalities in relative terms for circulatory diseases.

Teenage pregnancy – There has been a 13.3% drop in the rate of under-18 conceptions between 1998 and 2006 (with the average rate for the most disadvantaged areas also falling), with a slight narrowing of inequalities in absolute terms but no significant narrowing in relative terms.

Road accident casualties – There have been improvements in child road accident casualty rates since 1998, including for the most disadvantaged areas. There has been a narrowing of inequalities in absolute terms, but no significant change in relative terms.

Primary care services – There have been improvements in the number of full-time equivalent (FTE) GPs per 100,000 weighted population since September 2002, including for the most disadvantaged areas. But there has not been a significant narrowing of inequalities – with some signs of a widening in absolute terms by September 2006. The number of deprived primary care trusts (PCTs) who are more than 10% below the England average number of FTE GPs per 100,000 weighted population has increased since September 2002.

Flu vaccinations – Between 2002 and 2005 the percentage uptake of flu vaccinations by older people increased (including for the most disadvantaged areas), accompanied by a slight narrowing of inequalities in absolute and relative terms. This narrowing of inequalities was maintained in 2006 for the set of deprived PCTs for which comparison is possible with earlier data. This does not mean that all of the most deprived PCTs are improving relative to the least deprived PCTs. However, more deprived PCTs achieved the 70% uptake target in 2005 than in 2002.

Smoking – Since 1998, smoking prevalence among all adults has fallen (including among
manual groups), but there has been no significant change in inequalities for manual groups compared to non-manual groups or all adults in absolute terms, with some signs of a widening in relative terms.

Between 2000 and 2005, the overall prevalence of smoking throughout pregnancy decreased slightly, including a large fall in prevalence among women in the ‘never worked’ category but a slight increase among routine and manual groups. There were some signs of a widening of inequalities for routine and manual groups.

**Educational attainment** – Between 2002 and 2007, the proportion of pupils achieving five or more A*-C grades at GCSE increased (including among pupils eligible for free school meals), with signs of a narrowing of the attainment gap between pupils eligible for free school meals and all pupils.

**Fruit and vegetable consumption** – Between 2001 and 2006, consumption of five or more portions of fruit and vegetables per day increased (including for households with the lowest incomes), but there was no significant change in inequalities between households.

**Housing** – Between 1996 and 2006, the proportions of vulnerable private sector households and of social sector tenants living in non-decent housing (based on the fitness definition) decreased, with a narrowing of inequalities between these groups and non-vulnerable private sector households in both absolute and relative terms.

**PE and school sport** – In 2006/07, participation in PE and school sport in School Sport Partnership schools with a high proportion of pupils eligible for free school meals is, on average, almost the same as in other schools. Latest data for 2006/07 are not directly comparable with available data for earlier years.

**Poor children** – The proportion of children in England living in low-income households has fallen since the baseline of 1998–99. This fall is shown for both relative and absolute low-income measures.

**Homeless families** – Since March 2002 there has been a reduction in the number of homeless families with children in bed and breakfast accommodation. The number of homeless families with children living in all temporary accommodation is higher than at March 2002, but numbers have been falling recently and are at their lowest since March 2003.

**Additional aspects and future action**

In addition to providing information on progress towards the indicators outlined above, the report also discusses the contribution of a variety of additional factors to health outcomes. These include income, tax and benefits, ethnicity and geographical differences.

The progress report gives examples and discusses evidence of good practice and commends the health inequalities intervention tool developed by the Public Health Observatories.

**Comment**

The Acheson Report on health inequalities which set the benchmark for the action programme, argued that absolute measures of health inequality are more critical than relative measures. This is because an absolute measure is determined not only by how much more common the health problem is in one group than another, but also how common the underlying problem – for example the death rate in a particular population – actually is. In this light, the statistics on
cancer and circulatory disease which show a decrease in inequality in absolute terms are good news. By the same token, the absolute increase in inequality of access to primary care services is a matter of concern.

The progress report has some serious omissions. For example, in policy areas such as mental health, and in other dimensions of inequality such as ethnicity. While mental health problems may not constitute a major killer, they do constitute a major and growing cause of ill health. Inequalities in mental health are, therefore, an important indicator of overall inequality and should be measured as such. Similarly, inequalities between the health of different ethnic groups are also indicators of wider inequalities and perhaps also of lack of social cohesion. Again, this should be acknowledged in the presentation of future statistics on health inequalities. To do justice to the progress report, this need is explicitly pointed out.

The question of how important the inequalities gap is, is a matter of political controversy, with some arguing that, as long as the health of the population as a whole is improving, an increase in the gap is less important. But others argue that widening inequality is an indication of a society that is suffering from a lack of cohesion and that the very inequality and people’s perception of it contributes to a decrease in well-being. The government, as exemplified in recent remarks by Ministers such as John Hutton, appears to be moving away from the latter view and towards the former. Nonetheless, there still appears to be widespread acceptance that in the field of health, at least, it is desirable to reduce the inequalities gap. It will be interesting to see what targets are set for the years beyond 2010.

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Question

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