IPH response to the Strategic Review of Health Inequalities in England post 2010

05 Aug 2009

IPH contributed to the Strategic Review of Health Inequalities in England being carried out by Professor Sir Michael Marmot, Chair of the Commission on the Social Determinants of Health. Access further information on the Review here

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The Institute of Public Health in Ireland

The Institute of Public Health in Ireland (IPH) promotes cooperation for public health between Northern Ireland and the Republic of Ireland in the areas of information and research; capacity building; and policy advice. Its focus is on health inequalities and influencing public policies in favour of health.

General commentary

IPH acknowledges the immense work done by the Review team and welcomes the opportunity to inform its work.

We see the review as a vital opportunity to provide a "catalyst for concerted action" not only in England but in its near neighbours in Northern Ireland and Ireland.

Health inequalities are rife across the UK and Ireland despite a range of developments in policy and practice designed to create more equal opportunities for health. We commend the approach taken in the Review, which applies scientific rigour and the combined expertise of a number of defined task groups to seek solutions to the vexing challenge of health inequality.

Data presented in the Review show that current approaches to reduce health inequalities in England have not been successful. This epidemiological pattern of improvements in absolute health outcomes but static or worsening relative health outcomes for rich and poor groups is mirrored in Ireland and Northern Ireland. In this regard, we feel it is important to share some of the learning from the experience (successes and failures) in tackling inequalities on the island of Ireland.

We are especially keen to ensure that policy development in Ireland and Northern Ireland benefits from the knowledge gained through the English review process. We are keen to apply an ever-more evidence-based approach to health inequalities in Northern Ireland, which is the most disadvantaged of the UK regions in terms of higher levels of low-paid work, unemployment, fuel poverty and child poverty and performs poorly on a number of population health and health inequality measures 1. Similarly, in the Republic of Ireland nearly a decade of economic boom has failed to produce reductions in health inequalities. Ireland is now the fastest shrinking economy in Europe with the pace and ferocity of economic downturn creating living conditions that are damaging to health, most particularly for poor and vulnerable members of society. Garnering the best evidence on tackling health inequalities and reconfiguring our approach has never been more important.

Policy makers on the island of Ireland are grappling with how to be successful in reducing health inequalities. In Northern Ireland, the newly formed Public Health Agency is making renewed efforts to deliver on the health strategy Investing for Health, which has tackling health inequalities at its core 2. The concerns expressed in the Review, and in the House of Commons Report on Health Inequalities 3, regarding the lack of evidence on the health inequality impact of existing policies and services are also a major issue in Ireland. In the Republic of Ireland, the Department of Health and Children and the Health Service Executive (HSE) are also working to to address the health inequality commitments set out in Quality and Fairness- A Health Strategy for You and within the forthcoming HSE Health Inequalities Framework 4. We hope that there will be opportunities for learning from each others approaches now and in coming years.

IPH has been involved with the development of approaches to tackle health inequalities on the island of Ireland for over a decade. During this time we have been involved in a wide range of projects relating to health inequalities including research (primary and secondary data analysis/ health intelligence), policy work, and capacity building for tackling health inequalities across a range of sectors (e.g. training on health impact assessment) 5. Where relevant, we have included findings from IPH work in our commentary on the Review.

It is clear from the experience of specific projects tackling health inequalities on the island of Ireland (including those projects operating as part of the Investing for Health partnerships in Northern Ireland and the Building Healthy Communities projects operating in Ireland) that success can only be achieved by a genuine commitment to working in partnership with, rather than for, disadvantaged communities at local level (6,7). We recommend that the Review process exploits the full range of opportunities to consider the views of disadvantaged communities and front-line

service providers, taking into account barriers to meaningful participation such as literacy, numeracy, disability etc.

Questions on Section 2 of the First Phase Report: Overview of evidence on health inequalities and their social determinants

Question 1
Are the principles and values of social justice the right approach to addressing the social determinants of health inequality?

Yes. An approach to addressing the social determinants of health inequality that is driven by the principles and values of social justice is welcome. However, in terms of health inequalities, the principles and values of social justice will be strengthened by adoption of processes central to a population health approach. For example the hallmark of population health research includes the examination of systematic differences in outcomes across populations, complexity of interactions among determinants, biological pathways linking determinants to population health outcomes, and the influence of different determinants over time and throughout the life cycle. Population health also requires attention to the resource allocation issues involved in linking determinants to outcomes 8.

Question 2
Are there any significant gaps in the evidence presented in the task group reports?

We congratulate the task group members on their work. As we would expect form the expertise available to the Review the Task Group reports are comprehensive and we have not identified significant gaps in the evidence.

Figure 1 depicts the Commission on Social Determinants of Health Conceptual Framework which includes a section on the socio-economic and political context, comprising issues of (i) governance, (ii) macroeconomic, health and social policy and (iii) cultural and societal norms and values. While many of the governance and policy issues are analysed within the document and within the Task Group reports, little reference is made to the issue of cultural and societal norms and values. Cultural and societal norms and values interact significantly with health inequalities. Yet these issues have not received as much attention or been adequately valued in the research literature or policy discourse on health inequalities. This may be driven by a perception that cultural norms and values are simply not responsive to intervention or that interventions would be stigmatising and present an ethical minefield.

Policy initiatives aimed at promoting health behaviours, supporting social mobility and enhancing the life-chances of disadvantaged people may be enhanced by investing more time, more value and more expertise in exploring the role of cultural and social norms in disadvantaged communities from anthropological, sociological and psychological perspectives. For example, pronounced gender power differentials and poor life expectations, independent of a child's ability or opportunities, have been implicated as a factor in the higher number of teenage pregnancies among disadvantaged girls 9. Similarly cultural and societal norms relating to male risk-taking behaviour, joblessness and parenting in disadvantaged communities may present 'levers for change' in the generation of health inequalities.

The data presented in section 2.1 are enlightening on the pattern of absolute versus relative improvements in health among lower socio-economic groups. While we acknowledge that the thrust of the Review is to focus on actions to address inequalities, rather than revisit the data on the nature and extent of inequalities, we would welcome a brief consideration of data on disability-free life expectancy, health adjusted life expectancy and disability adjusted life years by socio-economic status, as recommended in the OECD set of indicators on health inequalities 10. Such data provides vital intelligence and may signpost useful directions for policy and practice.

In the overview of the evidence (final para 2.1) the point is made that policies may have contributed to health inequalities not rising more significantly or that policies have not had enough impact to reduce the gradient or close the gap. The point is also made that policy responses may have been insufficient. A further point might also be made that some policies may have been introduced (perhaps inadvertently) which actually widen the gradient. This could be illustrated by some of the recent financial policies introduced to "save" the banks.

The infant mortality and life expectancy targets from Tackling Health Inequalities: A Programme for Action 11 shape the presentation of data in Section 2.1, but we caution against using them to shape the boundaries of the final Review.

In the Republic of Ireland, a health inequality target for infant mortality does not exist. Instead a target relating to reducing inequalities in low birthweight was adopted as follows:
The gap in low birthweight rates between children from the lowest and the highest socio-economic groups should be reduced by 10% from the 2001 level, by 2007 (4,12)
Although not formally documented at the time, the reasons for adopting a low birthweight target in preference to an infant mortality target included –

- larger numbers of low birthweight babies compared to infant deaths – this means that statistical

issues arising from small numbers associated with infant deaths at regional/ maternity unit level can be minimised

- existing evidence of significant socio-economic patterning in low birthweight births in Ireland 13
- evidence that low birthweight is a significant driver of perinatal and infant mortality and linked to congenital anomaly which is also socially patterned
- the opportunity to monitor outcomes for disadvantaged children born low birthweight through emergent Irish longitudinal studies with a view to identifying levers to both preventing poor birth outcomes and to maximising the potential of such children in the long-term as a tool to break intergenerational cycles of poverty.

Our response is limited and the focus is on the Task Group reports 1, 4 and 5

Task Group 1: Education and Early Years

We welcome the attention given to education and the early years by the Task Group and the overall Review process. We would strongly concur with the Task Group's conclusion that renewed efforts to tackle child poverty through fiscal, welfare, transport and housing interventions is the cornerstone of any approach to tackle inequalities in child health. A Combat Poverty analysis of child poverty in the Republic of Ireland concluded that effectively addressing child poverty requires a two-tiered approach that affords equal importance to securing incomes for children in poor families and ensuring improvements in children's services, particularly those services which interface most commonly with deprived children 14.

In Northern Ireland and the Republic of Ireland, attempts have been made to bring relevant policy together within overarching children's strategies in each jurisdiction National Childrens Strategy and Our Children and Young People – Our Pledge (15, 16). However, the experience in Ireland and Northern Ireland has been one of persistent inequalities in child health and a plethora of unimplemented or partially implemented policies relating to children's education, health and well-being. We would also share the view that many of the policy tools required to equalise opportunities in early life and tackle inequalities in child health are already at hand, but their vision has not yet been realised.

On a positive note, and perhaps as an example of good practice, the formation of an Office of the Minister for Children and Youth Affairs in the Republic of Ireland has been a significant development in infrastructure relating to children's wellbeing. The formation of such a high-level interdepartmental organisational structure for children has contributed positively to both the integration of research and policy and the development of local level implementation and policy

structures specific to children (for example children's committees established in each county) – approaches which were recommended in the Task Group report. In addition, the Office for the Minister for Children and Youth Affairs has made some in-roads in terms of re-directing resources towards core provision and the development of large-scale research studies with the capacity to provide the best possible evidence on children's wellbeing (Growing Up in Ireland – the National Children's Longitudinal Study etc). The Office of the Minister for Children and Youth Affairs has included a focus on inequalities in children's outcomes across all aspects of it's work.

IPH research supports the Task Group's recommendation regarding improving the well-being of girls and women and the circumstances in which their children are born. IPH analysis of socio-economic inequalities in low birthweight recommended that interventions focus on the health of disadvantaged women pre-conception as well as during and between pregnancies. The report also found supportive evidence for the following interventions with respect to reducing inequalities in the occurrence of low birthweight babies 17:

- outreach services for pregnant teenagers that encompass
- increased attention to developing appropriate smoking cessation services, tailored to the needs of disadvantaged women
- fostering early and sustained attendance at antenatal services

We support the Task Group's call for a robust monitoring framework to ensure that the UK keeps on track to a 2020 free of child poverty.

3.3 Which interventions and policies might make a difference to major causes of morbidity and mortality in childhood?

We recognise that injury represents a significant avoidable cause of death in the early years but would contend the assertion that it is 'the single major avoidable cause of death in the early years and beyond'. Such an assertion does not adequately reflect the impact of the extent of neonatal deaths and the extent of socio-economic inequalities in neonatal deaths, on early years mortality, as demonstrated in Figure 1 below. The recently published CEMACH report on Perinatal Mortality in the UK shows that the stillbirth rate of women in the most deprived quintile was 1.8 times higher than the stillbirth rate in the most deprived quintile in 2007. Similarly, neonatal mortality of women resident in deprived areas was twice that of those in the least deprived areas 18. Whether these deaths are any more or less avoidable than those relating to childhood injury remains an open question.

We particularly welcome the Task Group's emphasis on the impact of the environment and housing on early life outcomes. Reports from Northern Ireland are increasingly emphasising the importance of tackling the impacts of fuel poverty on children and children's health in particular 19. Economic downturn and volatile global fuel prices are likely to increase fuel poverty in low-income families. Policy initiatives in terms of social protection and improving energy efficiency of low income housing have historically emphasised ameliorating the health impacts to older and disabled persons. We would welcome the development of particular recommendations regarding tackling fuel poverty among low-income households with children. There is now a substantial literature demonstrating that living in cold, damp houses has negative impacts on the physical and mental health of children and limits the growth of infants. Moreover results from intervention studies in New Zealand and the US indicate tangible improvements in child health, as referenced in the Task Group report on the built environment (20, 21) . Therefore investing in tackling fuel poverty in households with children could contribute to significant reductions in socio-economic inequalities in respiratory illness (infection, asthma and allergies) and the health offset of interventions targeting fuel poverty should be evaluated in the long-term (22, 23)
It is notable that fuel poverty among households with children in Northern Ireland are amongst the highest and are rising. The prevalence of fuel poverty in the homes of children and young people increased from 12% in 2004 to 27% in 2006 19.

We welcome the Task Group's thoughtful consideration of the links between educational inequality and health inequality. IPH has recently attempted to unknit and synthesise data relating to this issue in Health Impacts of Education: a review 24. This review describes several routes to health through education including employment, social behaviours and attitudes as well as personal behaviours and attitudes. The IPH review concurs with the Task Group's conclusion that that 'the relationship between education and health inequalities is best thought of as a network of interactions rather than a matter of linear causality'. The IPH review reaches the same conclusion as the Task Group - the need for a new policy framework that organises evidence on education and health inequalities into a meaningful and actionable format, based on a life-course perspective.

The Task Group raises the concern that progress in addressing educational inequality needs to be protected, be 'deeply embedded so that it is protected from financial turbulence'. Recent experience in the Republic of Ireland would reinforce this concern where funding supporting vulnerable children in both primary and secondary education has been cut in response to economic downturn. For example funding has been reduced or abolished for educating Traveller

children, English-language support, special needs teaching assistants and the free-books scheme, as well as a reversal of commitments to reduce class sizes. Further cuts are proposed for the December budget 2009.

The IPH review describes policies and practices designed to address educational inequalities in Ireland and Northern Ireland, which are broadly similar to those in operation in England. The challenge of 'turning the broad brush recommendations… [of the review] into policy recommendations with real bite' must be realised if educational inequalities and their impact of health inequalities are to be effectively reduced. A new type of accountability is needed where equality is given equal importance to quality in defining school outcomes. This accountability must encompass issues of access, environment, facilities, academic achievement and the quality of teaching and teachers.

Task Group 4: The Built Environment and Health Inequalities

We welcome Task Group 4's review of how the built environment contributes to health inequalities and its critique of current policies and initiatives to redress such inequalities. The report acknowledges the complexity of the relationship between areas/ neighbourhoods and health outcomes by exploring not only the different aspects of the built environment that affect health such as green and open spaces, houses and streets, but also by highlighting factors such as socioeconomic status, culture/ ethnicity, gender and age that can modify this relationship. We agree that while continued investment is vital, it is clear that initiatives and investment programmes aimed at creating and maintaining healthier built environments need to consider all of these factors if they are to be effective in reducing and eliminating health inequalities. We have made a number of observations including reference to policy and research on the island of Ireland which are detailed below under the themes identified in the report.

Open and green space

The Task Group highlights how the unequal distribution of useable green space contributes to health inequalities, through influencing levels of physical activity in particular as well as mental health and social wellbeing. With regard to the recommendation on green infrastructure (Recommendation 3), we note the substantial difference in walking time to local parks and play areas recommended by the Task Group (4 minutes) and that currently recommended in the Republic of Ireland's Guidelines for Planning Authorities (10 minutes). In Northern Ireland, planning policy indicates that 10% of all new residential developments should be dedicated to public open space However, in recognition of the importance of green space at all stages of the lifecycle, we feel that this recommendation could be strengthened to ensure all groups are

considered. A European Community funded project, GreenSpace , included an assessment by researchers in Dublin of the types of green spaces which best suit the needs of different population groups.

Housing conditions

The issue of fuel poverty raised by the Task Group is also receiving attention across the island of Ireland and IPH has conducted some work in this area . A Fuel Poverty Taskforce has been convened in Northern Ireland while an Interdepartmental Group on Affordable Energy has been established in the Republic of Ireland. New measures which may assist fuel-poor householders in budgeting their fuel costs have also been proposed. These include Smart Metering and Building Energy Ratings (introduced in January 2009) in the Republic and social tariffs and Bulk Purchase Schemes in the North. More generally, the Irish Government's Statement on Housing Policy prioritises the need to build sustainable communities .

Safe and secure streets

We welcome the Group's focus on the importance of perceived and actual street safety. Joint Policing Committees, which provide a mechanism for the police force and councillors to discuss issues of local concern, were introduced in selected local authority level in the Republic of Ireland on a pilot basis in 2006 and are now being rolled out to all areas . Additionally some local authorities have produced guidelines for designing out anti-social behaviour, in recognition that, while police or other security presence is useful, design features such as permeability, landscaping, sense of place and active frontage can all contribute to a safer environment . In Northern Ireland Community Safety Partnership have been in operation from 2002. These bring together a wide range of stakeholders including police, education and housing at the District Council level to provide local solutions to local problems and seek to address anti-social behaviour and crime

Traffic and road safety

With regard to the issues of road safety and active travel, some recent policy and programme initiatives from the Republic of Ireland may be of interest to the Group. The Green schools programme incorporates a schools travel section which supports walking, cycling and use of public transport. A recent evaluation of a two year pilot programme found that schools enrolled in the programme achieved sustained walking levels 15% higher than the national average . More broadly, the Department of Transport has recently introduced a Sustainable Transport Strategy and a National Cycle Policy Framework . The 'Safer Routes to School' campaign in Northern Ireland aims to encourage increased use of sustainable travel journeys for the school journey

Planning systems

We strongly support the Group's recommendation that public health should be involved with planning. IPH is contributing to progressing dialogue between relevant groups through a number of routes, including the production of guidance on 'The health impacts of the built environment' and supporting the process of Health Impact Assessment in development planning at policy and project level . The Best Practice Design Guide Criteria listed below highlights that current planning guidance in Ireland is actively considering and advocating many issues with important impacts on health and health inequalities.

Best Practice Design Guide criteria

1. Context: How does the development respond to its surroundings?
2. Connections: How well is the new neighbourhood / site connected?
3. Inclusivity: How easily can people use and access the development?
4. Variety: How does the development promote a good mix of activities?
5. Efficiency: How does the development make appropriate use of resources, including land?
6. Distinctiveness: How do the proposals create a sense of place?
7. Layout: How does the proposal create people-friendly streets and spaces?
8. Public realm: How safe, secure and enjoyable are the public areas?
9. Adaptability: How will the buildings cope with change?
10. Privacy / amenity: How do the buildings provide a high quality amenity?
11. Parking: How will the parking be secure and attractive?
12. Detailed design: How well thought through is the building and landscape design?

Task Group 5: Sustainable Development

We welcome Task Group 5's comprehensive assessment of how sustainable development can contribute to a reduction in health inequalities. We agree that the six principal areas identified (climate change, a sustainable economy, food, transport, use of green spaces and the future of the health system) are of paramount importance in tackling health inequalities. A number of Irish policy documents relevant to sustainable development have already been mentioned in our response to Task Group 4's review of the built environment and health inequalities. In addition we would like to highlight the work of the National Sustainable Development Council (Comhar) in the Republic of Ireland and that of the Sustainable Development Commission in Northern Ireland . Equity is a strong overarching theme of Comhar's 'Principles for Sustainable Development'.

Question 3

Is there additional alternative evidence available which the review should be considering?

Selected information on policy in Ireland and Northern Ireland has been included in the response to Task Group reports 1, 4 and 5

Section 3: Key Strategic Themes

Question 4
Are these the most relevant themes?

See response to Q 5

Question 5
Do the themes provide a sufficiently comprehensive and appropriate framework through which to develop the review's proposals?

The 9 emerging selected themes represent a helpful aid to synthesising the very broad range of points raised by the 9 Task Groups. They offer a way of increasing understanding of what needs to be done. The risk is that the headings became too vague and we believe it is therefore important to emphasise the section on the concepts and principles underpinning them as this is very helpful and clear.

Specific points on the themes

Theme 1 on potential has come mainly from the Task group on children, we think it important that this theme is extended to other groups eg ageing

Should theme 7 include public sector planning as well as performance? This would allow for an emphasis on joint vision, outcomes and objectives between public sector organisations including government departments (a theme reiterated in the Review).

We suggest that theme 9 is renamed

We find some of the classification/differentiation into themes and the cross cutting challenges a bit unclear. For example resilience might become a theme rather than a challenge?

Question 6
Are there alternative themes which need to be explored and what evidence exists to support their inclusion?

Suggest some of the cross cutting challenges become themes , eg resilience.

The ways in which intergenerational elements affect health inequalities might be explored as this might offer additional understanding of the persistence of inequalities.

Although there is strong reference to the need to build in the experience and views of people experiencing inequalities and the groups that represent them, we do not think this is given full expression in the final themes

Working groups 2 and 3 might consider forming a specific task group to examine the research strategy allied to the review.

We strongly support bullet point 8 on page 38, which refers to strengthening the approach to evidence-based policy - monitoring the impact of policy changes from an equity perspective, and the use of health impact assessment and health equity impact assessment useful tool across the broad range of policies which impact on health

Question 7
What are your views on the challenges raised?

We support the idea of cross cutting challenges and are pleased to see the importance of addressing the crucial issue of tackling material inequality being given some prominence

If the review is to move the debate beyond addressing poverty to include inequality we think there needs to be a much stronger and wider debate on why inequality matters.

In the text on this we think it would be interesting to include text on how material wealth also separates people from social life through gated communities, private health care and schooling etc and the impact of this in terms of lessening their stake in public services such as health, education and transport. We support the Review's emphasis on a combination of universal and targeted policy – but these must be integrated rather than operating separately.

Question 8
Are there other significant challenges the review needs to address?

There is little in the Review about the need for wider debate and the building of deeper public understanding of the harm done by inequality, to individuals, communities and to wider society. It

might also consider the importance of the need to build support for action across the private sector, churches, and the political parties.

Question 9
Are the current systems for delivering reductions in health inequalities the most appropriate?

In the section on creating the conditions that foster change key aspects of such an approach are highlighted. We agree with all the recommendations relating to the development of shared vision and agendas, ensuring health equity is part of every policy and breaking out of silos to work on holistic solutions – the slight downside is that we feel we have been part of discussion about several of these issues before and are wondering how to ensure that they become an agreed way of working.

We think that the point made in the Task group on early child development about local solutions for local problems is important. As well as this we would like to see the building of new relationships between civil servants, public service and people in local communities, with a renewed and serious commitment to community development.

First phase report and task group reports

Question 10
Are the proposed interventions those most likely to impact on health inequalities?

Although we have not been able to consider in detail the wide range recommendations made by the Task Groups we think the interventions seem comprehensive and appropriate.

Question 11
Are there examples of good practice and successful interventions which could be included and what evidence exists relating to their impact on the social determinants of health inequality?

For further information or queries on this submission, please contact Dr Helen McAvoy or Dr Jane Wilde

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