Department of Health

Tackling Health Inequalities: Status Report on the Programme for Action

Tackling Health Inequalities: Status Report on the Programme for Action

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Contents

Acknowledgements

The *Programme for Action* set out a national health inequalities strategy. Published in July 2003, the work set out in the *Programme for Action* is being taken forward across government by the following 12 departments who signed up to it. These departments are:

Cabinet Office

Department for Constitutional Affairs (DCA)

Department for Culture, Media and Sport (DCMS)

Department for Education and Skills (DfES)

Department for Environment, Food and Rural Affairs (Defra)

Department of Health (DH)

Department of Trade and Industry (DTI)

Department for Transport (DfT)

Department for Work and Pensions (DWP)

HM Treasury

Home Office

Office of the Deputy Prime Minister (ODPM)

Foreword by Caroline Flint MP, Minister for Public Health

This status report marks an important stage in the national health inequalities strategy launched by the *Programme for Action* in July 2003. It provides a first review of data against the 2010 health inequalities Public Service Agreement (PSA) target as well as against a set of national headline indicators. It also shows how far departmental commitments that contribute to the strategy have been delivered.

The PSA target is a challenging one, which is why we set a target for progress by 2010. We also agreed a range of headline indicators, to give early signs of progress, or the lack of it, and to help plan further action where this is necessary.

This report mainly covers developments up to 2003, reflecting the available data. There is, as expected over this short timescale, no narrowing of health inequalities against the PSA target. There is a continuing widening of these inequalities as measured by infant mortality and life expectancy, reflecting the long-term trend.

There are, however, signs that some of the indicators associated with health inequalities are moving in the right direction. The progress achieved in tackling and significantly reducing child poverty will contribute to reducing health inequalities in the future. It shows how a well-designed, focused and strongly supported programme can achieve change over time. Other indicators, such as housing, are also showing a narrowing of the gap.

We have recently published a report on the progress of the National Service Framework (NSF) for coronary heart disease, *Leading the way*, which shows that death rates from heart disease and stroke are falling and health inequalities are narrowing. The absolute gap between disadvantaged areas and the country as a whole has fallen by 22% over the last six years. This is encouraging progress, but there has been no narrowing in relative terms. There are slight signs too of a narrowing of inequalities in other areas, including cancer death rates in absolute terms as well as in flu vaccinations for older people and educational attainment.

Action in both the NHS and across government is designed to achieve future progress. Cross-government commitments that have been delivered by 2004 include:

- expanding and developing the Healthy Schools programme in the most deprived communities as measured by free school meals – rolled out in over 3,500 schools;
- expanding Sure Start to reach over 400,000 children under four with over 500 local programmes – with 524 up and running by the beginning of 2004;
- delivering services to hard-to-reach groups through healthy living centres (HLCs) – with 257 HLC awards made by 2004;

- establishing 5 A DAY in the top 20% of most deprived areas – all primary care trusts (PCTs) in this group have a 5 A DAY community initiative. Local evidence suggests manual groups are responding to the 5 A DAY scheme and the School Fruit and Vegetable Scheme, with greater improvements in fruit and vegetable consumption compared with other groups, and families in manual groups reported eating more fruit and vegetables at home as a result of the School Fruit and Vegetable Scheme.

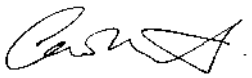
Addressing health inequalities through government action will also be assisted by the mandatory consideration of health impacts on the population of the various options assessed as part of the Government's Regulatory Impact Assessment (RIA) framework (announced in the *Choosing Health* White Paper). This means that all government departments now systematically take into account the health impacts and with that health inequalities when formulating new policy proposals.

Last year we published the *Choosing Health* White Paper, built on the twin pillars of improving health and tackling health inequalities. We set out our commitment to work with the spearhead group of 70 local authority areas (mapped by 88 PCTs) with the worst health and deprivation indicators. First steps in that work have been taken, with extra resource allocated to these areas and new initiatives, such as the development of the new health trainer's role, set to roll out first in these disadvantaged areas.

We will also contrive to build on existing, successful programmes that are having an impact across government, such as those described in this report. We will work to ensure that these are delivered on an appropriate scale to help meet the 2010 target and, beyond that, to deliver the 'fully engaged scenario' set out in the Wanless report.

There is no room for complacency. Reversing the trend in inequalities will need sustained commitment at national and local level. This report shows just how far we have to go, and it helps signal the way.

I would like to thank Professor Sir Michael Marmot and members of the Scientific Reference Group on Health Inequalities for their contribution in compiling this report. They have overseen the development of this report, mediated its judgements and endorsed its conclusions. This has provided for a report that is scientifically rigorous and a valuable prompt to action.



Caroline Flint MP
Minister for Public Health

Preface by Professor Sir Michael Marmot, Chair of the Scientific Reference Group on Health Inequalities

Inequalities in health arise, in part, because of inequalities in society. There is no society without inequalities. It is a major challenge to reduce the magnitude of social inequalities in health. To do so requires commitment and concerted action across many sectors of society. This is happening in England.

The Government has made reduction of health inequalities a major public health goal and it has set quantitative targets to achieve this reduction. A 10% reduction in the difference between disadvantaged groups and the average by 2010 may not seem large, but is, in fact, ambitious. As average health improves, health must improve even more for disadvantaged groups if inequalities are to be reduced. 'Ambitious' does not mean 'unrealistic'; it implies action across the whole of society, and if health inequalities are reduced we shall have a fairer society.

To serve this ambition, it is necessary to put policies and programmes in place and to monitor their effects. This report represents an important step in monitoring what is happening to health inequalities, both towards meeting the targets, and also through 12 headline indicators which were put in place to monitor intermediate progress.

The report contains several important messages. First, given that health inequalities arise because of the nature of society, changes will take time. The 'lead time' – the gap between change in exposure and change in disease rates – illustrates this point and shows up the differences between diseases. The 'lead time' is longer for cancer than for heart disease. For example, changes in smoking lead to a more rapid reduction in heart disease rates than in cancer rates. Comparing 2001–03 with 1995–97, the reduction in circulatory (heart) disease mortality has been more rapid than the reduction in cancer mortality rates. For circulatory diseases there has been some narrowing of the absolute difference in mortality rates between the most deprived areas and the average; less so for cancer. To change social inequalities in life expectancy means both important social changes and translating these differences into changing disease rates. This report gives no grounds for complacency that enough has yet been done.

Second, amid the sober acceptance that progress will take time, the report shows what can be achieved given strong government commitment. There has been a national commitment to the reduction of child poverty. Real progress has been made in England as a contribution towards the PSA target to reduce the number of children in Great Britain in relative low income by a quarter between 1998/99 and 2004/05. The proportion of children in England living in poor households, defined as 60% of Great Britain median income in the year in question (before housing costs), has fallen from 24% to 20% (before housing costs) between 1998/99 and 2003/04. Taking a fixed threshold (absolute low income) – below 60% of Great Britain median income in 1996/97 in real terms – the proportion of children in England living in poor households (before housing costs) fell from 22% to 11% between 1998/99 and 2003/04. The proportion of children in 'absolute poverty' in England has, therefore, been halved in five years. One would predict that this would feed forward to a reduction in inequalities in life expectancy over the long term, although not by 2010.

The report contains another message. Our analysis is only as good as the information we have. The level of information to monitor health, inequalities in health, and their determinants is high in this country. There are, nevertheless, gaps in the information base. Having high-quality information is essential to monitoring progress in this area.

This country has been at the forefront in documenting health inequalities, in analysing the causes of the problem, determining what can be done, putting policies in place and now monitoring progress. With the UK Presidency of the European Union (EU), there is the opportunity to link up with progress in other European countries and make the reduction of health inequalities a Europe-wide activity. This would be very welcome.

Professor Sir Michael Marmot
Chair of the Scientific Reference Group on Health Inequalities

The Scientific Reference Group on Health Inequalities

The Scientific Reference Group on Health Inequalities has overseen the development of this report and guided its judgements and conclusions. The members of the group are:

Professor Sir Michael Marmot (Chair)
Director of the International Centre for Health and Society, University College London

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Executive summary

1. In *Tackling Health Inequalities: A Programme for Action* (2003) we said that we would produce a report on the Public Service Agreement (PSA) target on health inequalities (2002) and, in particular, the 12 national headline indicators. The 2002 target was:

   by 2010 to reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth.
   This commitment was reiterated in the *Choosing Health* White Paper.

2. The extent of the challenge was set out in the first principle of the strategy – to prevent health inequalities from worsening, given that the long-term trend showed that the gap in mortality between professional (social class I) and unskilled manual men (social class V) has increased by two and a half times since 1930–32.

3. This report focuses on the steps being taken to narrow the health gap by improving the health of the poorest fastest. It summarises developments against the main indicators and provides a baseline against which to measure current and future action. This notion of the baseline is crucial in understanding developments. Many interventions will only be coming on stream after 2003, the date of most of the data in this report. In other areas, services are still building to a scale where they will be effective.

4. Taking account of the latest Office for National Statistics (ONS) figures on life expectancy and infant mortality, the report shows:

   - a continuing widening of inequalities as measured by infant mortality and life expectancy at birth in line with the trend;

   - an inconclusive picture on the indicators but with progress against two important headlines, child poverty and housing, and some signs of a narrowing of the gap in other areas, notably in circulatory (heart) disease mortality (in absolute terms) and, to a much lesser extent, cancer, as well as flu vaccinations and educational attainment. Other areas, like smoking, remain less susceptible to change;

   - the successful completion of almost all departmental commitments in the *Programme for Action* due for delivery by April 2004.

   More details are available on our website at www.dh.gov.uk/healthinequalities.

5. The headline indicators provide a summary of what is happening in key areas linked to the target. These areas were identified because programmes, policies and interventions in these areas are expected to make a significant impact on health inequalities and represent the best set given the available data.

6. One consequence of data availability is that this report does not cover all aspects of health inequalities. There are gaps, such as mental health, and the focus is primarily on area or socio-economic group with less attention to the experience of black and ethnic minorities and other groups, such as disabled people. Ethnicity is a powerful factor in health inequalities but it is not systematically covered in this report.

Life expectancy

7. The latest data for 2001–03 indicate that since the baseline (1997–99), the relative gap in life expectancy between England as a whole and the fifth of local authorities with the lowest life expectancy has increased for both males and females (continuing a long-standing trend), with a larger increase for females.

8. For males the relative gap increased by nearly 2%, for females by 5%.

Infant mortality

9. The new figures confirm the previously reported trend that the gap between 'routine and manual' groups and the whole population has widened since the target baseline, although there have been year-on-year fluctuations in intervening years.

10. For the latest three-year average period, 2001–03, the infant mortality rate (for all babies with father's occupation stated) was 5.0 deaths per 1,000 live births, and the rate for those in 'routine and manual' groups was 6.0 per 1,000. This was higher than the rates for those in the 'managerial and professional' (3.5 per 1,000) and 'intermediate' (4.7 per 1,000) groups.

11. The infant mortality rate among the 'routine and manual' group was 19% higher than for the total population in 2001–03, compared with 13% higher in the baseline period of 1997–99.

Headline indicators

12. Overall improvements in services, together with reductions in inequalities in wider determinants of health, should help narrow the health gap. A key area to show significant improvement is child poverty, where there has been a strong and continuing commitment to reduce the number of children in poverty since 1997. This strategy is showing real results with a large number of children taken out of poverty.

13. Housing is another area that has shown a narrowing of the gap, as measured by the proportion of households living in non-decent housing. It reflects a concerted programme of action and investment in this field and is also shown by the reduction in the numbers of people living in fuel poverty.

14. The evidence is less clear in other areas covered by these indicators. This highlights the difficulty of combining overall service improvements with a narrowing of the health gap. There are some signs that a narrowing of the gap is beginning to take place, most notably in death rates from circulatory disease (in absolute terms), and some slight signs in flu vaccinations among the over 65s, cancer death rates (in absolute terms) and educational attainment. Box 1 summarises the key developments against the indicators.

Box 1: Summary of national indicators

1. *The big killers* – there have been significant improvements in death rates from cancer and heart disease since 1995–97 (including in disadvantaged areas); there have been some signs of a narrowing of the inequalities in cancer death rates, and a narrowing of inequalities in heart disease death rates in absolute terms.
2. *Teenage pregnancy* – there has been a 9.8% drop in the rate of under-18 conceptions between 1998 and 2003; however, findings from a national evaluation of the teenage pregnancy strategy indicate that over a longer period (between 1994–98 and 1999–2002) teenage conception rates in the most deprived top tier of local authorities fell faster than in other areas.
3. *Road accident casualties* – there has been a significant reduction in the rate of road accident casualties for children since 1998, but no significant narrowing of the gap in such casualties.
4. *Primary care services* – there has been an improvement in the number of GPs since 2002 (including in disadvantaged areas), but no significant narrowing of the gap in the number of GPs.
5. *Flu vaccinations* – there has been an improvement in the percentage of uptake of flu vaccinations since 2002, accompanied by a slight narrowing of the gap in the uptake of these vaccinations.
6. *Smoking* – there has been a reduction in smoking prevalence among all adults since 1998 (including a slight reduction in manual groups), but no significant narrowing of the gap in smoking prevalence between manual groups and other groups; there is a strong social gradient in smoking prevalence among pregnant women.
7. *Educational attainment* – there has been a significant improvement in the proportion of those aged 16 who get five GCSEs at grade A*–C since 2002 (including for the most disadvantaged groups), and some signs of a narrowing of the gap between pupils eligible for free school meals (FSM) and all pupils.
8. *Fruit and vegetable consumption* – since 2001 there has been no improvement in fruit and vegetable consumption for the most disadvantaged groups and no significant narrowing of the gap.
9. *Housing* – there has been a significant reduction in the proportion of households living in non-decent housing since 1996, with a significant narrowing of the gap between vulnerable households and all households overall in absolute terms.
10. *PE and school sport* – nearly two-thirds of pupils in school sport partnerships spend at least two hours a week on high-quality PE and school sport but with lower participation rates in schools with a high proportion of FSM pupils.
11. *Poor children* – there has been a significant reduction in the proportion of children living in low-income households since 1998/99 on all measures.
12. *Homeless families* – since March 2002 there has been a significant reduction in the number of homeless families in bed and breakfast accommodation; there has been a significant increase in the number of families living in temporary accommodation overall, although this number has remained fairly constant since September 2004.

Departmental commitments

15. The *Programme for Action* featured a range of departmental commitments across government until 2006. This set of commitments derived from the 2002 Cross Cutting Spending Review exercise on health inequalities and associated PSA targets. This set of commitments has been revised, updated and extended in the 2004 Spending Review exercise.

16. Almost all of the departmental commitments to April 2004 set out in the *Programme for Action* have been realised. All of these commitments are set out in Box 2.

Box 2: Government commitments to 2004

- Improve the social and health context of school life by targeting the Healthy Schools programme on the most deprived communities.
- Expand Sure Start services for children under five and their families – reaching 400,000 children living in disadvantaged areas.
- Create more than 45,000 day care places through 1,279 neighbourhood nurseries in disadvantaged areas.
- Provide free nursery education for all three year olds as well as four year olds.
- Deliver services for hard-to-reach groups through 257 healthy living centres clustered around areas of deprivation.
- Meet the language needs of asylum seekers and refugees through NHS Direct.
- Increase participation in physical activity through the introduction of local exercise action pilots.
- Reduce significantly the number of homeless families with children in bed and breakfast accommodation.
- Establish 5 A DAY initiatives in deprived areas.
- Provide intermediate care for an extra 150,000 people, and
- Develop plans to improve the health and well-being of older people through the National Service Framework (NSF).

17. Action across government will contribute to the 2010 PSA target and provide the basis for longer-term changes which are necessary to effect a sustainable narrowing of the health gap.

Chapter 1: Introduction

The *Programme for Action*

1.1 *Tackling Health Inequalities: A Programme for Action* (*Programme for Action*) was published in July 2003. It identified two goals – meeting the national Public Service Agreement (PSA) health inequalities target and addressing the wider challenges set by the underlying causes of health inequalities. The national target set as part of the 2002 Spending Review is:

- *by 2010 to reduce the inequalities in health outcomes by 10 per cent as measured by infant mortality and life expectancy at birth.*

1.2 The PSA target is underpinned by two more detailed objectives:

- *starting with children under one year, by 2010 to reduce by at least 10 per cent the gap in mortality between routine and manual groups and the population as a whole;*

- *starting with local authorities, by 2010 to reduce by at least 10 per cent the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole.*

1.3 The priority the Government has given to tackling health inequalities is rooted in the fact that health and life expectancy are linked to social circumstances in adulthood and childhood and, despite overall improvement, the health gap between the top and bottom ends of the social scale remains large. For many people, these inequalities mean poorer health, reduced quality of life and avoidable early death.

1.4 The *Programme for Action* identified the themes and principles of the health inequalities strategy which reflect the need for long-term sustainable change. The themes are:

- supporting families, mothers and children;

- engaging communities and individuals;

- preventing illness and providing effective treatment and care;

- addressing the underlying determinants of health.

1.5 The first principle in the *Programme for Action* is to stop health inequalities from widening further before narrowing the gap. This will be done by:

- working through the mainstream;

- supporting action from the centre and through the regions;

- delivering at local level through effective partnership.

1.6 The range, quality and reach of public services in disadvantaged areas, or available to disadvantaged groups, can exacerbate health inequalities. Mainstreaming policies that contribute to reducing health inequalities through public services will be vital if the necessary scale of change required to achieve the national target is to be achieved.

Wanless review

1.7 The Wanless review, *Securing Good Health for the Whole Population: Final Report,* was published in February 2004. It concluded that achieving the goal of a population 'fully engaged' in improving its health, to avoid becoming sick rather than treating sickness, is a major prize for the whole community. The step change needed to achieve this will require strong leadership and organisation in public health delivery, and access to high-quality, personalised information, advice and increased support to help individuals take vital health and lifestyle decisions.

1.8 It said that while individuals are primarily responsible for their own and their families' health, the Government has a major role in the process by providing the necessary framework in improving health and tackling health inequalities.

Public health White Paper

1.9 The *Choosing Health* White Paper provides strong support for tackling health inequalities. It stresses the importance of health inequalities as well as that of health improvement, and it reiterates the importance of the PSA targets, including the new 2004 targets described in Annex 2, and the *Programme for Action.* Health inequalities are also identified as the first of six priorities in the White Paper delivery plan, *Delivering Choosing Health*, that was published in March 2005.

1.10 The White Paper is built around three principles of informed choice, 'personalisation' – personalised services and support delivered according to need – and working together. It includes recommendations across a range of issues including smoke-free public places, diet, nutrition and obesity, physical activity and sexual health, as well as health inequalities.

1.11 The 'spearhead group' of 70 local authority areas mapping to 88 primary care trusts (PCTs) will lead the work on narrowing the health gap and pilot several of the key White Paper recommendations, such as the introduction of personal health trainers and school nurses. These areas will need to make faster progress than elsewhere to help meet the 2010 target.

A cross-government approach

1.12 The challenging nature of the national target and the agenda set by the *Programme for Action* called for regular monitoring. To aid this process, 12 national headline indicators sit alongside the national target and give a more rounded assessment of developments. These indicators underline the concerted effort across government that is necessary to narrow the health gap.

1.13 The indicators provide a broad summary of the areas to be monitored and represent available and already collected data sets. The areas are those where interventions are expected to make a significant impact on the issue.

Box 3: The national headline indicators

The *Programme for Action* developed a set of national indicators to offer simple, summary snapshots of progress on key interventions, reflecting data already collected. They are:

- Death rates from the big killers – cancer and heart disease
- Teenage conception rate
- Road accident casualty rates in disadvantaged communities
- Numbers of primary care professionals
- Uptake of flu vaccinations
- Smoking among manual groups and among pregnant women
- Educational attainment
- Consumption of fruit and vegetables
- Proportion in non-decent housing
- PE and school sport
- Children in poverty
- Homeless families living in temporary accommodation

National performance, local action and disadvantaged areas

1.14 These indicators – and the wider range of commitments in the *Programme for Action* – are reflected in the local basket of indicators that has been developed by the London Health Observatory. This basket uses existing data to help local authorities, PCTs and other local partners identify need and monitor progress against action to support disadvantaged groups and areas.

1.15 The health poverty index provides a tool that enables local authority areas to compare progress locally against national data across a range of health, economic and social determinants.

1.16 Performance management of public services both nationally and locally is a key way of promoting local action on health inequalities. New developments will improve the responsiveness of public services in developing this agenda. The NHS planning and performance framework *National Standards, Local Action* (2004) sets out the approach that NHS organisations and social service authorities should use in planning for the next three financial years. As well as setting out expectations for contributions to the achievement of national priorities and targets, the framework defines principles for delivering local targets. The framework has highlighted the need to improve quality and equity by meeting population needs and addressing service gaps as part of a programme of tackling health inequalities and improving access to services. For example, in the NHS, PCTs are expected to conduct health equity audits to assess local need and inform planning with a view to reducing health inequalities. The Comprehensive Performance Assessment (CPA) 2005 will, for the first time, assess local authorities on their performance in creating healthier communities and tackling health inequalities. Healthier communities is included as a section of the CPA Corporate Assessment.

1.17 This framework is complemented by Local Delivery Plans (LDPs), which PCTs agree with strategic health authorities (SHAs). LDPs include information that the Department needs for monitoring of national targets and supporting modernisation strategies. PCTs will also include local policies and priorities in their own LDPs, agreed with SHAs.

1.18 These developments taken with the establishment of the spearhead group will clarify the difference between overall national performance and progress in areas with poorer health outcomes.

The focus of this report

1.19 As part of the overall goal of reducing health inequalities, the priority is to improve the health of the poorest groups and communities at a rate that brings their standards of health closer to those enjoyed by the rest of the country. The importance of narrowing the health gap has been emphasised in a number of policy developments, including the *Programme for Action* and the *Choosing Health* White Paper and its delivery plan. This report therefore focuses on monitoring health gaps for the national target and the headline indicators as well as providing a baseline against which to measure current and future action.

Other dimensions of health inequalities

1.20 The *Programme for Action* stressed the need for action on a broad front to address inequalities across different geographical areas, between genders and different ethnic communities, and between social and economic groups. This report focuses on the headline indicators but recognises the importance of other factors in tackling health inequalities, such as mental health and inequalities experienced by black and minority ethnic (BME) and other groups.

Chapter 2:
The scope of the report

2.1 Health inequalities are the result of a complex and wide-ranging network of factors. People who experience material disadvantage, poor housing, lower educational attainment, insecure employment or homelessness are among those more likely to suffer poorer health outcomes and an earlier death compared with the rest of the population. This disadvantage reinforces health inequalities and helps sustain these inequalities across the generations. For example, educational attainment at age 15–16 is significantly associated with coronary heart disease (CHD), according to an analysis of over 100 local education authority areas.

The NHS and the wider determinants of health

2.2 The *Programme for Action* recognised that effective action on health inequalities requires a cross-government response. It proposed a twin-track approach – firstly through the immediate action necessary to meet the 2010 target, and secondly through the longer-term changes resulting from the cross-government action that is needed to sustain a reduction in the health gap.

2.3 Health inequalities are not just a health service issue. Many of the major determinants of health lie beyond the reach of the NHS, in people's living and working conditions and in their health-related behaviours. The *Programme for Action* reflects the recognition that a wide range of government policies is needed to address the causes of health inequalities. A full statement on the progress in meeting departmental commitments to April 2004 is set out in Annex 2.

2.4 Healthcare organisations do have an important part to play in improving health and tackling health inequalities. This was underlined by the *Choosing Health* White Paper. In particular, they are a major contributor to achieving the national target on life expectancy. The 2010 timescale means focusing on those who already have – or are at high risk from – one of the main life-threatening diseases. PCTs have a key role of assessing the health and the healthcare needs of their local population, conducting health equity audits and then planning, prioritising and implementing effective healthcare and public health services and interventions with all parts of the NHS and other local partners.

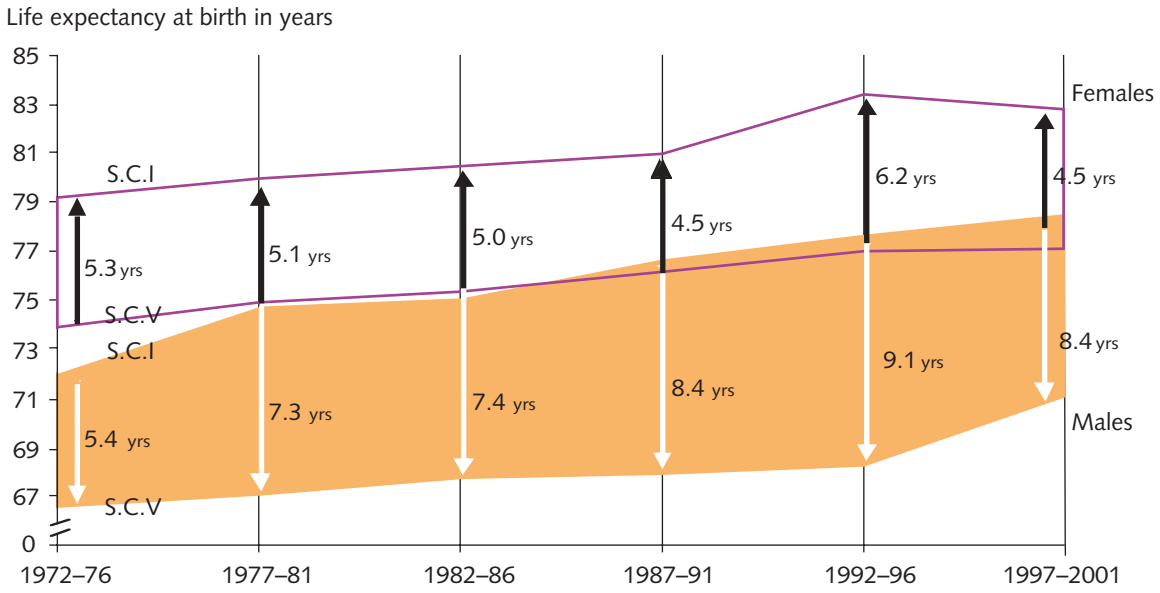
2.5 The NHS can directly contribute to the reduction in deaths from causes amenable to medical intervention, as well as provide the support for a framework for effective action. Direct action on the major killers like circulatory disease and cancer has resulted in death rates from circulatory disease in the under-75s falling by 27% in the six-year period to 2001–03. Survival rates for all the major cancers are increasing and the latest data show that the death rate from cancer among under-75s has fallen by over 12% since 1995–97. The NHS also has a key role to play in reducing inequalities in health resulting from injuries and illnesses where effective interventions can improve recovery and save lives.

2.6 The links across government are crucial in tackling disadvantage and sustaining change in the long term, and are the best guarantee of achieving a sustainable reduction in the health gap. Several major programmes reflect the importance of this cross-government engagement, notably the Sure Start and Neighbourhood Renewal programmes.

2.7 In addition, homeless or insecurely housed people are more likely to suffer poor physical and mental health than the rest of the population. Children from homeless families have an increased risk of a low birth weight and a greater likelihood of illness, behavioural problems and delayed development. Joint DH/ODPM guidance (2004) to local authorities and PCTs and other healthcare providers on *Achieving Positive Shared Outcomes in Health and Homelessness* encourages closer joint working to improve health outcomes for homeless people.

2.8 The *Programme for Action* showed a widening mortality gap between the social classes over time. It showed that since 1930-32, the gap in mortality between social classes I and V – between professional and unskilled men – had increased almost two and a half times. Figure 1 shows a more recent picture indicating that the health gap as measured by life expectancy was wider in the mid-90s with some signs of narrowing since then.

Figure 1: Life expectancy at birth in years, by social class and gender

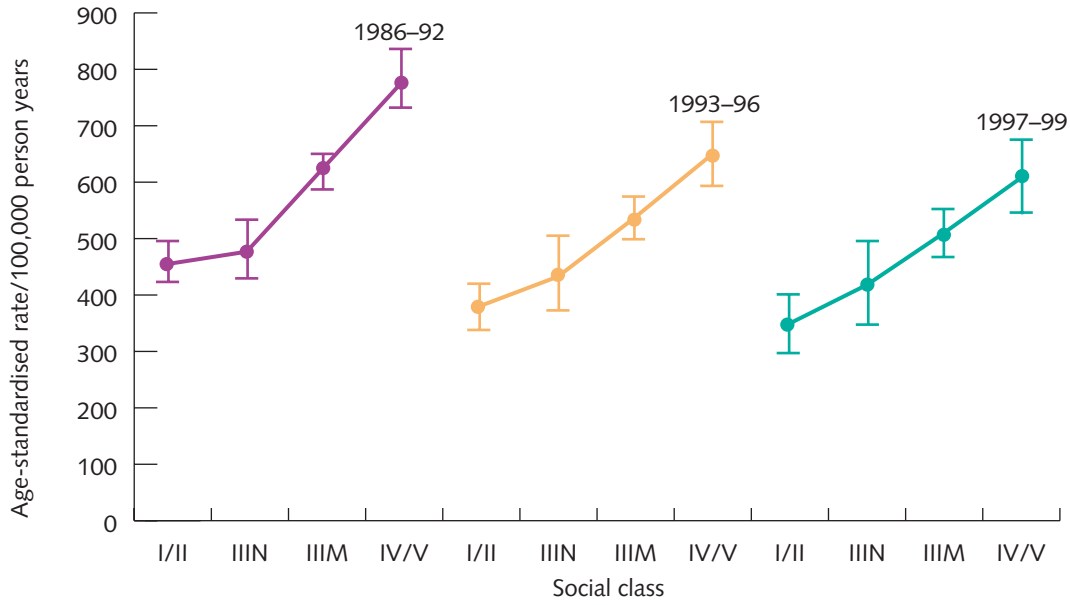


Source: ONS Longitudinal Survey

2.9 There is a social gradient in health. Despite overall improvements in health, those from manual groups continue to suffer the worst health. This gradient is also evident across a whole range of wider determinants of health, such as educational attainment and poor housing.

2.10 A more detailed analysis of mortality data for men aged 35 to 64 in England and Wales (Figure 2) shows that the gap in overall mortality between the highest and lowest social classes increased moderately from 1986-92 to 1997-99, continuing the trend for increasing inequality shown in earlier periods. Although mortality fell substantially in all social classes, there was a greater fall in social classes I and II than in social classes IV and V. For women aged 35 to 64, the gap in all-cause mortality between social classes I and II and IV and V narrowed between 1986-92 and 1997-99.

Figure 2: The health inequalities gradient – directly age-standardised all-cause mortality rates per 100,000 person years in males aged 35–64 by social class for selected time periods



Source: ONS Longitudinal Survey

2.11 People living in disadvantaged areas are more likely to express dissatisfaction with local services. They are likely to use local services more frequently than people in other areas, but find it harder to access services, largely due to lower levels of car ownership and inadequate public transport. The take-up of services is inhibited by a lack of social networks and role models, lack of confidence in providers and inflexible working patterns. The consequence is that people in disadvantaged areas access services differently and, for example, are more likely to use emergency services than preventive ones.

2.12 The *Programme for Action* recognised that a reversal of the 'inverse care law' – according to which people with the greatest need tend to have the poorest access to poorer quality services – would be needed in order to make further progress and provide fairer access to services.

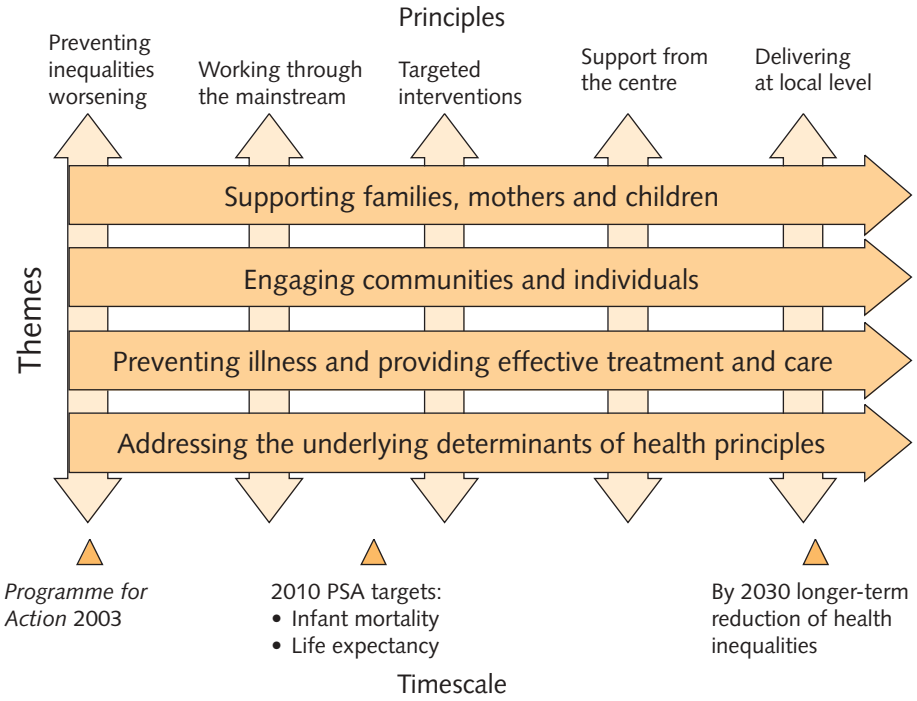
2.13 Targeting the most disadvantaged areas would not be sufficient to make an impact on the social gradient in health, or to meet the target, unless the rate of health improvement in these areas outstripped that of the population as a whole. The aim is, therefore, to raise life expectancy in the most disadvantaged groups and areas faster than elsewhere by producing a scale of health improvement that will help meet the target.

2.14 This gives a dual focus to the health inequalities agenda: to improve the health of those facing greatest disadvantage relative to better-off groups and to lift levels of health across society closer to the standards enjoyed by the best off.

Timescale and implications

2.15 The *Programme for Action* set out a plan to tackle health inequalities over a three-year period, and established the foundations required to achieve the challenging national target for 2010 to reduce the gap in infant mortality across social groups, and raise life expectancy in the most disadvantaged areas faster than elsewhere.

Figure 3: Themes and principles of the *Programme for Action*



2.16 However, it also recognised that tackling the wider determinants of health will take time, and long-term goals are needed to ensure that changes are embedded over time. This reflected the call for an approach that was long term and sustainable and achieved by tackling health inequalities as an integral part of wider policy development and implementation. Figure 3 shows how these themes and principles work over time, to 2010 and beyond.

Prevention and individuals

2.17 Prevention in a health inequalities context means more than improving health behaviours like diet and smoking in poorer groups and communities. It means improving access to the wider determinants of good health: to decent conditions in childhood, to well-resourced schools, to post-school training and employment opportunities.

2.18 The Acheson report underlined the importance of socio-economic position as the most fundamental of the social determinants of health. This is because it is the point at which broader determinants, like the structure of the labour market, enter the lives of individuals; socio-economic position, in turn, shapes a range of individual influences on health, like diet, smoking and exercise. An individual's socio-economic position arises from their education, occupation and income. Of these, occupation is used most frequently to measure socio-economic position.

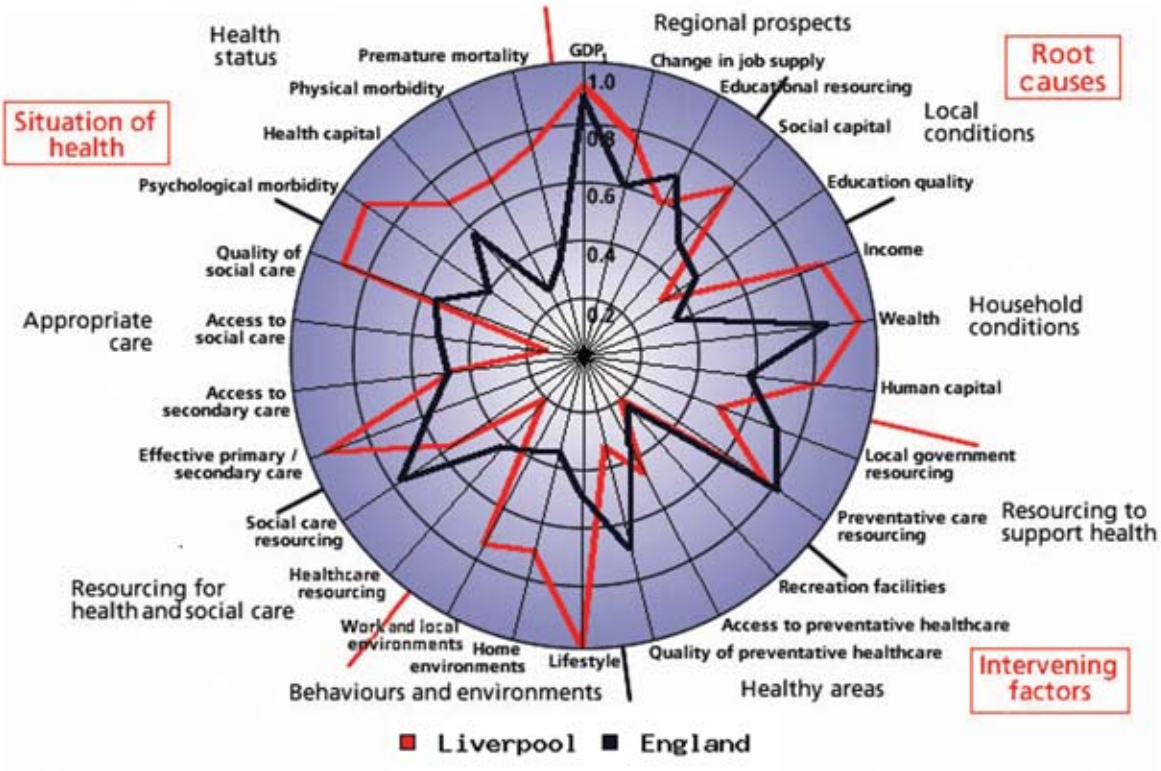
Chapter 3:
Measures of health

Socio-economic and other aspects of inequalities

3.1 The *Programme for Action*, in common with earlier work such as the Acheson inquiry into inequalities in health (1998), adopted a socio-economic approach to health inequalities – reflecting the risks associated with socio-economic position. This approach requires action on a broad front because of the links between different causal factors.

3.2 The health poverty index reflects the complexities of health inequalities taking full account of the wider determinants (see Figure 4 below). It was trailed in the *Choosing Health* White Paper and launched shortly afterwards. It is designed to allow health communities and their partners in local authorities and elsewhere to review the interacting factors, set local priorities and identify issues that can be built into their planning to improve health and tackle health inequalities. They will also be able to use it to monitor progress as it is updated.

Figure 4: The health poverty index



3.3 A note on some of the issues around measuring health inequalities is attached at Annex 1.

Absolute/relative differences – health improvement/health inequalities

3.4 The Acheson report concluded that the health gap penalises the whole of society and its effects usually increase from the top to the bottom along a social gradient. Thus, if policies only address the most disadvantaged, inequalities will still exist. Our approach addresses the socio-economic determinants of health as they affect the entire social spectrum.

3.5 Acheson also identified the difference between absolute and relative differences in health and their implications in respect of the narrowing of health inequalities. Box 4 summarises the differences – a more detailed description is set out in Annex 4.

Box 4: Absolute and relative inequalities

'Both relative and absolute measures have important implications. However, it may be argued that absolute measures are the most critical, particularly with respect to identifying the major problems which need to be addressed. 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. A doubling in social class V of the rate of occurrence of a rare disease is not as significant as a doubling in the rate of occurrence of a common disease. Major gains in attacking health inequalities are most likely to derive from addressing those health problems which occur reasonably frequently, even if less common diseases may in relative terms demonstrate a steep gradient, occurring, say, ten or twenty times more often in social class V than I. Relative measures are particularly useful for assessing the relative importance of different causal factors, and are important tools in aetiological enquiry.'*

3.6 Narrowing of the absolute gap is, therefore, one important indicator of success in reducing health inequalities. But where, for example, rates are declining among better off and disadvantaged groups, it is possible for a narrowing in the absolute gap to be associated with a static or increasing *relative* gap between the two groups.

3.7 We have taken the view that in order to interpret the underlying inequalities trends, it is important to assess both the absolute and relative gaps. Thus, our assessment of progress in relation to mortality from the major killers reflects trends in both the relative and absolute gaps. This is shown in the analysis relating to trends in circulatory disease and cancer mortality where significant overall improvements are accompanied by a widening of the relative health gap as measured by geographical area.

The limits to improvement

3.8 Health inequalities are a barrier to achieving overall improvements in health, notwithstanding the need to balance equity and efficiency in policy-making. This was recognised in *Securing Good Health for the Whole Population* (the Wanless review) and reflected in the *Choosing Health* White Paper.

3.9 The timescales for effecting a narrowing of the gap need to realise that change can also be a limiting factor. Policies aimed at improving health through action on the wider determinants of health would not be expected to reduce health inequalities in the short term. For example, improvements in educational achievement may reduce inequalities in adult mortality but much of this reduction would occur in later life.

*Independent Inquiry into Inequalities in Health Report. Chairman: Sir Donald Acheson, HMSO, 1998

National/local focus

3.10 Measurement and monitoring of national and local progress is important but it presents particular issues given both the time lag in the effectiveness of interventions and the developing – but incomplete – evidence of what works, as highlighted by Wanless.

3.11 The *Programme for Action* identified the need to:

- monitor PSA and Priorities and Planning Framework (PPF) targets – *National Standards, Local Action*, the latest PPF, makes clear the responsibilities for national and local monitoring;
- monitor the national headline indicators, and publish a report;
- publish a directory of indicators for use at local level to help monitor progress.

3.12 This monitoring is designed to:

- measure progress against targets – targets are now monitored through LDPs and against locally agreed three-year trajectories;
- assess progress on the range of areas where action is required to achieve the targets (ideally, to set out the baseline situation of where problems exist, to show whether action being taken is having the required effect, and to warn if sufficient progress is not being made so remedial action can be taken);
- communicate progress – or lack of progress – to a variety of audiences (including the public).

3.13 The indicator sets that have been identified to help the monitoring of the health inequalities strategy and progress to the 2010 target are:

- PSA target reports;
- national headline indicators;
- PPF/LDP target indicators;
- comprehensive performance assessment;
- local basket of indicators.

PSA target reports

3.14 The PSA target is the key measure of progress at national level, since achieving the PSA target is an overall goal of the programme. Interim reviews of progress against the target may indicate whether we are on track to achieve the target, and ultimately to assess whether the target has been met in 2010. However, the *Programme for Action* warned that measuring progress against the target presented particular issues given both the time-lag on the effectiveness of interventions and the incomplete evidence of what works.

National headline indicators

3.15 National headline indicators provide a proxy measure of progress. While time-lag between policy implementation and the achievement remains an issue, change is more likely to be seen here first than in terms of improved health outcomes and a narrowing of the health gap. To ensure sufficient information during the course of the programme and to assess whether the range of action being taken is having sufficient effect to achieve the PSA target, the headline and other indicators covering the areas where action is required to tackle health inequalities and achieve the PSA target will be monitored.

3.16 The latest evidence against the target shows that health inequalities are continuing to widen. This is in line with the long-term trend, despite more intensive and extensive efforts to address these issues in the last few years than ever before.

3.17 This raises a number of questions, not least the trends in wider determinants beyond those included in the PSA target indicators, and that of time-lags between policy implementation and improved health outcomes.

3.18 The stubbornness of the trend of the target was emphasised in the *Programme for Action*, not least in the expectation that PSA targets should be the last measures to show signs of improvement. Developments against the proxy indicators are more encouraging. They show improvements against two key indicators – child poverty and housing. Both indicators have been intensively pursued since 1997, showing that the gap can be narrowed. There are signs too that the gap may be narrowing in other areas, most evidently death rates from circulatory disease (in absolute terms) but also flu vaccinations among older people, cancer public services makes it harder to narrow the health gap without an explicit health inequalities focus.

3.19 It is crucial that the indicators cover both health outcomes/interventions and the impact of wider determinants. The *Programme for Action* identified those areas most likely to have an impact in the short/medium term, such as smoking, and those likely to have an impact in the longer term.

PPF and LDP indicators

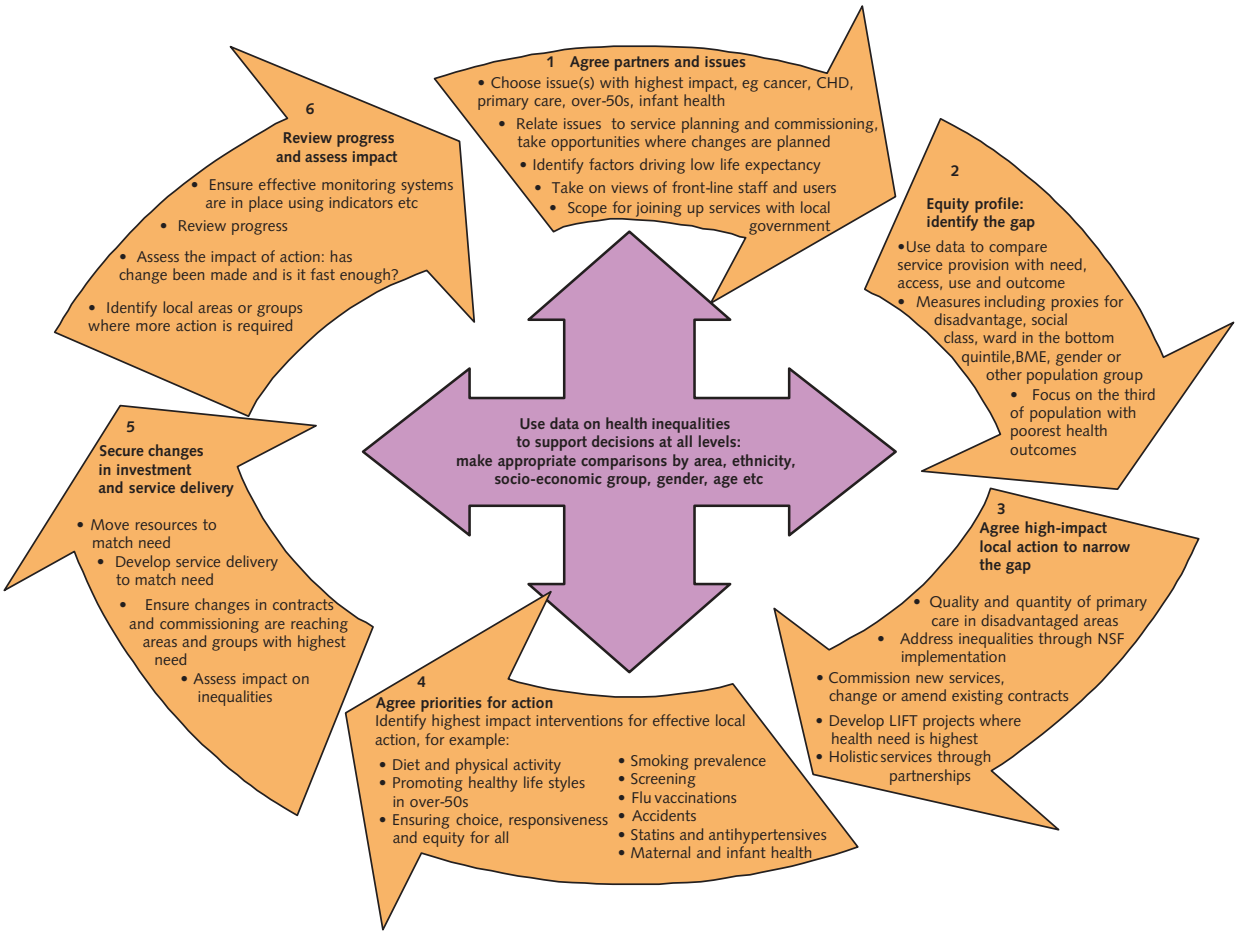
3.20 A key issue for the *Programme for Action* was the ability to mainstream health inequalities issues and deliver more effective public services that are more flexible and responsive to need, particularly for those in disadvantaged groups and areas where the reach of these services is often weakest. Performance management of public services is the key vehicle for delivering improved quality and equity of services. The challenge is for the NHS and local government to reflect health inequalities and the wider determinants of health in its planning and performance management systems.

3.21 In the NHS, action is required to support the achievement of PSA targets (with data available at PCT level) are set out in *Priorities and Planning Framework 2003–2006* and *National Standards, Local Action* for 2005–08. Planning is supported by planned performance trajectories based on PPF targets for 2003–06 and LDP lines for 2005–08. Since 2003, these trajectories have supported the monitoring of the *Programme for Action*. All but one of the 2003–06 PPF indicators are included in the national headline indicator set and their current status is set out in the following chapter.

3.22 *National Standards, Local Action* makes clear the desired outcome. It expects that all programmes and services will be designed and delivered in collaboration with all relevant organisations and will include commitments to promote, protect and improve the health of the population and reduce health inequalities between different population groups and areas, including delivering equity and addressing service gaps.

3.23 Health equity audits are a key tool that enables PCTs to target resources or implement changes in practice to tackle local health inequalities, and are now a mandatory part of the planning round for PCTs. They help identify how fairly services or other resources match to the health needs of different groups. By using evidence on inequalities to inform decisions on investment, service planning, commissioning and delivery, health equity audits should help organisations address inequalities in access to services and in health outcomes. Figure 5 summarises the main stages of the cycle.

Figure 5: Health equity audit cycle



Comprehensive performance assessment

3.24 In conducting the comprehensive performance assessment, the Audit Commission will ask local authorities the key question:

What has the council, with its partners, done to achieve its ambitions for the promotion of healthier communities and the narrowing of health inequalities and are these achievements recognised by the local population?

It will look for evidence:

- that the health of all the communities the council serves is improving as a direct result of the activities of the council
- that the council contributes to successful outcomes in promoting healthier communities through effective partnership working

- that the council has put in place specific services aimed at the most vulnerable people who are currently not accessing services and has a plan for integrating these into its mainstream provision
- that the council is improving integrated delivery of services for its target groups, such as families, mothers and children
- of how the council and its partners engage with individuals, communities and those most likely to be socially excluded
- of progress made given the council's ambitions to improve life expectancy in the short and medium term, to reduce health inequalities and the gap in life expectancy between wards
- demonstrating improvements in health following increases in the proportion of decent homes and in initiatives to address fuel poverty.

3.25 The roll-out of Local Area Agreements (LAAs) to all areas from April 2007 will support action to reduce health inequalities by introducing an important new planning process which brings health inequalities and health outcomes to the forefront of community planning. An LAA is an agreement between central government, represented by the Government Office, and a local area, represented by the local authority and Local Strategic Partnership (LSP). The agreement consists of outcomes, indicators and targets aimed at improving performance on a range of national and local priorities. These priorities will be grouped around four blocks: Children and Young People, Safer and Stronger Communities, Healthier Communities, and Older People and Economic Development.

Local basket of indicators

3.26 The national indicator sets will be used to monitor progress centrally and take account of the wider determinants. Local indicators and the health poverty index will support local organisations in monitoring health inequalities in their area. Some indicators are relevant to all areas, but given the differences in health inequalities across the country, each area will want to focus on local priorities and select those indicators that are most relevant to them.

3.27 The London Health Observatory led the work to develop a local basket of indicators for health inequalities. The local basket consists of a set of indicators suitable for use at local level to track progress against local priorities for action on health inequalities, covering both health outcomes/interventions and wider determinants.

3.28 The local basket includes local versions of the national headline indicators and PPF target indicators. Where local data are not available, suitable proxy indicators are included. The indicators in the basket are not mandatory. Each local area can select suitable indicators from the basket according to their local priorities, supplementing these with additional locally available and relevant indicators.

3.29 The local basket's purpose is to support local action and priority setting to tackle health inequalities. It is aimed at the NHS and a range of local organisations, including local authorities, Local Strategic Partnerships, and partner organisations in the voluntary, community and private sectors.

3.30 It was developed through cross-sectoral and cross-government consultation – and includes indicators relating to areas such as employment, poverty, homelessness, education, crime, lifestyle and health measures (including preventive interventions).

3.31 It is intended as a resource for local use, and for a range of purposes, including:

- monitoring progress towards achieving the targets;
- needs assessment (equity profiles);
- identifying local objectives;
- monitoring progress;
- performance management;
- equity audit;
- benchmarking.

3.32 The local basket of indicators and the health poverty index are important steps forward in developing and supporting local work. Issues remain to ensure that local data are available in ways that help people working on the ground to tackle health inequalities. These include:

- the need for locally relevant data on important determinants of health (eg smoking, physical activity and nutrition);
- the need for data broken down by different categories such as ethnicity and socio-economic group;
- the availability of relevant (and tailored) PCT-level data which can be shared with other partners and related to wider determinants. There are also confidentiality issues that need to be resolved;
- the need for intra-PCT/intra-local authority data about variations and inequalities in determinants of health;
- access to and use of Quality and Outcomes Framework data – an important source of information about equity of key interventions such as blood pressure control and cholesterol management.

Auditing and inspection

3.33 The Healthcare Commission was set up by the Health and Social Care (Community Health and Standards) Act 2003 and launched in April 2004. It has a wide-ranging mandate to assess the quality and value for money of healthcare across the NHS and the independent sector, and to promote improvements for patients and the public. Part of its remit is to review public health, notably in its role in reviewing progress on standards and targets. The 24 core standards contain aspects relevant to reducing health inequalities throughout; however, there is a particular focus on this within the seventh domain of *National Standards, Local Action*. NHS organisations will be assessed against core standards from 2005/06.

Chapter 4:
Tackling health inequalities

4.1 The *Programme for Action* emphasised the challenge of narrowing the health gap. Health inequalities, it concluded, were stubborn, persistent and difficult to change. This verdict is borne out by a review of the national targets and headline indicators in this report. The publication of a national strategy for health inequalities will not, of itself, start reversing the accumulated trends of generations. Indeed, the health gap is still continuing to widen, albeit slightly. The first aim of the *Programme for Action* was to stop health inequalities worsening further.

4.2 Many policies and programmes that will have an impact on the health gap are already in place and more are being planned. The evidence suggests that these measures will have an impact on the health gap, especially where existing projects that are known to work are applied on a suitably large scale. But for this report many of these developments are still at too early a stage to show an impact. As such, they provide a baseline against which future progress will be shown. Other programmes are showing promise, and some have a focus on small areas or among particular groups. These programmes will need to be scaled up if they are to have an impact on the gap and contribute to the 2010 target.

4.3 The establishment of a spearhead group of local authority areas with the worst health and deprivation indicators will provide a focus for these efforts and should allow the necessary scale of response to be developed. The lesson from a review of the headline indicators is that long-term, concerted effort on a sufficient scale can achieve significant results. This is clearest in the reduction of child poverty – an important determinant of health inequalities in childhood and adulthood. A map showing the distribution of the spearhead areas is at Figure 6.

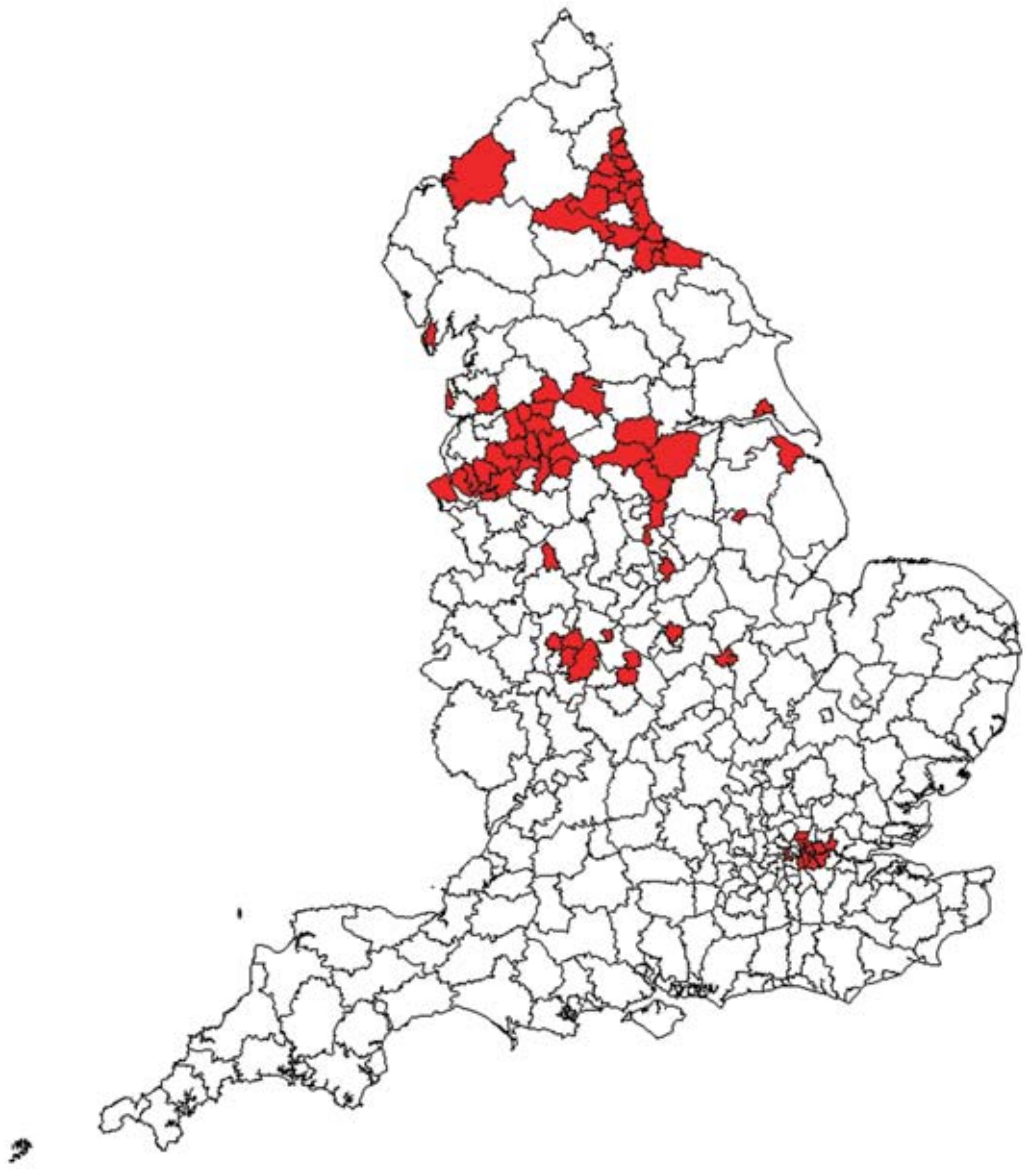
4.4 The continuing commitment to tackling health inequalities, such as through the *Choosing Health* White Paper, *Delivering Choosing Health* and other major policy statements, offers the best prospect for reversing the long-term trend on health inequalities and narrowing the health gap.

Some headlines

The national targets

4.5 The two national health inequalities targets announced in February 2001 focused on infant mortality and life expectancy (see below). They complemented other targets with an inequalities focus, such as in the areas of smoking in manual groups and teenage pregnancy. Taken together these targets are intended to reflect efforts to reduce the broad spectrum of inequalities. Although formulated in specific terms – socio-economic groups and geographical areas – they are intended to encompass a much more general strategy to address all of the major health inequalities including gender, ethnicity and age, as well as health in specific disadvantaged groups such as lone parents and homeless people. The targets have been updated into the current (2004) departmental PSA targets.

Figure 6: The spearhead group of most disadvantaged local authority areas



Source: ONS (mortality, life expectancy data); ODPM Index of Multiple Deprivation

The target for life expectancy was:
starting with local authorities, by 2010 to reduce by at least 10% the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole

This has been reformulated as:
starting with local authorities, by 2010 to reduce by at least 10% the gap between the areas with the worst health and deprivation indicators (the spearhead group) and the population as a whole

4.6 The latest data for 2001–03 indicate that since the baseline (1997–99), the relative gap in life expectancy between England and the fifth of local authorities with lowest life expectancy has increased for both males and females (continuing a long-standing trend), with a larger increase for females. For males the relative gap increased by nearly 2%, for females by 5%.

4.7 The long-term trend is for the life expectancy gap to widen in both relative and absolute terms.

The 2004 target for infant mortality is:
starting with children under one year, by 2010 to reduce the gap in mortality by at least 10% between 'routine and manual' groups and the population as a whole

4.8 The latest data on infant mortality by National Statistics Socio-Economic Classification (NS SEC) up to 2003 is summarised in Table 1 and shows trends since 1994–96. For infant mortality, this enables us to measure both the gap and the change in the gap in mortality rates between social groups.

4.9 Although infant mortality rates have declined in the routine and manual group, the rate of decline was faster in the other groups. As a result, the trend shows a small widening in the relative gap between infant mortality in the routine and manual group and the total population between the target baseline 1997–99 and the latest period 2001–03.

Table 1: Infant mortality rates per thousand live births (England and Wales)

	NS SEC90					NS SEC*		
	1994–96	1995–97	1996–98	**1997–99**	1998–2000	1999–2001	2000–02	2001–03
Infant deaths per 1,000 live births				**Baseline period**				
All within marriage and joint registrations	5.9	5.8	5.7	**5.6**	5.4	5.3	5.2	5.0
NS SEC three-class version – routine and manual group	6.7	6.6	6.4	**6.3**	6.2	6.2	6.0	6.0
Ratio: routine & manual/all	1.15	1.14	1.12	**1.13**	1.14	1.17	1.16	1.19

Source: ONS.
Notes:
(a) Figures for live births are a 10 per cent sample coded for father's occupation
(b) Information on the father's occupation is not collected for births outside marriage if the father does not attend the registration of the baby's birth.
* Using NS SEC90 for data up to 2000 and NS SEC for 2001, 2002 and 2003 data.

4.10 As part of the commitment to assess progress towards this target, the importance has also been stressed of reviewing in greater detail infant mortality trends in disadvantaged groups within and outside the target categories. This issue is discussed later in this chapter. Of particular concern are trends among sole registered births. The rate for such births is consistently above both the 'all social class groups (within marriage, joint registrations only)' category and the NS SEC 'routine and manual group' category. After remaining static at 7.6 per 1,000 live births between 1997–99 and 1999–2001, the rate fell slightly to 7.3 in 2000–02 and fell further in 2001–03 to 7.2 per 1,000. The three-year average rates mask fluctuations in the single-year figures.

The national headline indicators

4.11 The 12 national headline indicators were summarised in Chapter 1. This section provides data against each indicator, usually on the basis of the lowest fifth of the population (as measured by deprivation or area using local authority districts (LADs) against the national average and against the highest (or least deprived) fifth, from a given baseline to the latest data.

Data issues

4.12 The use of indicators for quantitative monitoring is limited by the availability of data. Data may not be available for all areas relevant to tackling health inequalities. Even where data are available, there will be limitations due to the time it takes for the figures to become available after the period to which they relate. Qualitative monitoring of action taken is also required, to supplement quantitative monitoring of indicators.

4.13 Data are presented for the national headline indicators, focusing on measures of inequality in relation to the indicators. An assessment of progress in reducing inequalities since the baseline period is presented.

Measures of inequality

4.14 For most of the indicators the inequality measures presented are the absolute and relative gap between the most disadvantaged group and a reference group (the least disadvantaged group and/or the whole population). That is, the position of the most disadvantaged group is compared to the national average and/or the least disadvantaged group.

4.15 The most and least disadvantaged groups are identified using socio-economic measures (area deprivation, occupation-based socio-economic status, income) or suitable proxy measures (vulnerable households, eligibility for free school meals). Limitations of data availability mean it is not possible to identify the comparison groups in the same way for all the indicators.

4.16 The absolute gap is measured by the difference between indicator values in the groups compared. Differences closer to 0 indicate lower inequality. The relative gap is measured by the ratio between indicator values in the groups compared. Ratios closer to 1 indicate lower inequality.

4.17 The gap between comparison groups measures the inequality between the average level of the indicator in each group, based on aggregate data for each group as a whole. There are likely to be inequalities within each group as well as between groups. (Where groups are defined by geographical areas, there will be inequalities within the areas – ie at a smaller area level – as well as between the areas.) Within-group inequalities are not measured by the gap between groups, but could be revealed by data at a lower level of aggregation.

4.18 A narrowing of the gap between comparison groups indicates a reduction in inequality between the average level of the indicator in each group. However, the picture at a lower level of aggregation may be more complex. For the gap to narrow, some parts of the disadvantaged group must improve relative to the reference group. But this does not mean all parts of the disadvantaged group will improve relative to the reference group, and the gap between groups can narrow while inequalities within the disadvantaged group widen. For example, the average death rate for the most deprived fifth of LADs may improve faster than the England average while the gap in death rates between particular LADs within the most deprived fifth widens and some LADs improve more slowly than the England average (so improvements in service delivery designed to narrow inequalities between areas may leave within-area inequalities unchanged or potentially widen them).

4.19 Analysis of the gap between groups is presented in this report as a high-level summary measure of inequalities between groups at aggregate level.

4.20 For two indicators data are not analysed using the gap between comparison groups. For indicator 11 the extent of child poverty is monitored (as measured by the proportion of children living in low-income households). For indicator 12 the extent of homelessness is monitored (as measured by the number of

homeless families with children living in temporary accommodation). For both indicators a reduction in extent indicates a reduction in inequality.

Baselines

4.21 For each of the indicators baseline periods have been selected against which progress is measured. While it is desirable to have a consistent baseline period across the indicators, this is not possible because of data availability. Where possible, baselines have been set at or close to 1997. However, for many of the indicators data are not available prior to more recent years, or comparable data are only available for more recent years due to changes in the data collection.

Assessment of change

4.22 Data are presented for the latest year and for the baseline period. An assessment is made of whether inequalities are narrower in the latest year compared to the baseline on each of the inequality measures presented. For some indicators data are only available for the baseline period, so no assessment of change can be made

- improving the financial position of the disadvantaged groups relative to to other groups - important advances have been made in tax and benefit changes since 1997, and through the introduction of the national minimum wage
- providing support for parents in the education of their children through the commitments in *The Five Year Strategy for Children and Learners*, and through such programmes as Children's Centres and Extended Schools
- delivering better services to disadvantaged groups through *Supporting People* which offers high quality and strategically planned housing-related services for vulnerable people, such as those of the Home Improvement Agencies that help deliver decent homes for vulnerable people
- promoting sustainable development through the agenda set out in *Securing the Future* as part of a broader effort to improve health and well being and tackle health and environmental inequalities, and in areas like fuel poverty where significant steps have been made.

4.23 The statistical significance of any change in the inequality measures is taken into account in assessing progress. Approximate 95% confidence intervals have been calculated for many of the inequality measures, to give an indication of the extent of possible sampling error (for those indicators based on sample surveys) or of expected random variation over time (for those indicators not based on sample surveys). Assessment of significant change is based on whether the confidence intervals for the differences and ratios between the baseline and latest year overlap. Confidence intervals for some of the measures based on sample surveys are quite wide, so it is difficult to make a robust assessment of progress.

Headline indicators summary tables

Indicator 1a: Age-standardised death rates per 100,000 population for the major killer diseases (cancer, circulatory diseases), ages under 75 (for the 20% of areas with the highest rates compared with the national average) – CANCER

Overall summary: There have been improvements in cancer death rates since 1995–97 (including for the most disadvantaged areas), and some signs of a narrowing of inequalities.

Figure 7: Age-standardised death rates per 100,000 population for cancer, ages under 75, by area (deprivation), England

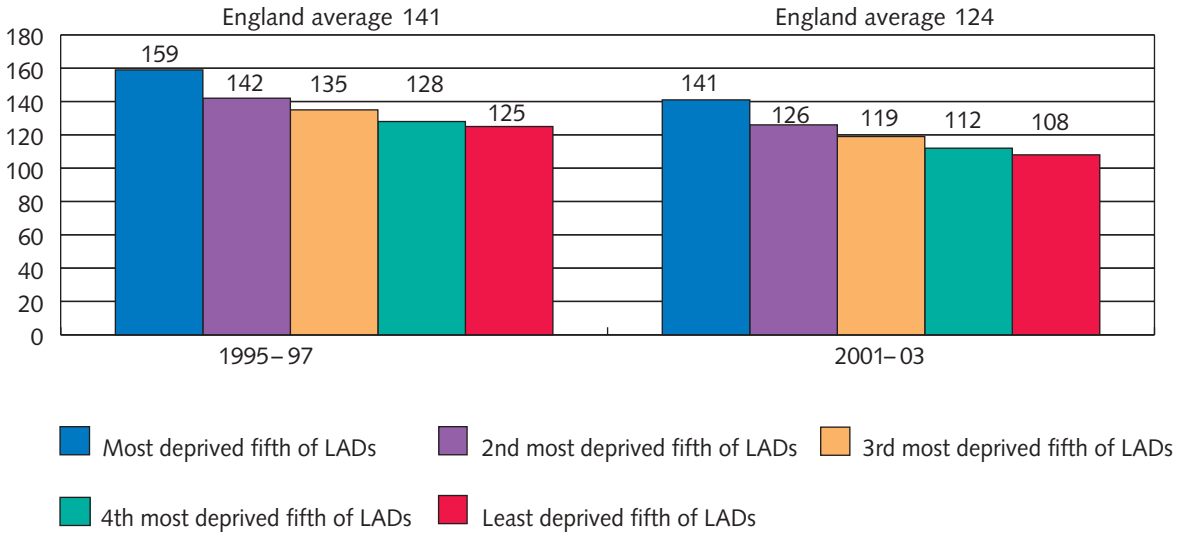
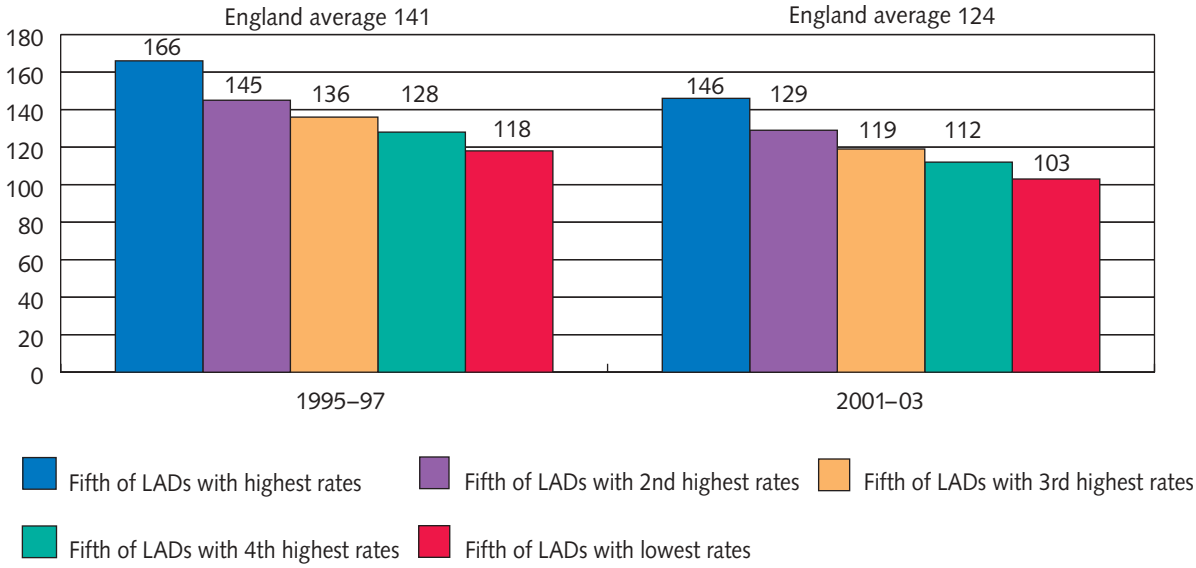


Figure 8: Age-standardised death rates per 100,000 population for cancer, ages under 75, by area (death rate), England



COMPARISON	ABSOLUTE GAP (DIFFERENCE) BASELINE 1995–97	LATEST 2001–03	TREND	RELATIVE GAP (RATIO) BASELINE 1995–97	LATEST 2001–03	TREND
Area, by deprivation						
Most deprived fifth of LADs vs England	18.0 *(17.1, 19.0)*	16.9 *(16.0, 17.8)*	●	1.13 *(1.12, 1.14)*	1.14 *(1.13, 1.15)*	●
Most deprived fifth of LADs vs least deprived fifth	34.7 *(32.8, 36.6)*	33.3 *(31.6, 35.0)*	●	1.28 *(1.26, 1.30)*	1.31 *(1.29, 1.33)*	●
Area, by death rate						
Fifth of LADs with highest death rates vs England	24.9 *(23.6, 26.1)*	21.9 *(20.8, 22.9)*	✓	1.18 *(1.17, 1.19)*	1.18 *(1.16, 1.19)*	●
Fifth of LADs with highest death rates vs fifth with lowest rates	48.2 *(46.3, 50.2)*	42.9 *(41.1, 44.7)*	✓	1.41 *(1.39, 1.43)*	1.42 *(1.40, 1.44)*	●

COMMENTARY

- There is a gradient in cancer death rates (ages under 75) by area deprivation, with the most deprived fifth of LADs having the highest death rates and the least deprived fifth the lowest death rates.
- For example, in 2001–03 the cancer death rate (ages under 75) in the most deprived fifth of LADs was 33 deaths per 100,000 higher than in the least deprived fifth. In relative terms, the cancer death rate (ages under 75) in the most deprived fifth of LADs was 1.31 times the rate in the least deprived fifth, ie 31% higher.
- Since 1995–97 the gap in cancer death rates between the most deprived fifth of LADs and the England average has not changed significantly in absolute or relative terms. This also applies to the gap between the most deprived fifth of LADs and the least deprived fifth.
- The gap between the fifth of LADs with highest death rates and the England average has decreased slightly in absolute terms since 1995–97, but with no significant change in relative terms. This also applies to the gap between the fifth of LADs with highest death rates and the fifth with lowest rates.
- The Department of Health has set a PSA target to reduce the absolute gap in cancer death rates (ages under 75) between the fifth of areas with the worst health and deprivation indicators (known as the Spearhead Group) and the population as a whole (see Annex 2). Between 1995–97 and 2001–03, the absolute gap between the spearhead group and the England average cancer death rate narrowed by 8% but with no narrowing of the relative gap.

Data notes:
Source: ONS.
Area deprivation is measured by the Index of Multiple Deprivation 2004, LA summary (average score) (ODPM).

KEY: ✓ = decreasing inequality ✖ = increasing inequality
● = no significant change — = insufficient data

Indicator 1b: Age-standardised death rates per 100,000 population for the major killer diseases (cancer, circulatory diseases), ages under 75 (for the 20% of areas with the highest rates compared with the national average) – CIRCULATORY DISEASES

Overall summary: There have been improvements in circulatory disease death rates since 1995–97 (including for the most disadvantaged areas), accompanied by a narrowing of inequalities in absolute terms, with signs of a widening of inequalities in relative terms.

Figure 9: Age-standardised death rates per 100,000 population for circulatory diseases, ages under 75, by area (deprivation), England

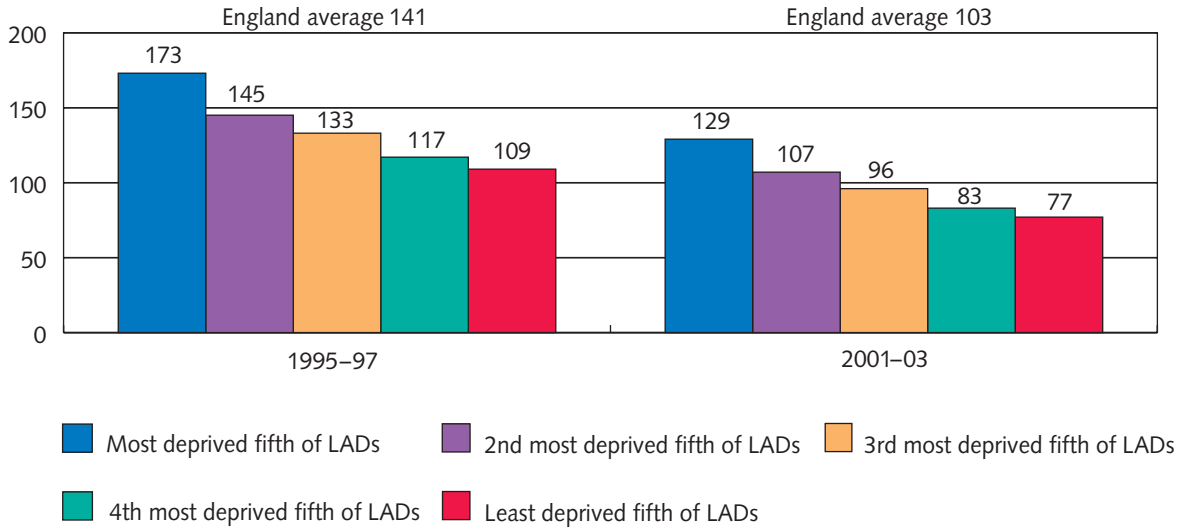
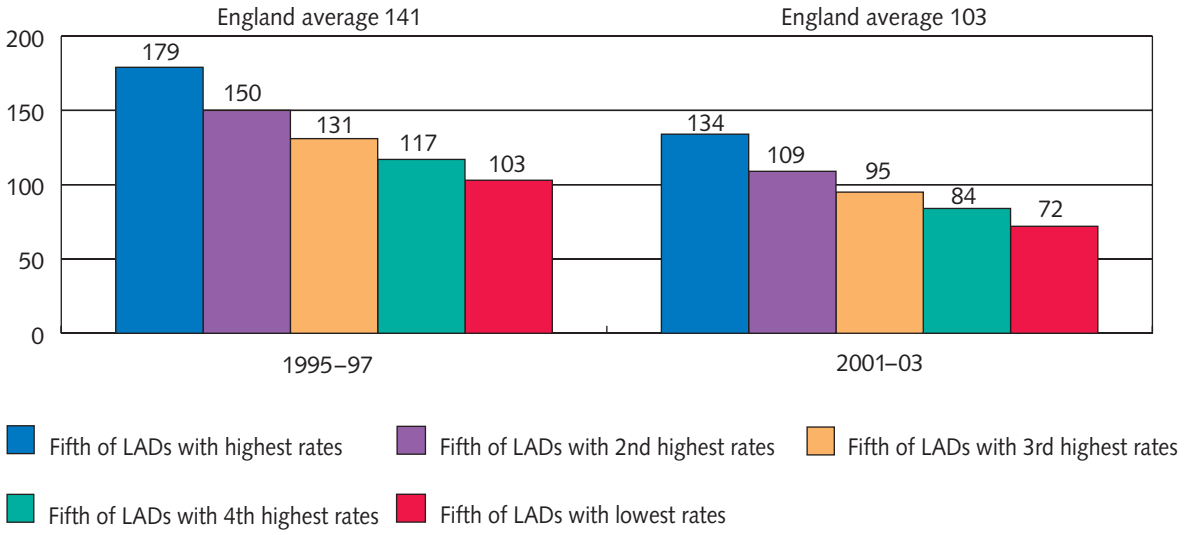


Figure 10: Age-standardised death rates per 100,000 population for circulatory diseases, ages under 75, by area (death rate), England



COMPARISON	ABSOLUTE GAP (DIFFERENCE) BASELINE 1995–97	LATEST 2001–03	TREND	RELATIVE GAP (RATIO) BASELINE 1995–97	LATEST 2001–03	TREND
Area, by deprivation						
Most deprived fifth of LADs vs England	31.3 *(30.3, 32.3)*	26.1 *(25.2, 26.9)*	✓	1.22 *(1.21, 1.23)*	1.25 *(1.24, 1.27)*	✖
Most deprived fifth of LADs vs least deprived fifth	63.8 *(62.0, 65.6)*	51.6 *(50.1, 53.1)*	✓	1.59 *(1.56, 1.61)*	1.67 *(1.64, 1.69)*	✖
Area, by death rate						
Fifth of LADs with highest death rates vs England	37.9 *(36.8, 38.9)*	31.2 *(30.3, 32.2)*	✓	1.27 *(1.26, 1.28)*	1.30 *(1.29, 1.32)*	✖
Fifth of LADs with highest death rates vs fifth with lowest rates	76.0 *(74.1, 77.8)*	62.0 *(60.4, 63.5)*	✓	1.74 *(1.71, 1.76)*	1.86 *(1.83, 1.89)*	✖

COMMENTARY

- There is a gradient in circulatory disease death rates (ages under 75) by area deprivation, with the most deprived fifth of LADs having the highest death rates and the least deprived fifth the lowest death rates.
- For example, in 2001–03 the circulatory disease death rate (ages under 75) in the most deprived fifth of LADs was 52 deaths per 100,000 higher than in the least deprived fifth. In relative terms, the circulatory disease death rate (ages under 75) in the most deprived fifth of LADs was 1.67 times the rate in the least deprived fifth, ie 67% higher.
- Since 1995–97 the gap in circulatory disease death rates between the most deprived fifth of LADs and the England average has decreased in absolute terms but increased in relative terms. This also applies to the gap between the most deprived fifth of LADs and the least deprived fifth.
- Since 1995–97 the gap in circulatory disease death rates between the fifth of LADs with highest death rates and the England average has decreased in absolute terms but increased in relative terms. This also applies to the gap between the fifth of LADs with highest death rates and the fifth with lowest rates.
- The Department of Health has set a PSA target to reduce the absolute gap in circulatory disease death rates (ages under 75) between the fifth of areas with the worst health and deprivation indicators (known as the spearhead group) and the population as a whole (see Annex 2). Between 1995–97 and 2001–03, the absolute gap between the spearhead group and the England average circulatory disease death rate narrowed by 22% but with no narrowing of the relative gap.

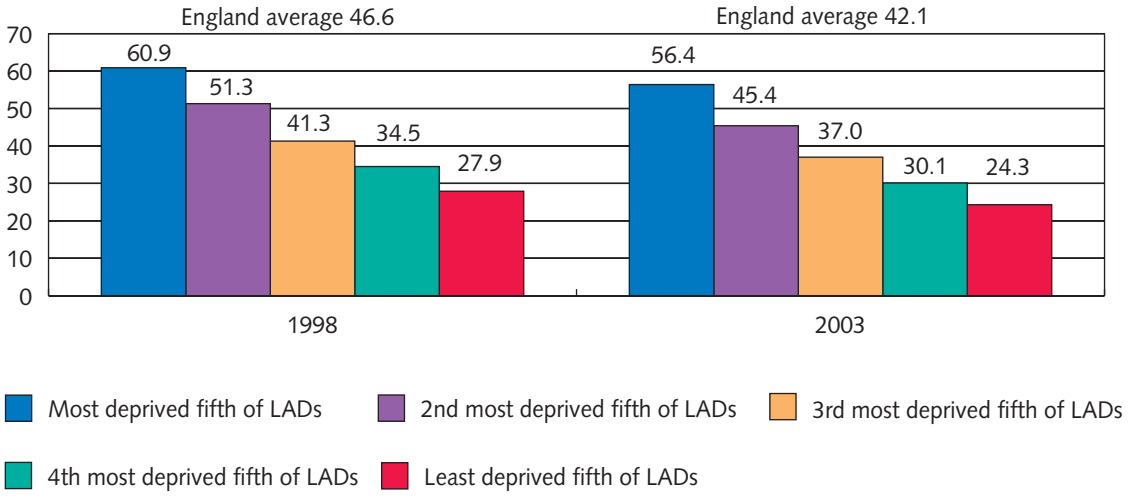
Data notes:
Source: ONS.
Area deprivation is measured by the Index of Multiple Deprivation 2004, LA summary (average score) (ODPM).

KEY: ✓ = decreasing inequality ✖ = increasing inequality
● = no significant change — = insufficient data

Indicator 2: Rate of under-18 conceptions

Overall summary: There has been a 9.8% drop in the rate of under-18 conceptions between 1998 and 2003, but no significant narrowing of the gap in teenage conceptions between 1998 and 2003; however, findings from a national evaluation of the teenage pregnancy strategy indicate that over a longer period (between 1994–98 and 1999–2002) teenage conceptions in the most deprived top tier of local authorities fell faster than in other areas.

Figure 11: Rate of under-18 conceptions per 1,000 female population aged 15–17 by area (deprivation), England



COMPARISON	ABSOLUTE GAP (DIFFERENCE) BASELINE 1998	LATEST 2003	TREND	RELATIVE GAP (RATIO) BASELINE 1998	LATEST 2003	TREND
Area, by deprivation						
Most deprived fifth of LADs vs England	14.3 *(13.6, 15.0)*	14.3 *(13.6, 14.9)*	●	1.31 *(1.29, 1.32)*	1.34 *(1.32, 1.35)*	●
Most deprived fifth of LADs vs least deprived fifth	33.0 *(31.7, 34.2)*	32.0 *(30.9, 33.2)*	●	2.18 *(2.11, 2.26)*	2.32 *(2.23, 2.40)*	●

COMMENTARY

- There is a gradient in under-18 conception rates by area deprivation, with the most deprived fifth of LADs having the highest conception rates and the least deprived fifth the lowest conception rates.
- For example, in 2003 the under-18 conception rate in the most deprived fifth of LADs was 32 conceptions per 1,000 higher than in the least deprived fifth. In relative terms, the under-18 conception rate in the most deprived fifth of LADs was 2.32 times the rate in the least deprived fifth.
- Between 1998 and 2003 the gap in under-18 conception rates between the most deprived fifth of LADs and the England average has not changed significantly in absolute or relative terms. This also applies to the gap between the most deprived fifth of LADs and the least deprived fifth.
- A recent independent national evaluation of the Teenage Pregnancy Strategy examined inequalities in teenage conception rates over a slightly longer time period (comparing 1994–98 with 1999–2002) and at a higher geographical level (top-tier local authorities rather than local authority districts). Many top-tier local authorities contain several districts, and different patterns may be shown at district level than at top-tier level. The evaluation found the greatest decline in teenage conception rates at top-tier local authority level between 1994–98 and 1999–2002 was in the most deprived quartile of authorities. This indicates that over a longer time period, progress has been made in reducing inequalities between the most deprived top-tier local authorities and other areas.
- The Teenage Pregnancy Strategy has agreed local conception reduction targets of 40–60% by 2010 for each top-tier local authority in England, with the greatest reductions sought in the highest-rate areas. Achieving these targets will underpin delivery of national targets while reducing inequality between areas with the highest rates and the average by at least a quarter. Around four in five local authorities experienced an overall decline in their under-18 conception rate from 1998 to 2003, and around half are on track to meet interim 2004 15% reduction targets.

Data notes:
Source: ONS.
Area deprivation is measured by the Index of Multiple Deprivation 2004, LA summary (average score) (ODPM).
The report of the national evaluation of the Teenage Pregnancy Strategy is: Wellings K et al (June 2005), *Teenage Pregnancy Strategy Evaluation: Final Report Synthesis*, London School of Hygiene & Tropical Medicine, commissioned by Department of Health and Department for Education and Skills.

KEY: ✓ = decreasing inequality ✖ = increasing inequality
● = no significant change — = insufficient data

Indicator 3: Road accident casualties

Overall summary: There have been improvements in child road accident casualty rates since 1998 (including for the most disadvantaged areas). There has not been a significant narrowing of inequalities in absolute terms, and there has been a widening of inequalities in relative terms.

Figure 12: Road accident casualties per 100,000 resident population, children (ages 0–15), by area deprivation

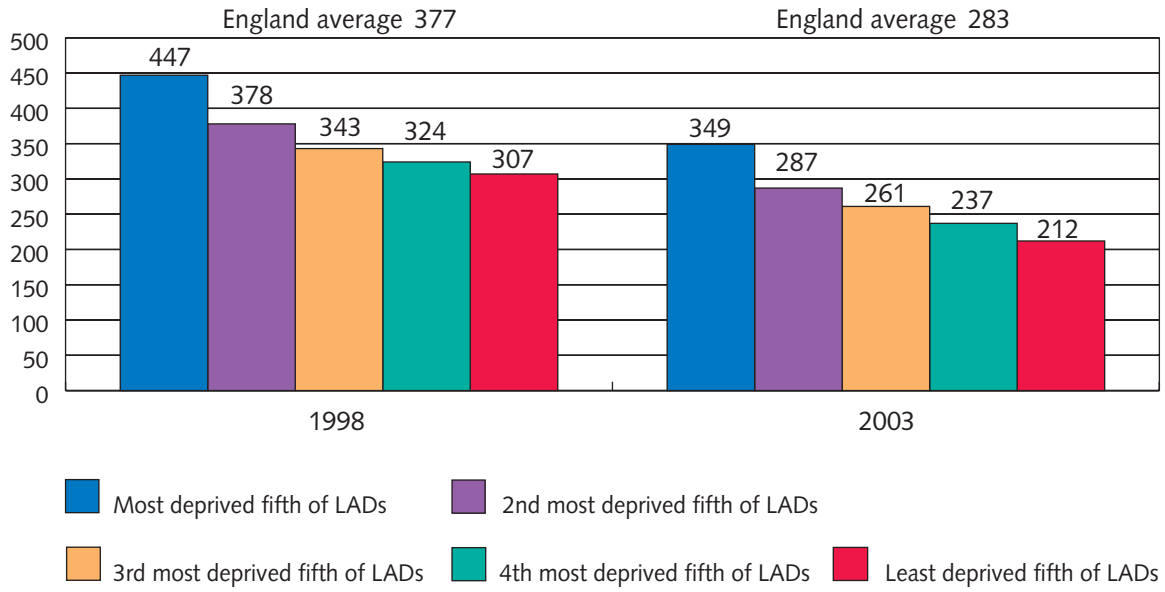
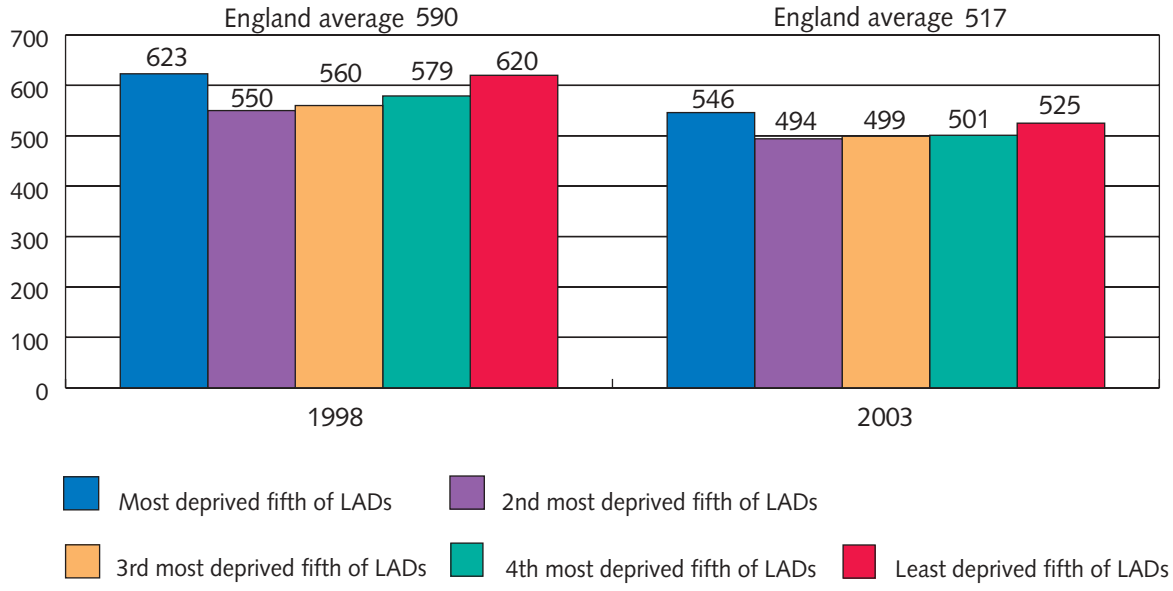


Figure 13: Road accident casualties per 100,000 resident population, all ages, by area deprivation



COMPARISON	ABSOLUTE GAP (DIFFERENCE) BASELINE 1998	LATEST 2003	TREND	RELATIVE GAP (RATIO) BASELINE 1998	LATEST 2003	TREND
Children – area, by deprivation						
Most deprived fifth of LADs vs England	70 *(65, 76)*	65 *(60, 70)*	●	1.19 *(1.17, 1.20)*	1.23 *(1.21, 1.25)*	✖
Most deprived fifth of LADs vs least deprived fifth	140 *(129, 151)*	136 *(127, 146)*	●	1.46 *(1.41, 1.50)*	1.64 *(1.58, 1.71)*	✖
All ages – area, by deprivation						
Most deprived fifth of LADs vs England	32 *(29, 36)*	28 *(25, 31)*	●	1.05 *(1.05, 1.06)*	1.05 *(1.05, 1.06)*	●
Most deprived fifth of LADs vs least deprived fifth	2 *(-4, 9)*	20 *(14, 27)*	✖	1.00 *(0.99, 1.02)*	1.04 *(1.03, 1.05)*	✖

COMMENTARY

- There is a gradient in road accident casualty rates for children by area deprivation, with the most deprived fifth of LADs having the highest casualty rates and the least deprived fifth the lowest casualty rates.
- For example, in 2003 the child road accident casualty rate in the most deprived fifth of LADs was 136 casualties per 100,000 higher than in the least deprived fifth. In relative terms, the child road accident casualty rate in the most deprived fifth of LADs was 1.64 times the rate in the least deprived fifth, ie 64% higher.
- The gap in child road accident casualty rates between the most deprived fifth of LADs and the England average has shown no significant change in absolute terms since 1998, but has increased in relative terms. This also applies to the gap between the most deprived fifth of LADs and the least deprived fifth.
- The gradient in road accident casualty rates for all ages by area deprivation is less clear, with both the most and least deprived fifths of LADs having higher casualty rates than other areas.
- To help tackle the higher incidence of road casualties among people from disadvantaged communities, the Department for Transport has set a target to reduce casualty numbers in disadvantaged areas (identified as Neighbourhood Renewal Fund areas) by more than the percentage decline across England as a whole. Latest data for 2003 show that since the baseline year (1999–2001) there has been a greater reduction in the number of road accident casualties in disadvantaged districts than in England as a whole (10.6% compared with 9.0% – figures are for all ages).

Data notes:
Source: DfT (STATS19 road casualty data), ONS (resident population data).
Area deprivation is measured by the Index of Multiple Deprivation 2004, LA summary (average score) (ODPM).

KEY: ✓ = decreasing inequality ✖ = increasing inequality
● = no significant change — = insufficient data

Indicator 4: Number of primary care professionals per 100,000 population

Overall summary: There have been improvements in the number of whole-time equivalent (wte) 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. The number of deprived PCTs more than 10% below the England average number of whole-time equivalent GPs per 100,000 weighted population has increased since September 2002.

Figure 14: Number of whole-time equivalent GPs per 100,000 weighted population by area deprivation

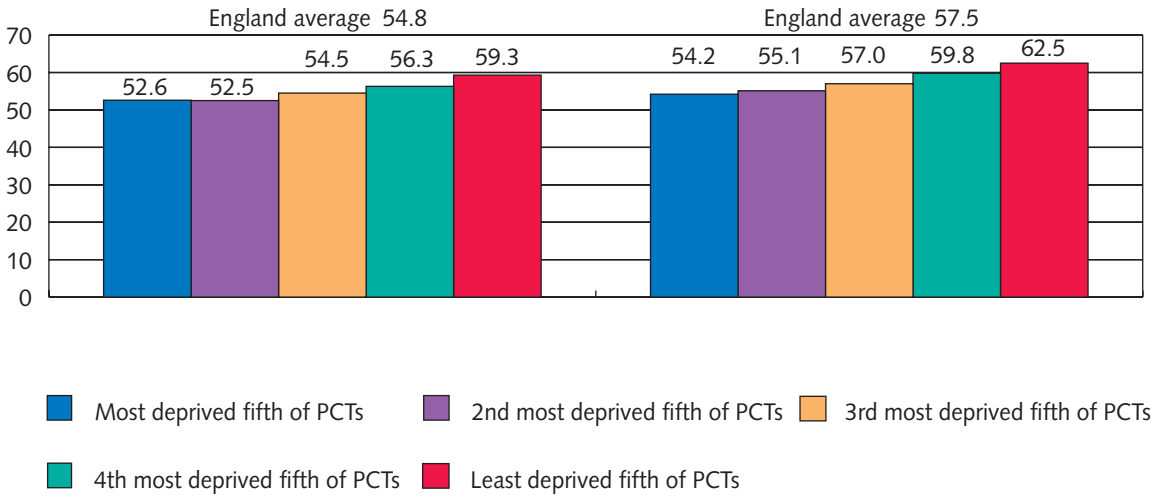
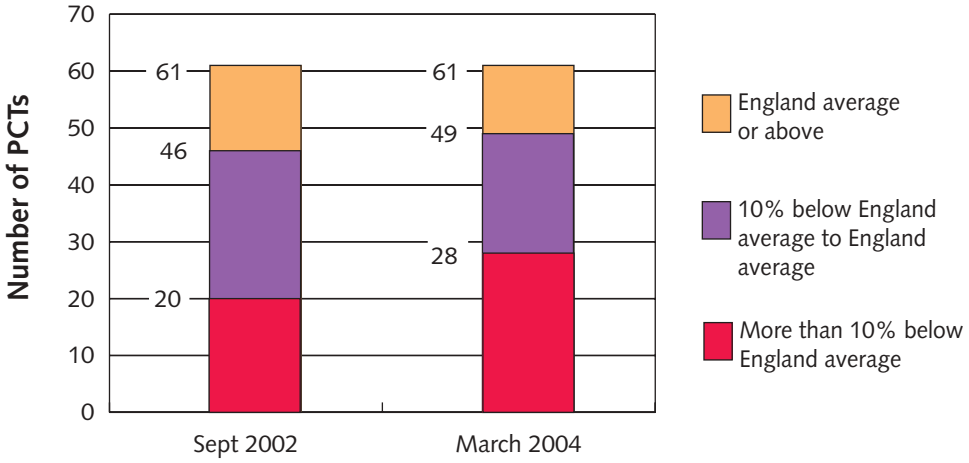


Figure 15: PCTs in the most deprived fifth by wte GPs per 100,000 weighted population band



COMPARISON	ABSOLUTE GAP (DIFFERENCE) BASELINE Sept 2002	LATEST Mar 2004	TREND	RELATIVE GAP (RATIO) BASELINE Sept 2002	LATEST Mar 2004	TREND
Area, by deprivation						
Most deprived fifth of PCTs vs England	-2.2 *(-3.4, -1.0)*	-3.2 *(-4.5, -2.0)*	●	0.96 *(0.94, 0.98)*	0.94 *(0.92, 0.97)*	●
Most deprived fifth of PCTs vs least deprived fifth	-6.7 *(-8.8, -4.6)*	-8.3 *(-10.5, -6.1)*	●	0.89 *(0.85, 0.92)*	0.87 *(0.84, 0.90)*	●

COMMENTARY

- Figures are based on the number of wte GPs per 100,000 population weighted for age and need.
- There is a gradient in the number of wte GPs per 100,000 weighted population by area deprivation, with the most deprived fifth of PCTs having the fewest wte GPs per 100,000 and the least deprived fifth of PCTs the most wte GPs per 100,000.
- Although some deprived PCTs have a relatively high number of wte GPs per 100,000 weighted population, at March 2004 a high proportion of PCTs in the most deprived fifth (49 out of 61) were below the England average level. Around half of PCTs in the most deprived fifth (28 out of 61) were more than 10% below the England average level (an increase from September 2002, when around a third (20 out of 61) were more than 10% below the England average level).

Data notes:
Source: DH Census of General and Personal Medical Services.
GP retainers and registrars are excluded. The population is the GP-relevant population constrained to 2001 ONS population estimates, weighted for age and to reflect need for GP consultations.
Area deprivation is measured by the Index of Multiple Deprivation 2004, PCT summary (average score) (produced by the Healthcare Commission based on ODPM data).

KEY: ✓ = decreasing inequality ✖ = increasing inequality
● = no significant change — = insufficient data

Indicator 5: Percentage uptake of flu vaccinations by older people (aged 65+)

Overall summary: Between 2002 and 2004 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 does not mean all of the most deprived PCTs are improving relative to the least deprived PCTs. However, more deprived PCTs achieved the 70% uptake target in 2004 than in 2002.

Figure 16: % uptake of flu vaccinations among over-65s by area population

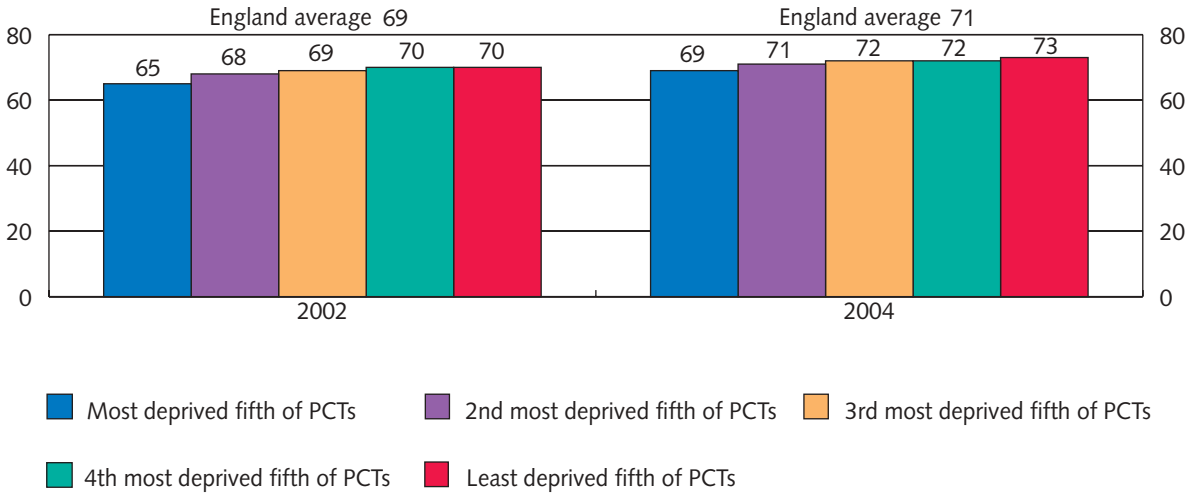
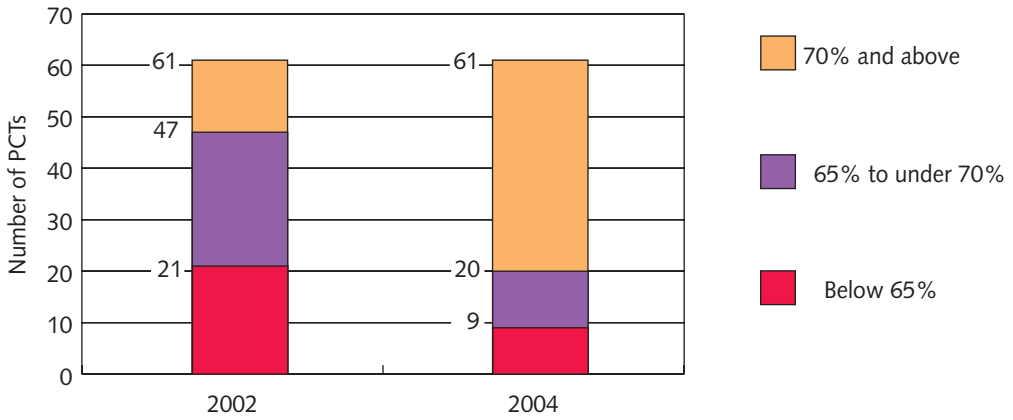


Figure 17: PCTs in the most deprived fifth by % uptake band for flu vaccinations among over-65s



COMPARISON	ABSOLUTE GAP (DIFFERENCE) BASELINE 2002	LATEST 2004	TREND	RELATIVE GAP (RATIO) BASELINE 2002	LATEST 2004	TREND
Area, by deprivation						
Most deprived fifth of PCTs vs England	-3.6 *(-3.7, -3.5)*	-2.0 *(-2.1, -2.0)*	✓	0.95 *(0.95, 0.95)*	0.97 *(0.97, 0.97)*	✓
Most deprived fifth of PCTs vs least deprived fifth	-5.4 *(-5.5, -5.3)*	-3.4 *(-3.5, -3.3)*	✓	0.92 *(0.92, 0.92)*	0.95 *(0.95, 0.95)*	✓

COMMENTARY

- There is a slight gradient in the uptake of flu vaccination among over-65s by area deprivation, with the most deprived fifth of PCTs having the lowest uptake and the least deprived fifth having the highest uptake.
- Between 2002 and 2004 the gap in flu vaccination uptake between the most deprived fifth of PCTs and both the England average and the least deprived fifth of PCTs narrowed slightly in absolute and relative terms.
- Although some deprived PCTs achieved the target uptake of flu vaccinations by older people of at least 70%, in 2002 the uptake in a high proportion of PCTs in the most deprived fifth (47 out of 61) was below 70%. Uptake in around a third of PCTs in the most deprived fifth (21 out of 61) was below 65%. In 2004 more PCTs in the most deprived fifth achieved 70% uptake. Uptake in around a third of PCTs in the most deprived fifth (20 out of 61) was below 70%, with only nine PCTs in the most deprived fifth having uptake below 65%.
- All PCTs in the most deprived fifth that achieved at least 70% uptake in 2002 were also above 70% uptake in 2004. There were seven PCTs in the most deprived fifth that moved to above 70% uptake between 2002 and 2003, but slipped back to below 70% uptake in 2004.

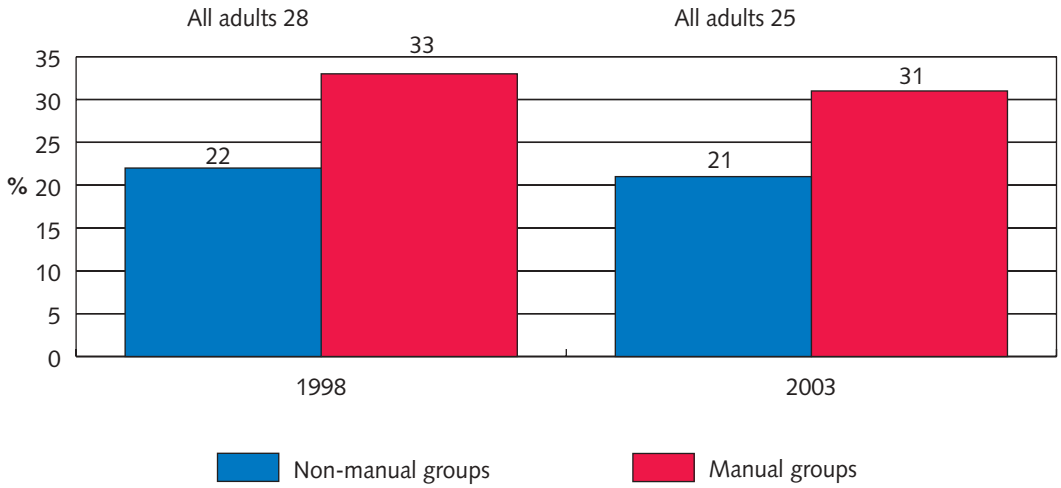
Data notes:
Source: Data collection from GPs, managed by the Centre for Infection (CfI) – part of the Health Protection Agency – on behalf of DH. Area deprivation is measured by the Index of Multiple Deprivation 2004, PCT summary (average score) (produced by the Healthcare Commission based on ODPM data).

KEY: ✓ = decreasing inequality ✖ = increasing inequality
● = no significant change — = insufficient data

Indicator 6a: Prevalence of smoking among people in manual social groups (Part 1 of: Prevalence of smoking among people in manual social groups, and among pregnant women)

Overall summary: Since 1998 smoking prevalence among all adults has fallen (including a slight fall in prevalence among manual groups), but there has been no significant change in inequalities for manual groups compared with non-manual groups or all adults.

Figure 18: Smoking prevalence (aged 16 and over) by socio-economic group, England (weighted data)



	ABSOLUTE GAP (DIFFERENCE)			RELATIVE GAP (RATIO)		
COMPARISON	**BASELINE** 1998	**LATEST** 2003	**TREND**	**BASELINE** 1998	**LATEST** 2003	**TREND**
Socio-economic group						
Manual groups vs all adults	5 *(4, 6)*	5 *(4, 6)*	●	1.19 *(1.15, 1.23)*	1.21 *(1.17, 1.25)*	●
Manual groups vs non-manual groups	11 *(9, 13)*	10 *(8, 12)*	●	1.49 *(1.38, 1.61)*	1.48 *(1.38, 1.58)*	●

COMMENTARY

- Smoking prevalence among manual groups is consistently higher than in non-manual groups and in the adult population as a whole.
- For example, in 2003 smoking prevalence in manual groups was 10 percentage points higher than in non-manual groups. In relative terms, smoking prevalence in manual groups was 1.48 times the prevalence in non-manual groups, ie 48% higher.
- Smoking prevalence fell steadily from 1974 to 1992, and remained broadly flat between 1992 and 1998. Since 1998 smoking prevalence among all adults has fallen, including a slight fall in prevalence among manual groups.
- Since 1998 the gap in smoking prevalence between manual groups and the average for all adults has not changed significantly in absolute or relative terms. This also applies to the gap between manual and non-manual groups.

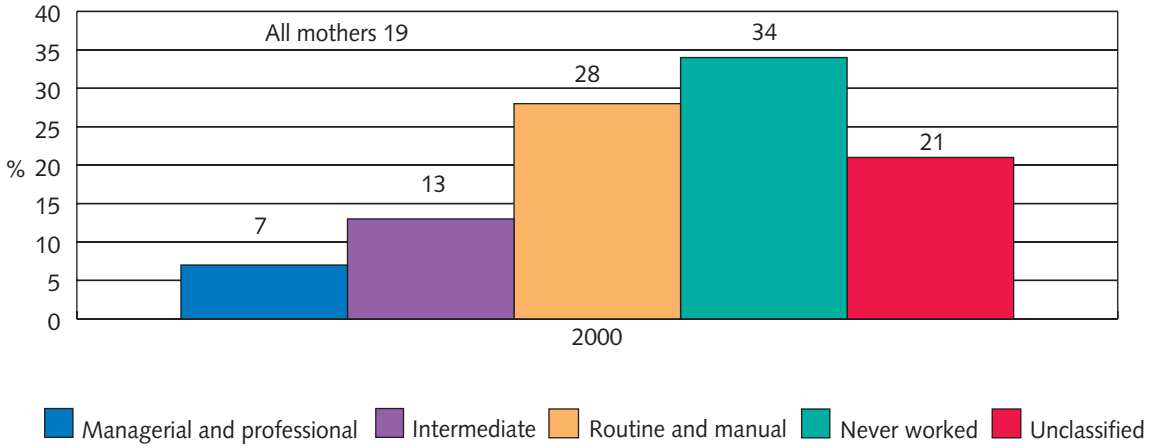
Data notes:
Source: General Household Survey (ONS).
GHS data were weighted from 2000 onwards and retrospectively for 1998 for comparative purposes. Data were weighted to compensate for non-response in the sample and also to match known population distributions. Weighted data cannot be reliably compared with the unweighted data for 1998 and previous years.
From 2001 onwards figures are based on the new NS SEC classification recoded to produce socio-economic groups (SEG) (ie manual/non-manual groups).

KEY: ✓ = decreasing inequality ✖ = increasing inequality
● = no significant change — = insufficient data

Indicator 6b: Prevalence of smoking among pregnant women (Part 2 of: Prevalence of smoking among people in manual social groups, and among pregnant women)

Overall summary: Comparable data are only available for the baseline. In 2000 there was a strong gradient in smoking throughout pregnancy by socio-economic group, with managerial and professional groups having the lowest prevalence.

Figure 19: Percentage of women who smoked throughout pregnancy by socio-economic group (NS SEC), England



	ABSOLUTE GAP (DIFFERENCE)			RELATIVE GAP (RATIO)		
COMPARISON	**BASELINE** 2000	**LATEST** As baseline	**TREND**	**BASELINE** 2000	**LATEST** As baseline	**TREND**
Socio-economic group (NS SEC) (England data)						
Routine and manual group vs all mothers	9	—	—	1.48	—	—
Routine and manual group vs managerial and professional group	21	—	—	3.80	—	—

COMMENTARY

- Data from the 2000 Infant Feeding Survey show a clear social gradient in the prevalence of smoking throughout pregnancy in England, with prevalence decreasing from the routine and manual group to the intermediate group, and from the intermediate group to the managerial and professional group. The 'never worked' socio-economic group had the highest prevalence (34%). The ratio of prevalence of smoking throughout pregnancy in the routine and manual group to that in the managerial and professional group was 3.80.
- Comparable data are only available for the baseline year. The Infant Feeding Survey is carried out every five years. The questions on smoking used in the 2000 Infant Feeding Survey were changed so that the emphasis was on changes in smoking behaviour, rather than simply changes in cigarette consumption. This means that results from the 2000 survey are not robustly comparable with results from the 1995 and earlier surveys.
- However, data from the 1995 Infant Feeding Survey on the prevalence of smoking during pregnancy in the UK by social class also showed a social gradient. The prevalence of smoking *during* pregnancy in social class V was 37%, 1.5 times the prevalence for all mothers (24%) and over 5 times the prevalence in social class I (7%).

Data notes:
Source: Infant Feeding Survey.

KEY: ✓ = decreasing inequality ✖ = increasing inequality
● = no significant change — = insufficient data

Indicator 7: Proportion of those aged 16 who get qualifications equivalent to five GCSEs at grades A* to C

Overall summary: Between 2002 and 2004 the proportion of pupils achieving five or more A*–C grades at GCSE increased (including among pupils eligible for free school meals), with some signs of a narrowing of the attainment gap between pupils eligible for free school meals and all pupils.

Figure 20: Percentage of 16-year-olds achieving five or more GCSE grades A*–C (or equivalent) by FSM eligibility, England

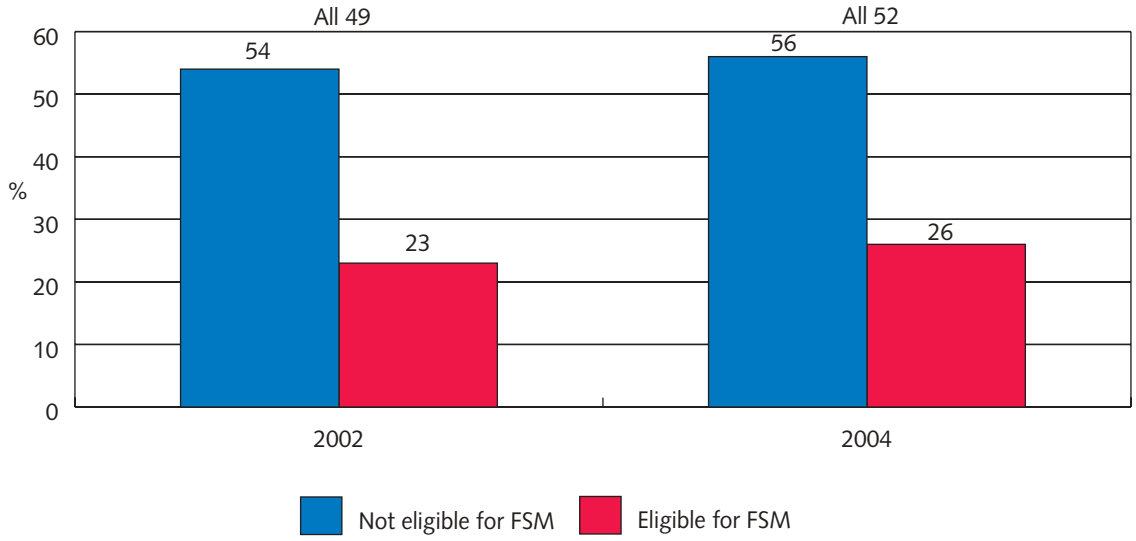
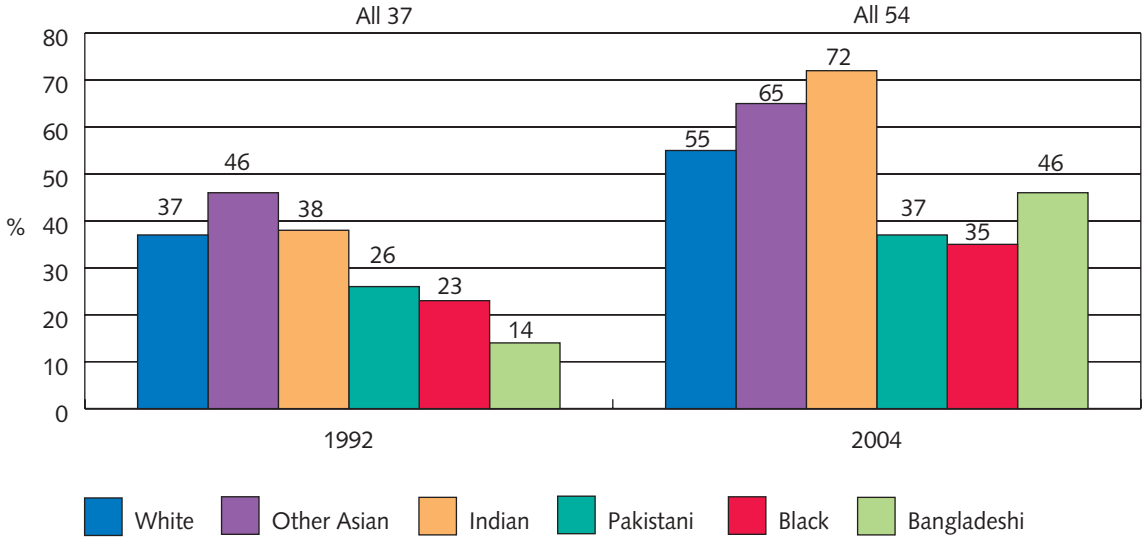


Figure 21: Percentage of 16-year-olds attaining five or more GCSE grades A*–C by ethnic group, England and Wales



	ABSOLUTE GAP (DIFFERENCE)			RELATIVE GAP (RATIO)		
COMPARISON	**BASELINE** 2002	**LATEST** 2004	**TREND**	**BASELINE** 2002	**LATEST** 2004	**TREND**
Eligibility for free school meals (FSM)						
Eligible for FSM vs all pupils	-26 *(-26, -26)*	-26 *(-26, -26)*	●	0.47 *(0.46, 0.48)*	0.50 *(0.50, 0.51)*	✓
Eligible for FSM vs not eligible for FSM	-31 *(-31, -30)*	-30 *(-30, -30)*	●	0.43 *(0.42, 0.43)*	0.47 *(0.46, 0.47)*	✓

COMMENTARY

- The proportion of pupils achieving five or more A*–C grades at GCSE is lower among pupils who are eligible for free school meals (FSM) than among pupils who are not eligible for FSM.
- For example, in 2004 the proportion of pupils achieving five or more A*–C grades at GCSE among pupils eligible for FSM was 30 percentage points lower than the proportion among pupils not eligible for FSM. In relative terms, the proportion among pupils eligible for FSM was 0.47 times the proportion among pupils not eligible for FSM, ie 53% lower.
- Between 2002 and 2004 the proportion of pupils achieving five or more A*–C grades at GCSE among pupils eligible for FSM increased. In addition, the attainment gap between pupils eligible for FSM and all pupils overall narrowed slightly in relative terms, but with no significant change in absolute terms. This also applies to the gap between pupils eligible for FSM and pupils not eligible for FSM.
- Data for earlier years by socio-economic group for England and Wales from the Youth Cohort Study show that the inequality in attainment of five or more A*–C grades at GCSE between pupils with parents from managerial/professional backgrounds and pupils with parents from unskilled manual backgrounds fluctuated between 1992 and 2000, with no clear trend.
- Data for England and Wales from the Youth Cohort Study show that GCSE attainment varies between minority ethnic groups. Indian and Other Asian pupils perform above the England and Wales average. Black, Pakistani, and Bangladeshi pupils perform below the England and Wales average attainment of five or more A*–C grades at GCSE. However, the gap in GCSE attainment between Bangladeshi pupils and all pupils in England and Wales narrowed between 1992 and 2004 in both absolute and relative terms. (Note that confidence intervals are wide and the narrowing in absolute terms does not exceed the bounds of expected sampling error.)

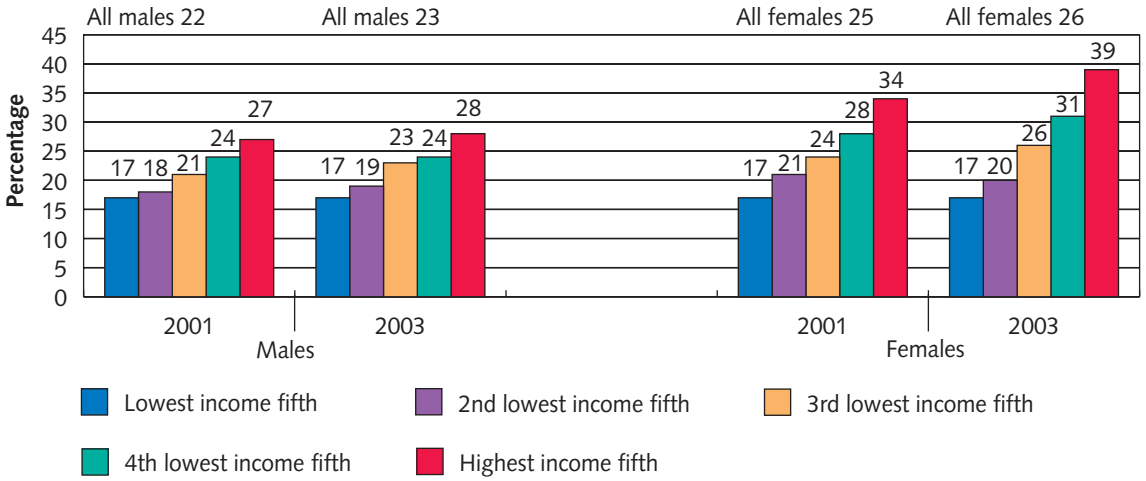
Data notes:
Source: Figures by FSM eligibility are from matched data in the National Pupil Database (DfES); data by socio-economic group and ethnic group are from Youth Cohort Study (DfES).

KEY: ✓ = decreasing inequality ✖ = increasing inequality
● = no significant change — = insufficient data

Indicator 8: Proportion of people consuming five or more portions of fruit and vegetables per day in the lowest quintile of household income distribution

Overall summary: Between 2001 and 2003, inequalities in consumption of five or more portions of fruit and vegetables per day did not change significantly in absolute or relative terms.

Figure 22: Percentage of adults (aged 16 and over) consuming five or more portions of fruit and vegetables per day, England, by household income quintile



COMPARISON	ABSOLUTE GAP (DIFFERENCE) BASELINE 2001	LATEST 2003	TREND	RELATIVE GAP (RATIO) BASELINE 2001	LATEST 2003	TREND
Household income						
Adults, male – lowest income fifth vs England	-6 *(-8, -3)*	-6 *(-8, -3)*	●	0.75 *(0.64, 0.87)*	0.75 *(0.64, 0.87)*	●
Adults, female – lowest income fifth vs England	-8 *(-10, -6)*	-9 *(-11, -7)*	●	0.69 *(0.61, 0.77)*	0.66 *(0.59, 0.74)*	●
Adults, male – lowest income fifth vs highest income fifth	-11 *(-15, -7)*	-12 *(-15, -8)*	●	0.61 *(0.50, 0.73)*	0.59 *(0.49, 0.71)*	●
Adults, female – lowest income fifth vs highest income fifth	-17 *(-20, -13)*	-22 *(-26, -18)*	●	0.51 *(0.44, 0.59)*	0.44 *(0.38, 0.51)*	●

COMMENTARY

- There is a gradient in the proportion of adults consuming five or more portions of fruit and vegetables per day by household income, with the fifth of households with lowest income having the lowest proportion consuming 'five a day' and the highest income fifth the highest proportion.
- For example, in 2003 the proportion of adult males consuming five or more portions of fruit and vegetables per day in the lowest household income fifth was 12 percentage points lower than the proportion in the highest household income fifth. In relative terms, the proportion of adult males consuming five or more portions of fruit and vegetables per day in the lowest household income fifth was 0.59 times the proportion in the highest household income fifth, ie about 40% lower.
- Between 2001 and 2003, inequalities in consumption of five or more portions of fruit and vegetables per day did not change significantly in absolute or relative terms. (Confidence intervals are wide for the inequality measures as data are based on a sample survey, so it is difficult to make a robust assessment of change over time.)

Data notes:
Source: Health Survey for England.

KEY: ✓ = decreasing inequality ✖ = increasing inequality
● = no significant change — = insufficient data

Indicator 9: Proportion of households living in non-decent housing

Overall summary: Between 1996 and 2003 the proportion of vulnerable households living in non-decent housing decreased, with a narrowing of inequalities between vulnerable households and all households in absolute terms but no significant change in relative terms.

Figure 23: Percentage of households living in non-decent housing by vulnerable household status

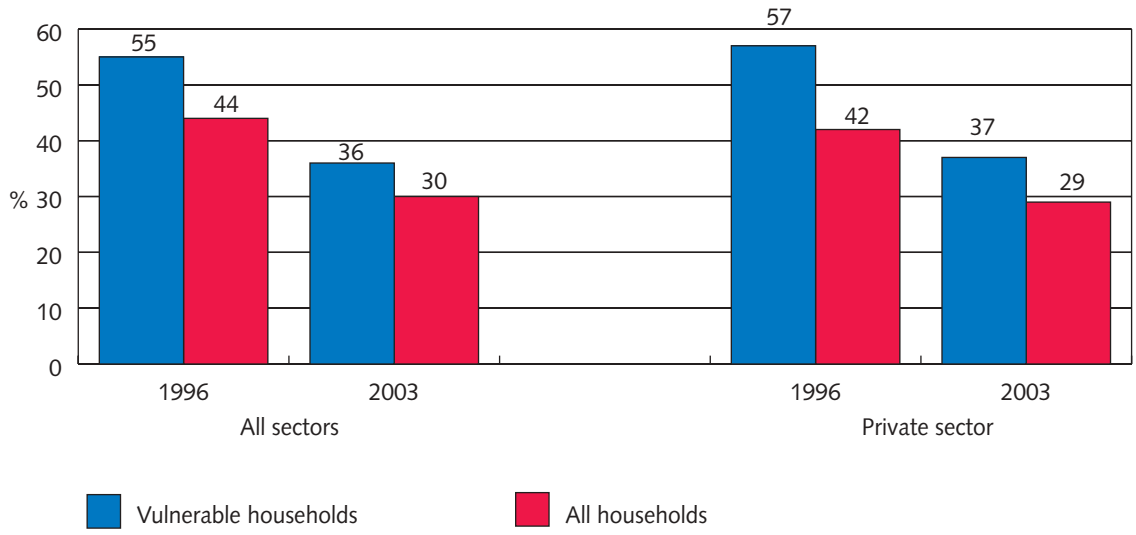
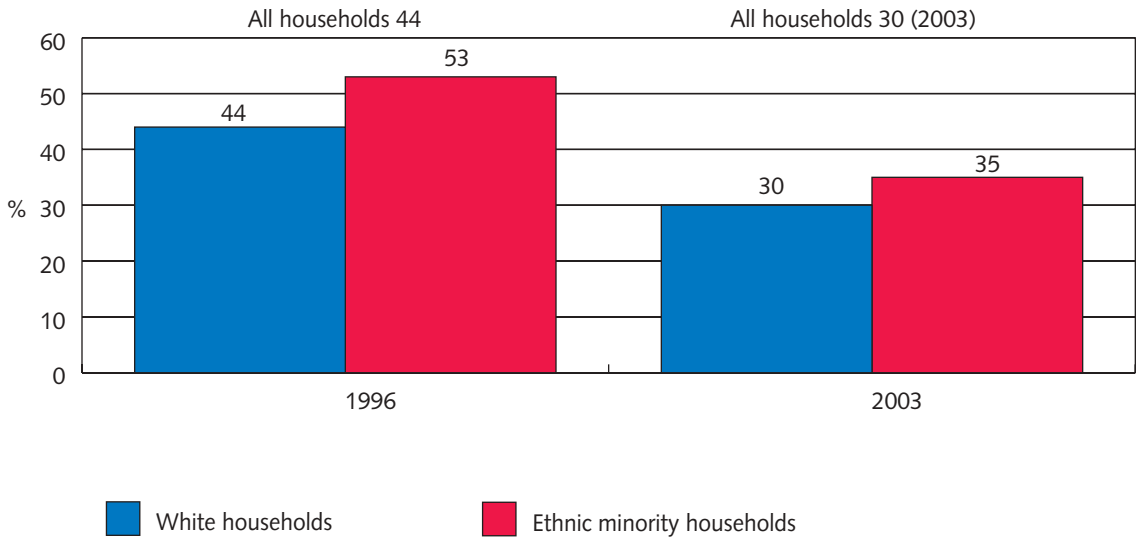


Figure 24: Percentage of households living in non-decent housing by ethnic identity, England



	ABSOLUTE GAP (DIFFERENCE)			RELATIVE GAP (RATIO)		
COMPARISON	**BASELINE** 1996	**LATEST** 2003	**TREND**	**BASELINE** 1996	**LATEST** 2003	**TREND**
Vulnerable household status						
All sectors – vulnerable households vs all households	10 *(8, 13)*	5 *(4, 7)*	✓	1.24 *(1.18, 1.29)*	1.18 *(1.12, 1.25)*	●
Private sector – vulnerable households vs all households	15 *(11, 19)*	8 *(5, 11)*	✓	1.36 *(1.26, 1.47)*	1.27 *(1.16, 1.38)*	●

COMMENTARY

- Vulnerable households are those in receipt of income- or disability-related benefits. Vulnerable households are more likely to live in non-decent housing than all households overall, a difference that is mainly due to private-sector households. In 2003 the proportion of vulnerable households living in non-decent housing was 1.18 times the proportion of all households, ie 18% higher. The proportion of private-sector vulnerable households living in non-decent housing was 1.27 times the proportion of all private-sector households, ie 27% higher.
- The proportion of vulnerable households living in non-decent housing fell substantially between 1996 and 2003.
- Between 1996 and 2003 the gap between the proportion of vulnerable households and all households living in non-decent homes narrowed in absolute terms. The narrowing in the gap occurred in all sectors considered together and in the private sector on its own. There was no significant change in the gap between vulnerable households and all households in relative terms. (Although the relative gap measures indicate a reduction in inequalities, this is within the bounds of expected sampling error.)
- Although the majority of households living in non-decent homes are white – 91% in 2003, with only 9% belonging to any other ethnic group – ethnic minority households are more likely to live in non-decent homes. In 2003, 35% of ethnic minority households lived in non-decent homes, compared to 30% of white households. This compares with 53% of ethnic minority households and 44% of white households living in non-decent homes in 1996. While this suggests there has been greater improvement since 1996 for ethnic minority households that for white households, this is not yet statistically significant.

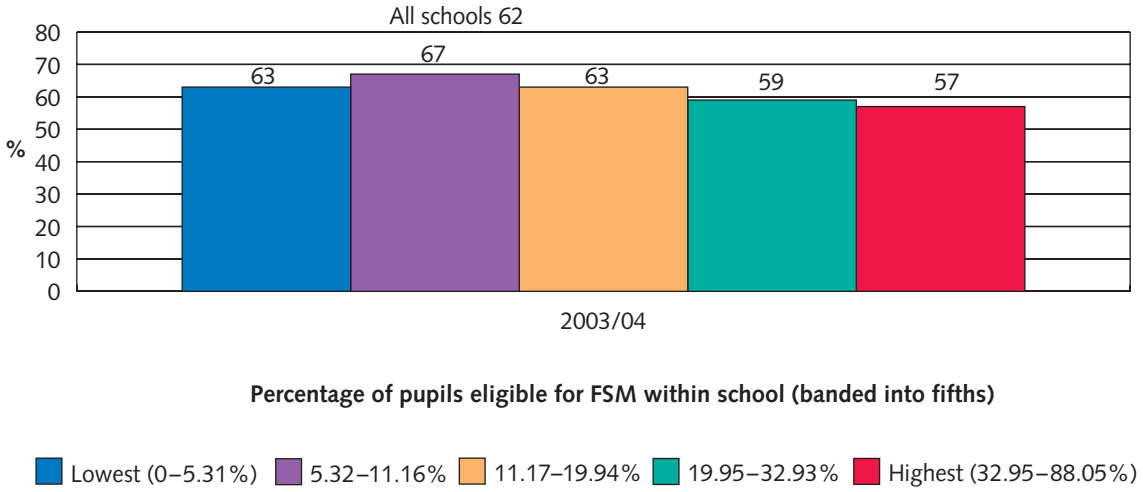
Data notes:
Source: English House Condition Survey (EHCS).
The EHCS was carried out five-yearly until 2001, from when the survey was reorganised with the introduction of continuous fieldwork from April 2002 to provide annual results from 2003.

KEY: ✓ = decreasing inequality ✖ = increasing inequality
● = no significant change — = insufficient data

Indicator 10: Percentage of schoolchildren who spend a minimum of two hours each week on high-quality PE and school sport within and beyond the curriculum

Overall summary: Data for the baseline show that 62% of pupils in School Sport Partnership schools spent at least two hours in a typical week on high-quality PE and school sport within and beyond the curriculum, as at spring 2004. Participation in PE and school sport is lower on average in School Sport Partnership schools with a high proportion of pupils eligible for free school meals. Data are only available for the latest year.

Figure 25: Percentage of schoolchildren who spend a minimum of two hours in a typical week on high-quality PE and school sport by level of eligibility for free school meals (FSM)



	ABSOLUTE GAP (DIFFERENCE)			RELATIVE GAP (RATIO)		
COMPARISON	**BASELINE** 2003/04	**LATEST** As baseline	**TREND**	**BASELINE** 2003/04	**LATEST** As baseline	**TREND**
Eligibility for free school meals (FSM) (schools banded into fifths by percentage of pupils eligible for FSM)						
Highest FSM eligibility fifth vs all schools	-5	—	—	0.92	—	—
Highest FSM eligibility fifth vs lowest FSM eligibility fifth	-6	—	—	0.90	—	—

COMMENTARY

- Data are only available for the latest year, so no commentary on trends is possible. Overall, 62% of pupils in School Sport Partnership schools spent at least two hours in a typical week on high-quality PE and school sport within and beyond the curriculum, as at spring 2004.
- Participation in PE and school sport is lower on average in School Sport Partnership schools with a high proportion of pupils eligible for FSM. The fifth of Partnership schools with the highest proportion of pupils eligible for FSM has 57% of pupils participating in at least two hours of PE and school sport in a typical week. This compares to 63% of pupils in the fifth of Partnership schools with the lowest proportion of pupils eligible for FSM and 67% of pupils in the fifth of Partnership schools with the second-lowest proportion of pupils eligible for FSM.
- DfES and the DCMS have a Public Service Agreement target to enhance the take-up of sporting opportunities by 5 to 16-year-olds so that the percentage of schoolchildren in England who spend a minimum of two hours each week on high-quality PE and school sport within and beyond the curriculum increases to 75% by 2006 and to 85% by 2008, and to at least 75% in each School Sport Partnership by 2008.

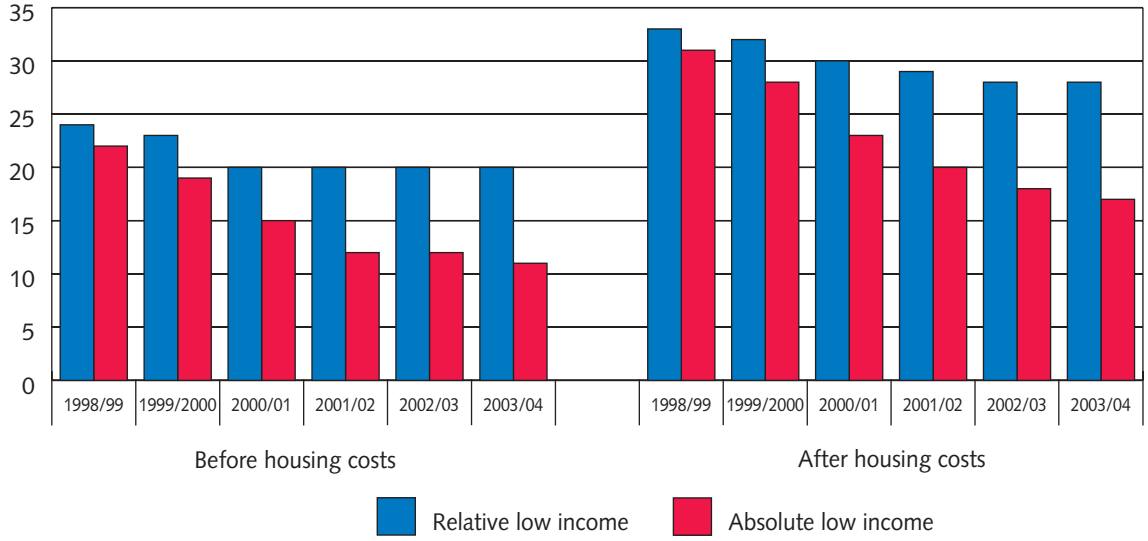
Data notes:
Source: Annual survey of School Sport Partnerships.
The survey only covers School Sport Partnerships. School Sport Partnerships will not cover all schools in England before September 2006.

KEY: ✓ = decreasing inequality ✖ = increasing inequality
● = no significant change — = insufficient data

Indicator 11: Proportion of children living in low-income households

Overall summary: 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 and across all low-income thresholds, and on both before and after housing cost measures.

Figure 26: Percentage of children in England living in low-income households (below 60% of Great Britain median income)



MEASURE	BASELINE 1998/99	LATEST 2003/04	TREND
Relative low income (before housing costs)	24%	20%	✓
Absolute low income (before housing costs)	22%	11%	✓
Relative low income (after housing costs)	33%	28%	✓
Absolute low income (after housing costs)	31%	17%	✓

COMMENTARY

- The data shown are for the percentage of children in England living in low-income households (the low income threshold being 60% of GB median household income). For relative low income, the threshold moves each year. For absolute low income, the threshold is fixed at 1996/97 levels in real terms.
- In addition to the improvement on the relative and absolute low-income measures, the proportion of children in England living in households with persistent low incomes (below 60% of the GB median) has fallen from 20% in the period 1991–94 to 15% in the period 1999–2002. (Persistent low income is defined as low income before housing costs in three out of the four years in each period.)
- The investment in financial support for families, combined with continued progress against employment targets, means that the Government is broadly on course to meet the target to reduce the number of children in Great Britain living in relative low-income households by a quarter by 2004/05.

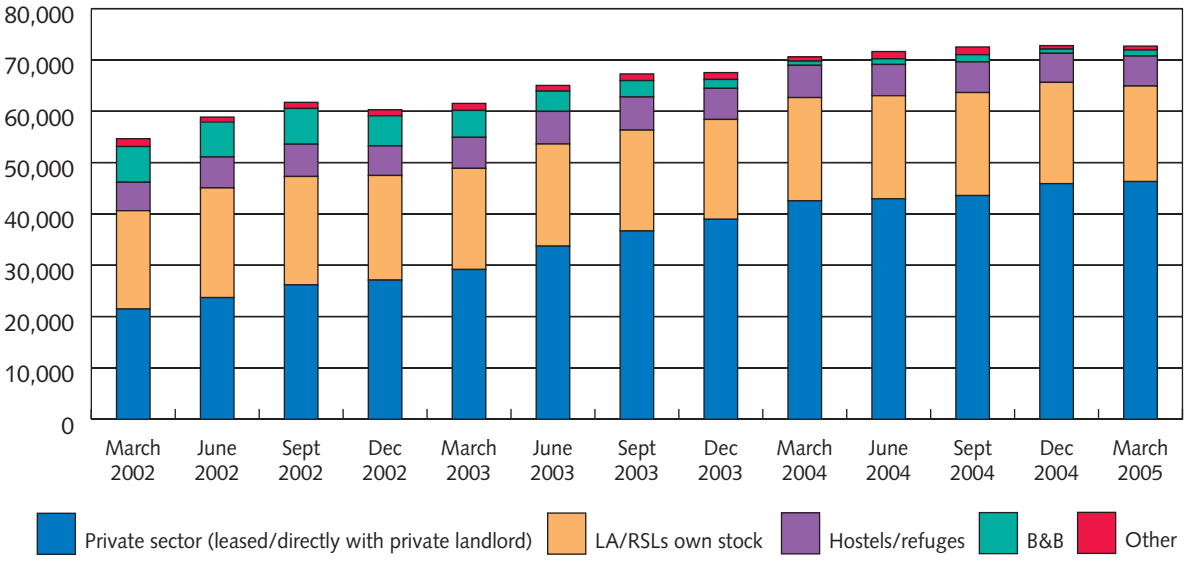
Data notes:
Source: Households Below Average Income.

KEY: ✓ = decreasing inequality ✖ = increasing inequality
● = no significant change — = insufficient data

Indicator 12: Number of homeless families with children in temporary accommodation

Overall summary: Since March 2002 there has been a significant reduction in the number of homeless families with children in bed and breakfast accommodation, but a significant increase in the number of homeless families with children living in temporary accommodation overall, although this number has remained fairly constant since September 2004.

Figure 27: Homeless families in temporary accommodation arranged by local authorities by type of accommodation, England



MEASURE	BASELINE Mar 2002	LATEST Mar 2005	TREND
Number in temporary accommodation, incl. B&B	54,660	72,670	✖
Number in bed and breakfast accommodation	6,960	1,180	✓

COMMENTARY

- The number of homeless families with children in bed and breakfast accommodation fell from 6,960 at the end of March 2002 to 1,180 at the end of March 2005 (ie reduced by 83%).
- The number of homeless families with children in all forms of temporary accommodation increased between March 2002 and March 2005, from 54,660 to 72,670. However, the number of families with children *going into* temporary accommodation reduced during 2004 (compared to 2002 and 2003), and the total number in temporary accommodation has remained fairly flat since September 2004.
- People from black and minority ethnic groups continue to be over-represented among those accepted as homeless. Of the 120,860 households accepted as homeless during 2004/05, 21% were from a black or minority ethnic background. (There were a further 5% where the ethnic origin was not known.)
- The Government set a target in March 2002, that by the end of March 2004 no homeless family with children should be accommodated in a bed and breakfast by a local authority, except in an emergency and even then for no longer than six weeks. This target was met, with the number of homeless families with children in bed and breakfast for over six weeks falling by 99.3% between March 2002 and the target date of March 2004.
- Although the number of homeless families with children in all forms of temporary accommodation has increased since March 2002, the proportion in shared accommodation such as bed and breakfast hotels, hostels or women's refuges has fallen. At the end of March 2005, 90% of families with children in temporary accommodation were in self-contained homes, compared to around 75% at the end of March 2002.
- In March 2005 the Government published *Sustainable Communities: settled homes; changing lives*, setting out a strategy for halving the number of households in insecure temporary accommodation by 2010.

Data notes:
Source: Data collected by ODPM's Housing Data and Statistics (HDS) and Homelessness and Housing Support Directorate (HHSD) from P1E, P1E(AS) and other monitoring returns from local authorities.
'Homeless families with children' means homeless households with dependent children and/or an expectant mother.
Figures are grossed (imputed) national totals based on local authority returns.

KEY: ✓ = decreasing inequality ✖ = increasing inequality

Other developments

4.24 Concerted government action on the wider determinants of health inequalities is showing results. This is reflected in progress reducing the numbers of children in poverty and improving housing quality. Outside of the 12 headline indicators, action across government will help address the wider determinants of health and narrow the health gap, both now and in the future. Action includes

- improving the financial position of the disadvantaged groups relative to to other groups - important advances have been made in tax and benefit changes since 1997, and through the introduction of the national minimum wage
- providing support for parents in the education of their children through the commitments in The Five Year Strategy for Children and Learners, and through such programmes as Children's Centres and Extended Schools
- delivering better services to disadvantaged groups through Supporting People which offers high quality and strategically planned housing-related services for vulnerable people, such as those of the Home Improvement Agencies that help deliver decent homes for vulnerable people
- promoting sustainable development through the agenda set out in Securing the Future as part of a broader effort to improve health and well being and tackle health and environmental inequalities, and in areas like fuel poverty where significant steps have been made.

Box 5: Progress in eliminating fuel poverty

The Government's commitment in England is to eradicate fuel poverty among vulnerable households by 2010 as far as is reasonably practical. Schemes to assist the fuel poor, such as Warm Front, which provides a range of energy efficiency and heating measures for private-sector vulnerable households in England, will have a key role to play in driving progress towards this target. Work towards the Decent Homes Standard will have a beneficial effect in limiting the number of individuals who suffer from fuel poverty in the social housing sector.

Estimates indicate that in 2002, 1.4 million households were in fuel poverty in England – a reduction of around half a million households since 2001, or 2.8 million since 1996.

The local basket of indicators for health inequalities

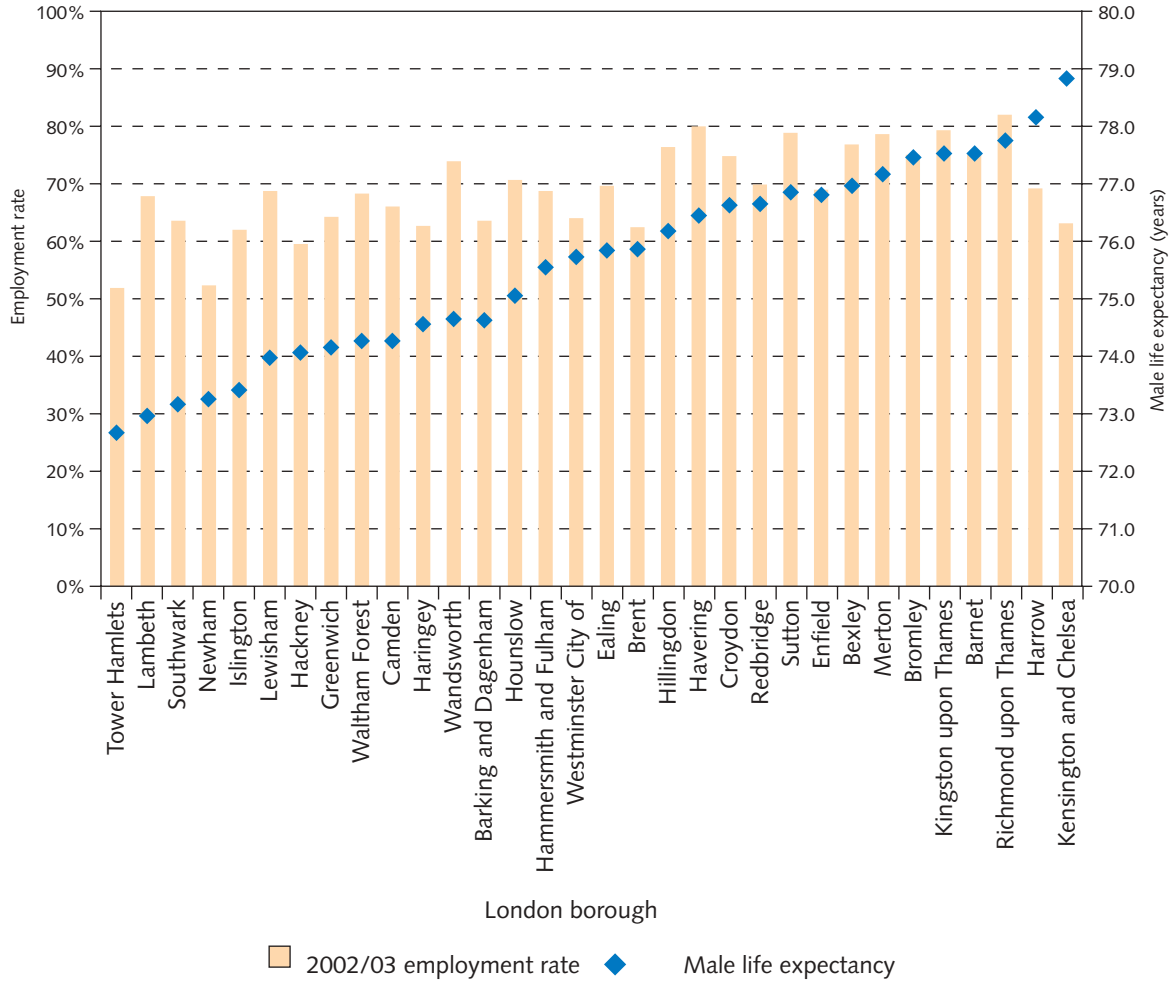
4.25 The 12 national headline indicators help provide an overview of progress at national level. Local indicators also have a crucial role and the local basket of indicators provides a guide to progress. It was published on the London Health Observatory (LHO) website (www.lho.org.uk) in October 2003.

4.26 The local basket will also highlight the relationship between health inequalities and the wider determinants such as education, employment and housing and health inequalities.

4.27 It draws on existing data collections – there are no requirements on the service to collect additional data, indicators are not mandatory and targets have not been imposed by DH. Its value is in drawing together existing measures of inequalities in a single package.

4.28 The local basket will develop as new indicators are identified and others become less relevant over time. Feedback has been encouraged as part of further development as a way of improving the use of the basket.

Figure 28: Employment rate 2002/03 according to male life expectancy 2000–02 for London boroughs



4.29 One key wider determinant of health picked up by the local basket is employment. Generally, areas with highest male life expectancy tend to have the highest employment rates. Figure 28 shows the relationship in London between the employment rate in London and male life expectancy 2000–02. Newham and Tower Hamlets had the lowest employment rates, but Lambeth and Southwark had lower male life expectancy rates than Newham. Harrow, Kensington and Chelsea had the highest male life expectancy rates but did not have the highest employment rate.

Role of performance management in the NHS

4.30 The *Programme for Action* emphasised the need for supporting action from the centre and through the regions to ensure a secure foundation for meeting the national health inequalities target. In particular, through the need to integrate service planning, performance management and monitoring to reflect national priorities and local need. This is crucial to local government and the NHS and this will help improve service performance on health inequalities, essential to achieving the 2010 target.

4.31 The importance of the NHS to the target is shown by the fact that the life expectancy gap between the areas with lowest life expectancy and the national average is caused principally by premature deaths from cancer, circulatory diseases and respiratory diseases with smaller effects from suicide and violence in men. The over-50s contribute around three-quarters of this gap. Accordingly, the *Programme for Action* identified the priorities that will have the greatest impact on narrowing the gap as:

- addressing cancer and circulatory diseases within manual social groups because these major killers exhibit strong social class gradients;
- improving the life expectancy of the over-50s;
- improving the quality of care in disadvantaged areas, especially primary care.

To achieve the target, faster improvement is needed in disadvantaged areas, so the spearhead group is a key focus for action.

4.32 The key areas for interventions to narrow the gap in life expectancy to meet the 2010 target are:

- reducing smoking in manual social groups (eg through extended cessation services, complementary tobacco education campaigns and other supporting interventions) – smoking cessation is a good example of the need for at least a medium-term strategy to allow ex-smokers to achieve the same disease risks as non-smokers (and this varies by disease);
- prevention and effective management of other risk factors in primary care (eg through early identification and intervention on poor diet, obesity and hypertension through lifestyle and therapeutic interventions including use of statins, anti-obesity drugs and anti-hypertensives according to need);
- targeting influenza and pneumococcal immunisation to over-65s, all those at increased risk and those living in long-term residential care homes;
- working proactively with partners on issues affecting life expectancy, including Local Strategic Partnerships and other stakeholders having a positive impact on health and health inequalities such as housing, environment and transport planners.

4.33 The NHS has started to address these issues in the way the service works to prevent a further widening of health inequalities in the future. Box 6 suggests some possible ways to help strategic health authorities (SHAs) address this issue.

Box 6: Five suggested steps to help SHAs address health inequalities

- Raise the profile of health inequalities by including the topic regularly within discussions in the health authority, and focusing on results as well as processes. The service needs to believe that health inequalities are a priority and that its performance on them will be assessed.
- Make health inequalities an integral part of planning, commissioning and delivery. Narrowing inequalities is a service issue, and not solely about disease prevention.
- Promote health equity audits as tools to support discussions about how well PCTs did on the self-assessment tool, and what action they are taking now to ensure their use of health equality audits will be effective and focused on high-impact issues.
- Address health inequalities through the LDP process in line with *National Standards, Local Action.*
- Emphasise the importance of partnership working and achieving positive shared outcomes. This needs real engagement from the service – and the whole NHS has much to gain from influencing partners to tackle the wider determinants of health and health inequalities.

4.34 The Healthcare Commission's Standards call on healthcare organisations to provide leadership, and collaborate with relevant local organisations and communities will help to ensure that the design and delivery of programmes and services reduce health inequalities between different population groups and areas. This has been supported by planning guidance from DH to promote action that will help support the 2010 target, and lay the foundations for a long-term sustainable reduction in health inequalities.

Box 7: Health equity audit is motivating change to improve health within PCTs in Bedfordshire and Hertfordshire

Reversing 'inverse care': health equity audit in West Hertfordshire

A health equity audit in West Hertfordshire compared coronary revascularisation provision with need based on standardised mortality ratios. This revealed a typical 'inverse care law' with lowest provision in areas of highest need. As a result of the NSF for coronary heart disease, West Hertfordshire focused upon equitable development of cardiology services, including a £3 million shift in recurrent resources. The result has been that services are now directed towards areas of high need.

An assessment against the target and longer term aims

Life expectancy target

4.35 The latest data for 2001–03 indicate that since the baseline (1997–99), the relative gap in life expectancy between England and the fifth of local authorities with the lowest life expectancy has increased for both males and females (continuing a long-standing trend), with a larger increase for females. This is summarised in Table 2.

4.36 For males, the relative gap increased by nearly 2%, for females by 5%.

4.37 The England average life expectancy at birth in 2001–03 was 76.2 for males and 80.7 for females. The average life expectancy for the fifth of local authorities with the lowest life expectancy was 74.2 for males and 79.1 for females.

4.38 In 2001–03, male life expectancy for the lowest fifth of local authorities was 2.7% lower than the England average; female life expectancy for the lowest fifth was 2.0% lower than the England average.

4.39 In 2001–03, the local authority with the highest life expectancy at birth for males was East Dorset, at 80.1 years. Kensington and Chelsea had the highest life expectancy for females, at 84.8 years.

4.40 In 2001–03, the local authority with the lowest life expectancy at birth for males was Manchester, at 71.8 years. Blackburn with Darwen had the lowest life expectancy for females, at 77.6 years.

4.41 The difference in life expectancy at birth between the local authorities in England with the highest and lowest figures was 8.3 years for males and 7.2 years for females.

Table 2: Life expectancy at birth for England and the fifth of areas with the lowest life expectancy

		1995–97	1996–98	1997–99	1998–00	1999–01	2000–02	2001–03	1997–99** (baseline)
England	Males	74.61	74.84	75.09	75.38	75.71	76.01	**76.24**	**75.13**
(source: ONS)	Females	79.69	79.84	79.97	80.19	80.42	80.66	**80.72**	**80.02**
Lowest fifth of LAs*	Males	72.67	72.86	73.06	73.35	73.67	73.98	**74.17**	**73.12**
(source: ONS)	Females	78.23	78.32	78.43	78.61	78.84	79.05	**79.09**	**78.49**
Absolute gap	Males	1.94	1.98	2.03	2.03	2.04	2.03	**2.07**	**2.00**
(difference)	Females	1.46	1.52	1.54	1.58	1.58	1.61	**1.63**	**1.54**
Relative gap	Males	2.60%	2.65%	2.70%	2.69%	2.69%	2.67%	**2.72%**	**2.67%**
(% difference)	Females	1.83%	1.90%	1.93%	1.97%	1.96%	2.00%	**2.02%**	**1.92%**

* ie the fifth of local authorities in England with the lowest life expectancy.
** The baseline figures for the target are fitted data for 1997–99 (from a fitted trendline based on data for 1995–97 to 1999–01).

Infant mortality target

4.42 New figures for 2003 were published in *Health Statistics Quarterly* no. 24 (winter 2004).

4.43 A new definition of socio-economic status was introduced in 2001 which affected reporting of infant mortality by socio-economic status. The National Statistics Socio-Economic Classification (NS SEC) replaced the Registrar General's Social Class; the ten-yearly update of the standard occupational classification was implemented; and a change was made to the coding of employment status (see Annex 5).

4.44 The infant mortality target formulation encompasses much of the disadvantaged population, including teenage mothers. New figures show that babies born to teenage mothers have a 60% increased risk of infant mortality.

4.45 However, some important groups are not included, specifically, sole registrations and the 'other' social groups. Sole registrations now account for around 10% of all infant deaths and are associated with above average rates of mortality (7.4 deaths per 1,000 live births in 2003). And the NS SEC 'other' category – including the long-term unemployed and those who have never worked – accounts for almost a further 10% of all infant deaths and is associated with particularly high death rates in infancy (8.9 deaths per 1,000 live births in 2003). We have stated our intention to monitor progress in *all* social groups (including sole registrations) to ensure that trends are improving and gaps in mortality are narrowing. More detailed trend data are therefore presented in Table 3 – detailed NS SEC categories and Table 4 – 'other' category and sole registrations

4.46 The latest figures confirm the previously reported trend that, despite overall improvements in infant mortality rates, the relative gap between the 'routine and manual' groups and the population as a whole has widened over the recent years since the target baseline.

4.47 The target to narrow this gap by at least 10% by 2010 remains extremely challenging. For the latest three-year average period, 2001–03, the overall infant mortality rate (for all babies with father's occupation stated) was 5.0 deaths per 1,000 live births, and the rate for those in 'routine and manual' groups was 6.0 per 1,000.

4.48 The infant mortality rate among the 'routine and manual' group was 19% higher than in the total population in 2001–03, compared with 16% higher in 2000–02. This compares with 13% higher in the baseline period of 1997–99.

4.49 The infant mortality rate among the 'routine and manual' group was 69% higher than the rate in the 'managerial and professional' group in 2001–03.

Table 3: Infant mortality rates by socio-economic group

Three-year average infant mortality rates by NS SEC90 for 1994–2001, and by NS SEC for 2001 onwards, by NS SEC analytical classes

England and Wales *Infant deaths per 1,000 live births*

	NS SEC90						NS SEC*		
	1994–96	1995–97	1996–98	1997–99	1998–2000	1999–2001	1999–2001	2000–02	2001–03
1.1 Large employers and higher managerial	4.3	4.4	3.7	3.5	3.1	3.1	3.0	2.8	2.9
1.2 Higher professional	4.3	4.3	4.2	4.2	3.9	3.7	3.7	3.5	3.4
2 Lower managerial and professional	4.5	4.4	4.3	4.2	4.1	4.0	4.1	3.9	3.9
3 Intermediate	6.1	6.3	6.7	6.4	6.1	5.7	5.6	5.4	5.4
4 Small employers and own-account workers	4.9	5.0	5.0	4.9	4.7	4.7	4.6	4.7	4.4
5 Lower supervisory and technical	5.3	5.1	4.9	4.7	4.6	4.7	4.7	4.4	4.2
6 Semi-routine	7.6	7.4	6.9	7.0	7.0	7.2	7.3	7.2	7.4
7 Routine	7.4	7.4	7.3	7.2	7.0	6.9	7.0	6.7	6.6
All**	5.9	5.8	5.7	5.6	5.4	5.3	5.3	5.2	5.0

Source: ONS.
Notes:
(a) Figures for live births are a 10% sample coded for father's occupation.
(b) Information on the father's occupation is not collected for births outside marriage if the father does not attend the registration of the baby's birth.
* Using NS SEC90 for data up to 2000 and NS SEC for 2001, 2002 and 2003 data.
** Infants born inside marriage or outside marriage jointly registered by both parents.

4.50 Table 4 shows the high infant mortality rates associated with the 'other' social class/NS SEC category, particularly for those births outside marriage. There is substantial year-on-year variation and no clear evidence for an increasing or decreasing trend. Single year figures are presented here because the figures for 'other' social groups are not comparable pre- and post-2001.

Table 4: Infant mortality rate (per 1,000 live births) – sole registrations and social class/NS SEC 'other' category

England and Wales

	Registrar General's social class						NS SEC	
	1996	1997	1998	1999	2000	2001	2002	2003
Sole registration	7.1	7.6	7.6	7.6	7.7	7.6	6.6	7.4
'Other' social class/NS SEC								
Inside marriage	8.3	9.0	8.5	7.3	7.7	7.1	9.1	8.4
Outside marriage/ joint registration	13.8	13.3	14.7	15.4	16.8	12.5	13.3	9.4
All	10.2	10.6	10.7	10.3	11.2	9.3	11.0	8.9

Source: ONS.

4.51 Assessment of progress towards the target is primarily on the basis of three-year aggregate data – this moderates the impact of any random year-on-year variation associated with small numbers. Nevertheless, as part of the monitoring process, it is useful to keep recent changes under close review by inspection of single-year figures. Data for 2003 show that, overall, the infant mortality rate continues to fall. In 2003:

- the infant mortality rate for all births inside marriage and outside marriage jointly registered by both parents (for which father's occupation was recorded) fell to 4.9 deaths per 1,000 live births, compared with 5.0 in 2002. This is the group that represents the 'total' population for the target;
- the infant mortality rate among routine and manual social groups rose to 6.1 deaths per 1,000 live births, compared with 5.8 in 2002;
- the overall infant mortality rate for all cases for which birth and death records could be linked was 5.2 deaths per 1,000 live births. This represents the total *population* relevant for comparison with sole registrations and for other comparisons not involving occupational breakdowns;
- the infant mortality rate among *sole registrations* (ie births registered by mother only) rose to 7.4 per 1,000 live births, compared with 6.6 in 2002 (which was a low point for recent years) and is now 40% higher than the overall rate;
- the infant mortality rate among the residual *'other' category* (ie births where father's occupation could not be assigned to one of the eight NS SEC classes) fell to 8.4 per 1,000 live births 'inside marriage' and 9.4 'outside marriage', compared with 9.1 and 13.3 respectively in 2002;
- among babies born in England and Wales of mothers who were born in Pakistan, the infant mortality rate was 10.5 per 1,000 live births – a drop from 11.4 in 2002 – yet a rate still more than double the overall infant mortality rate of 5.2 per 1,000.

4.52 The numbers of deaths involved in individual categories provide important context to these trends. In 2003, numbers of infant deaths in England and Wales were:

- all (where linkage of birth and deaths was possible): 3,240;
- inside marriage: 1,687 (52%);
- outside marriage: 1,553 (48%), of which:
  - joint registration/same address: 890;
  - joint registration/different address: 336;
  - sole registrations: 327 (10% of all 'linked' infant deaths).

And with respect to infant deaths for which NS SEC categorisation is possible based on father's occupation:

- routine and manual groups: 1,313 (41% of all 'linked' infant deaths);
- 'other' category: 279 (9% of all 'linked' infant deaths).

Chapter 5:
State of the evidence base

5.1 The aim of the *Programme for Action* is to improve the health of the poorest fastest. This needs robust evidence of effective practice to help highlight what works and to mainstream health inequalities in the delivery of public services. This evidence will also be crucial to the delivery of the 2010 target; and while recognising that a focus on what works and good practice is necessary, it is not sufficient by itself – action will also be needed on the wider determinants that shape life chances and social position.

5.2 The systematic development of effective practice through shared learning also shows to health professionals and other front-line staff how this approach can make a difference in their local areas. Effective practice is also important as part of the communication process of highlighting achievement and recognition of front-line staff and organisations in how they have used their creative talent and energies to make a qualitative difference in the lives of families and communities in deprived neighbourhoods.

5.3 The urgent need to address the issues of what works reflects the poorly developed nature of the evidence base on health inequalities. Evidence on ethnicity, gender, disability and age is sparse. Consequently, the relationships between these factors and health inequalities are poorly understood. This is crucial since targeting sectors of the population is a key characteristic of most effective interventions. There is also a lack of systematically recorded information about the process or 'how it was done'.

5.4 The further development of the evidence base for tackling health inequalities faces a number of specific challenges. The evidence base is very thin generally; a review by the Health Development Agency (HDA) discovered that less than 4% of all public health research is focused on assessments of interventions aimed at tackling health inequalities. Measurement of change and identification of criteria for success also need to be developed to sustain this work and recognise progress. Target setting is an important first step. *National Standards, Local Action* set targets for the NHS. Local PSA targets and the Comprehensive Performance Assessment (CPA) drives local government action.

What works?

5.5 Effective action that can be shown to have a measurable impact on health inequalities is vital and an important stimulus to further work. The Sheffield city-wide initiative for reducing cardiovascular disease showed an important difference in its impact on social groups with the health of the poorest groups improving faster than the city average. This initiative is summarised in Box 8.

Box 8: What works? CIRC – a city-wide initiative for reducing cardiovascular disease

The work of the Sheffield CIRC programme shows how clinical services can help reduce health inequalities and make an impact on the health of disadvantaged people in their area.

The city's response to the *NSF for Coronary Heart Disease* (CHD) highlighted that only 25% of the full secondary prevention needs were being met, and that there were marked inequalities in terms of early deaths and provision of care. In the wake of these findings, the CIRC programme was set up to identify at least 85% of people with symptomatic CHD so as to deliver a comprehensive programme of secondary prevention to 80% of those in practices with above average prevalence and with large numbers of high-risk ethnic minorities.

Targeted resources were directed through PCTs, and CHD teams implemented the programme through five linked action projects:

- development of protocols and learning manuals;
- training and mentoring programmes;
- support resource packaging;
- specific programmes for South Asian ethnic groups;
- patient and user involvement.

The programme has yielded positive results:

- 8,000 people with CHD have been identified (87% of the expected number).
- Prevention has improved in the CIRC target practices, contributing to a reduction in health inequalities.
- Between 2000 and 2002 the most deprived fifth of areas saw a faster decline in heart disease than the city as a whole – mortality declined by 16% overall in Sheffield and by 23% in the deprived areas.

The success of the CIRC programme has resulted in it being mainstreamed into each of the four Sheffield PCTs' CHD programmes. Each PCT has continued to emphasise the main principles from CIRC and has adapted the programme to its individual needs.

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5.6 There is also a need to assess the impact of 'upstream' policy interventions across government so that their success can be monitored systematically. The Wanless review highlighted the importance of such public health research, including economic evaluations of public health interventions to help show what works. In particular, Wanless called for:

- appropriate outcome measurements to demonstrate effectiveness and cost-effectiveness of interventions;
- use of controls to attribute outcome to intervention, if ethically possible;
- use of appropriate timeframes for evaluation of outcomes; and
- consideration of the degree of change to outcomes that would constitute success.

5.7 Examples of good practice that show a quantifiable impact are rare; for most other programmes demonstrating effectiveness is especially challenging. This ability to show an impact will become increasingly important if work addressing health inequalities is to be developed on a suitable scale to contribute to achieving local and national targets. This work is, of course, not just confined to health but reflects action across government to address the wider determinants of health.

5.8 A particular difficulty arises where there is agreement about the need for action but uncertainty about what action should be taken due to a lack of evidence. In such circumstances, there may be a need for piloting, innovation, trial and experimentation to assist learning, as well as for the systematic gathering of all available intelligence. This will help inform action.

5.9 It is important that such an approach is not a barrier to action, or does not cause unnecessary delay. Wanless addressed this issue and made it clear that lack of evidence should not be an excuse for inaction:

> *Given the lack of a solid evidence base for the effectiveness of public health interventions, the pursuit of the ideal should no longer be allowed to be used as an excuse for inaction, rather promising approaches should be piloted with evaluation as a condition for funding.**

Sharing learning

5.10 Learning across boundaries through public health networks, public health observatories, regional public health groups and Local Strategic Partnerships will be crucial if effective interventions are to be developed. The HDA developed a list of the characteristics of effective intervention. These are set out in Box 9 below:

Box 9: Characteristics of effective interventions

- prior local assessment of needs;
- community involvement in needs assessment, target setting, delivery and evaluation;
- multifaceted, intensive and sustained interventions;
- appropriate training and support for those delivering the interventions;
- clear aims to be set out and owned by deliverers and the community receiving support;
- clear mechanisms for organisations to work together;
- intervention programmes evolving in response to experience and changing conditions;
- interventions emphasising continuing, respectful and trusting relationships, and other hard-to-measure attributes;
- political, managerial and institutional commitment;
- supportive performance management and regulatory context;
- feedback that facilitates appropriate organisational development and change;
- a theoretical perspective that is congruent with the form and focus of the intervention.

Source: Health Development Agency

* *Securing Good Health for the Whole Population* (Wanless report), Final Report, 2004

5.11 The Health Development Agency had a key role in identifying what works. Its Evidence Briefings and Evidence Review series summarised review level and other evidence about effectiveness across range of public health topics. This series included papers on the prevention of teenage pregnancy, the prevention of the transmission of HIV and STIs, the prevention of the uptake of smoking and the increase in smoking cessation, the prevention of alcohol and drug misuse, the prevention of low birth weight, the prevention of obesity and overweight, the promotion of breast feeding, social support in pregnancy, the promotion of physical activity, the prevention of accidental injury to children and older adults, suicide prevention in young people, the prevention dividend in cancer and coronary heart disease, and, the life course and health inequalities. Further details of these papers are available from the NICE public health evidence base website http://www.publichealth.nice.org.uk/page.aspx?o=508295

5.12 Following the merger of the Health Development Agency and the National Institute for Clinical Excellence to form the new NICE (the National Institute for Health and Clinical Excellence), the work of building the evidence base about effectiveness will continue as part of the process of developing public health guidance on disease prevention and the promotion of good health with particular reference to reductions in health inequalities.

Box 10: National Institute for Health and Clinical Excellence public health Evidence Base

The Evidence Base is an information resource that was originally developed by the former Health Development Agency to support one of its core functions: 'to build and disseminate the evidence base for public health, focusing on reducing inequalities'.

It consists of a series of briefing papers and reviews of other forms of evidence across a range of topic areas which aim to provide accounts of the state of the evidence in these areas, identify gaps in the research base and make recommendations for future research. These topic-specific briefing documents are called *Evidence Briefing* documents and are based on a collation and synthesis of review-level data. Details of the original systematic reviews, upon which the *Evidence Briefings* draw, and full bibliographical information about primary sources are also available.

http://www.publichealth.nice.org.uk/page.aspx?o=508295

5.13 DH continues to contribute to the evidence base on what works by investing in evaluative research at national and local level. For example, an evaluation of Stop Smoking Services was able to show that these new services were successful in targeting smokers living in the most disadvantaged areas. Work has also been commissioned that will explore how locality-based initiatives, such as New Deal for Communities, might be assessed in terms of their impact on inequalities in health.

Learning lessons regionally and locally

5.14 This report has shown that action against the headline indicators and in other areas, which has been led by other government departments, has been successfully delivered. This includes a reduction in child poverty, led by HM Treasury and DWP; the creation of childcare and Sure Start places, led by DfES and the Sure Start Unit; and the reduction in families in bed and breakfast accommodation, led by ODPM. These successes emphasise the importance and potential of working across the full range of the public sector to co-ordinate and deliver interventions aimed at reducing health inequalities. This is important both regionally and locally.

5.15 Government Offices (GOs) for the Regions have a key role in co-ordinating action across a range of departmental interests, especially given the co-location of Regional Directors of Public Health (RDsPH) in the Government Offices. This action includes promoting social inclusion through public sector modernisation and regeneration, as well as addressing the wider determinants of health inequalities.

5.16 The *Programme for Action* suggested that GO Regional Directors should produce an action plan for tackling health inequalities across the broad range of their activity, advised by RDsPH, and informed by policy developments across the region, but without seeking to impose additional requirements or targets on the NHS. The GO for the East Midlands adopted a corporate approach in developing its action plan.

Box 11: Regional action plan in the East Midlands

The regional action plan provides a focus for Investment for Health, the regional strategy for health improvement and tackling health inequalities which provides a consensus on the key areas for action to reduce health inequalities. The plan makes provision for the GO to:

- develop regional health inequalities data sets to support targeted business planning;
- draw up development plans which will identify how to build the capacity, awareness and skills of GO for the East Midlands teams towards health and tackling health inequalities;
- encourage all teams/directorates to perform an annual self-assessment audit based on the health equity audit tool for PCTs;
- pilot and disseminate the East Midlands integrated tool kit which brings together all current appraisal tools used throughout the region to help planners, project managers, investors and decision-makers assess their contribution to regional priorities and sustainable development;
- target development opportunities at the most deprived communities, with leadership and practical support;
- explore how its activities can be targeted to maximise its influence on the local economy and disadvantaged neighbourhoods in a sustainable way.

5.17 The Healthier Communities Shared Priority Pathfinder Programme, managed jointly by the Local Government Association and DH, involves 12 local authorities undertaking projects helping to develop the evidence base on the most effective and sustainable contributions local government can make to tackling health inequalities. The learning from this programme is available on the Improvement and Development Agency's Healthier Communities website at www.idea-knowledge.gov.uk

5.18 In 2005, four local authorities, Cannock Chase, Gateshead, Manchester and Stockton-on-Tees, were awarded Beacon Council status for Healthier Communities, the first year of this award. Tackling health inequalities was a key theme of the award.

5.19 The Beacon Scheme offers every local authority in England an opportunity to hear positive messages about how some of the country's leading local authorities are succeeding in meeting the latest challenges. Beacon status is not simply an award, but comes with a responsibility on Beacon authorities to share their learning and good practice over a 15-month period. Independent research by Warwick Business School has shown that four out of five authorities that attend a Beacon event go on to instigate improvements to their own services. The four Healthier Communities Beacons launched their dissemination programme in June 2005.

5.20 A great deal of knowledge exists about what works in the experience and knowledge of practitioners and communities who run real projects on the ground. A key challenge is to capture this knowledge. All front-line staff, organisations, communities and individuals have a key role to play in this work.

5.21 Projects such as the Engaging Communities Learning Network provide a conduit for sharing this learning. The Network helps PCTs engage with local people and front-line staff and the results of some of this learning have been recently published in *Stories that can change your life: communities challenging health inequalities* (see www.natpact.nhs.uk). Adopting a systematic approach, the lessons in these stories underline what works and how this can help other needs in the country. They also show how such work can be mainstreamed into wider public services.

Conclusion

5.22 This report has established a baseline against which to

- measure progress of the work to tackle health inequalities;
- identify necessary action to help fulfil the strategy set out in the Programme for Action; and
- meet the 2010 PSA target on reducing the gap in life expectancy and infant mortality.

5.23 It notes that the gap as reflected in the national target continues to widen in line with the existing trend. While this movement is against a background of overall improvements in health, it also underlines the challenge of the target. Stopping health inequalities widening further has always been recognised as the first challenge to be met. The *Programme for Action* was quite clear about the time this would take. No change to the trend was expected in the first years towards the target date. Most of the data in this report does not go beyond 2003 which makes it difficult to identify changes past that point. The report does identify some signs that action on the wider determinants of health is beginning to have an impact. This is likely to feed into the long-term movement of the health inequalities trend.

5.24 The successful delivery of current government commitments is also noted in this report. The work of existing and future programmes together with emerging developments across government, often across a range of PSA targets, reflects the government's determination to build on the strategy set out in the *Programme for Action*, deliver the target, and narrow the health gap on a long-term and sustainable basis. This work is being intensified and developed on a larger scale to help meet the targets and contribute to a long-term and sustainable narrowing of health inequalities.

Annex 1: Explanatory note on measuring health inequalities[1]

Tackling health inequalities can be interpreted in a number of different ways (note that the following discussion relates to tackling inequalities in health, but also applies to inequalities in other areas, eg education). It can mean improving the health of disadvantaged groups (tackling **health disadvantage**), reducing health differences between disadvantaged groups and other groups (tackling **health gaps**), and reducing the gradient in health outcomes across all groups in the population, from the most advantaged to the most disadvantaged (tackling **health gradients**).

Tackling health disadvantage directs attention to the groups and communities who have lost out in the general rise in living standards and life expectancy, and aims to improve the absolute level of health in these groups.

Although tackling health disadvantage will improve the health of the most disadvantaged, it has limitations. Better health for the most disadvantaged can be associated with a widening health gap between them and the rest of the population (if the health of the rest of the population improves at a faster rate), leaving the most disadvantaged slipping further behind the most advantaged groups and the population average. Tackling health gaps overcomes this – here the aim is to improve the health of disadvantaged groups at a faster rate than the rest of the population, so the health gap narrows.

Tackling health disadvantage and health gaps focuses attention on disadvantaged groups which can represent a substantial proportion of the population, for example, the spearhead group represents around 28 per cent of the population. However, the gradient in health outcomes across the whole population means that inequalities in health have a wider impact beyond the most disadvantaged. Intermediate groups between the top and the bottom of the social gradient have better health than the most disadvantaged, but still have poorer health than the most advantaged. Tackling the health gradient addresses the impact of health inequalities across the whole population. Different measures are used to monitor progress in the different aspects of tackling health inequalities, as set out in Table 5.

Table 5: Definition of health inequalities

Aspect of inequality	Measure(s)	Sign of reducing inequality
Absolute disadvantage	• Health outcome indicator value for disadvantaged group	• Indicator value shows improving health outcome against baseline period
Gap	• Difference between health outcome indicator values for disadvantaged group and reference group	• Difference is closer to 0 than in baseline period
	• Ratio of health outcome indicator values for disadvantaged group to reference group	• Ratio is closer to 1 than in baseline period
Gradient	• Change (since baseline period) in health outcome indicator value for each group across the gradient	• Improvement in indicator value increases with each step from most advantaged group to most disadvantaged group

1 Based on *Health inequalities: concepts, frameworks and policy* (HDA Briefing Paper, 2004) by Hilary Graham and Michael P Kelly

For example, there is a gradient in circulatory disease mortality rates (among under-75s) across local authorities grouped by deprivation level, with the most deprived fifth of local authorities having the highest mortality rates.

Between 1995–97 and 2001–03, the mortality rate for the most deprived fifth of local authorities decreased, ie the absolute disadvantage of the most deprived fifth decreased.

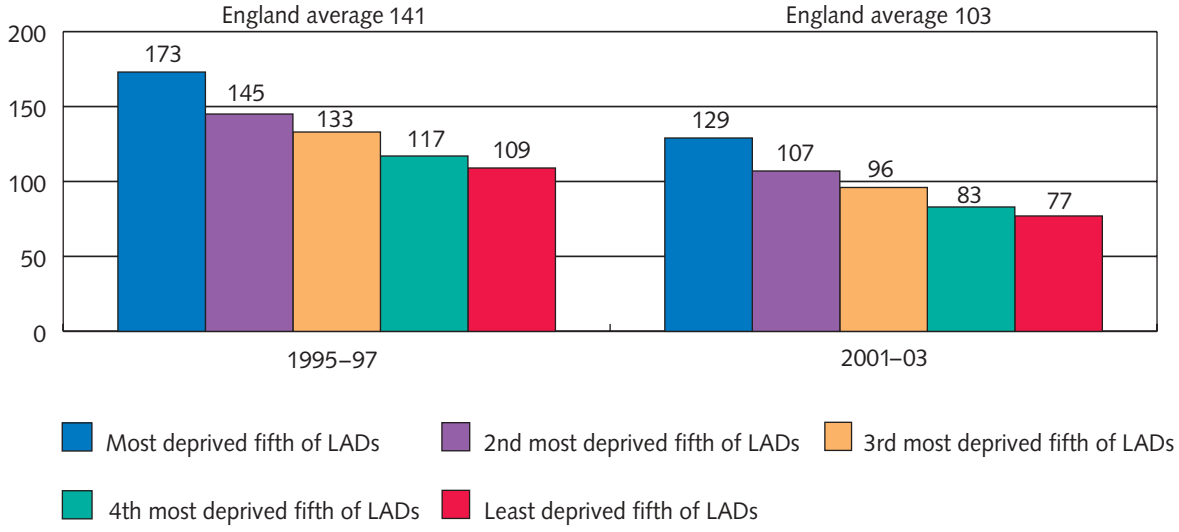
Between 1995–97 and 2001–03, the mortality rate difference between the most deprived fifth of local authorities and the least deprived fifth decreased, ie the absolute health gap (as measured by the difference) decreased. However, the mortality rate ratio increased, so the relative health gap (as measured by the ratio) increased.

The percentage reduction in mortality rate was highest for the least deprived fifth of local authorities, and decreased with each step towards the most deprived fifth, ie the health gradient increased.

Table 6: Age-standardised circulatory disease death rates per 100,000 population aged under 75, by area deprivation

	1995–97 (baseline)	2001–03	% change (2001–03 against baseline)
Most deprived fifth of LADs	**173**	**129**	**-25.4%**
2nd most deprived fifth of LADs	145	107	**-26.3%**
3rd most deprived fifth of LADs	133	96	**-27.8%**
4th most deprived fifth of LADs	117	83	**-28.8%**
Least deprived fifth of LADs	109	77	**-29.0%**
Difference (most deprived fifth minus least deprived fifth)	**63.8**	**51.6**	
Ratio (most deprived fifth to least deprived fifth)	**1.59**	**1.67**	

Figure 29: Age-standardised death rates per 100,000 population for circulatory diseases, ages under 75, by area (deprivation), England



We have focused on monitoring health gaps for the national headline indicators presented in this report.

Annex 2: The 2004 PSA Spending Review targets

This report is primarily concerned with the conclusions of the 2002 Spending Review (SR) designed to support the 2002 PSA targets, which were reflected in the *Programme for Action*.

More recently, the 2004 SR stepped up the emphasis on health inequalities. It reaffirmed the national PSA target on health inequalities for infant mortality and life expectancy:

- *reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth.*

It identified a spearhead group as a focus for action. This group covers the 70 local authority areas with the worst health and deprivation indicators. It also highlighted the relevance of health inequalities in a new health improvement target to 'substantially reduce mortality rates by 2010:

- *from heart disease, stroke and related diseases by at least 40% in people under 75, with at least a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole;*

- *from cancer by at least 20% in people under 75, with a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators and the population as a whole'.*

It reiterated the targets to tackle the underlying determinants of ill health and health inequalities by:

- *reducing adult smoking rates to 21% or less by 2010, with a reduction in prevalence among routine and manual groups to 26% or less;*

- *reducing the under-18 conception rate by 50% by 2010 as part of a broader strategy to improve sexual health;*

and set a new target for:

- *halting the year-on-year rise in obesity among children under 11 by 2010 in the context of a broader strategy to tackle obesity in the population as a whole.*

All three of these targets are characterised by a strong social gradient. The teenage pregnancy and childhood obesity targets are owned jointly with other government departments, DfES and DCMS. Some of the PSAs of other departments also have a strong impact on health inequalities.

Annex 3: Departmental commitments

Twelve government departments signed up to the *Programme for Action* and committed themselves to making progress in key areas that will have an impact on reducing health inequalities. The *Programme for Action* sets out in detail the commitments of government departments from July 2003 to March 2006. From a total of 77 commitments, 11 were scheduled for completion by April 2004. This annex sets out the progress against these commitments.

Theme 1: Supporting families, mothers and children

1. Improve the social and health context of school life by targeting the Healthy Schools programme on the most deprived communities – action: DfES/DH

Commitment achieved

The Healthy Schools programme is targeting schools in the most deprived communities and, to date, over 3,500 schools with more than 20% FSM eligibility have achieved 'healthy school status' (level three). The aim is for all schools that fall within this category (7,500) to reach this standard by 2006, with the rest of schools working to healthy school status by 2009.

2. Expand Sure Start services for children under five and their families; Sure Start local programmes to reach 400,000 children living in disadvantaged areas, including a third of children under four living in poverty – action: DfES/Sure Start Unit

Commitment achieved

The 'offer of services' in this context is about the numbers of children living in the catchment areas for the programmes. Families can use as many or as few services as they wish. Programmes are asked to provide annual data and currently offer services to over 400,000 children.

By December 2003, there were 524 local programmes up and running, aimed at reaching 400,000 children under four and their families, including a third of children under four living in poverty, in disadvantaged areas of the country. The Government's target was 500 programmes by March 2004 so this target has been exceeded.

Many Sure Start local programmes are expected to become children's centres and have already been designated as such. There are currently 280 children's centres (July 2005) with a target of 2,500 to be in place by March 2008 and 3,500 by March 2010. By 2006, 650,000 children living in disadvantaged areas will be reached through children's centres. Some 350,000 of these are children in Sure Start local programmes that will evolve into children's centres; 300,000 will be new children.

3. Establish 45,000 new day-care places through the Neighbourhood Nursery Initiative – action: DfES

Commitment delivered

By the end of March 2004, more than 37,000 new day-care places for children under five in 1,073 neighbourhood nurseries had been created in the most disadvantaged parts of the country. By September 2004, 45,107 day-care places had been created in 1,279 neighbourhood nurseries in disadvantaged areas.

4. Provide free nursery education for all three-year-olds – action: DfES

Commitment achieved

From 1 April 2004, six months ahead of the original commitment date, all three-year-olds whose parents want it are entitled to a free, part-time (two and a half hours per day) nursery education place. Four-year-olds have benefited from a guaranteed free, part-time place entitlement since 1998. Provision is underpinned by a clear statutory framework and a detailed Code of Practice.

Theme 2: Engaging communities and individuals

5. Deliver services for 'hard-to-reach' groups through the 257 healthy living centres clustered round areas of deprivation – action: DH

Commitment achieved

In total, 257 healthy living centre awards (worth £204 million) have been made in England (350 in the UK) through the New Opportunities Fund. Healthy living centres are targeted at the most disadvantaged sections of the population. Together these healthy living centres are delivering services that are accessible to over 40% of the population.

6. Meet the language needs of asylum seekers and refugees through developing an online resource of health information in key languages and a national scoping study on models of providing interpreting services for NHS Direct – action: DH

Commitment achieved

Online resource

A multilingual appointment card has been launched by HARP (Health for Asylum Seekers and Refugees Portal). This online resource translates appointment information into 31 languages and is freely available to NHS staff and other agencies. An online protocol for developing and translating written material has been developed. DH has also made available translated consent forms. In the early months of 2004, the protocol for developing and translating information was piloted. The final version will be launched this summer.

National scoping study

In 2003, DH commissioned Silkap Consultants to conduct research into communication support services. The Silkap Report provides an assessment of different approaches to providing language support for people with a variety of communication needs. The report illustrates current provision as diverse and complex, but with many individual examples of good practice.

NHS Direct has completed a year-long procurement exercise for a national contract for interpretation (including interpretation for British Sign Language). From 1 October 2004, a new telephone and interpreting and translation service has been available to callers through NHS Direct.

7. Ensure no homeless family with children is in bed and breakfast accommodation by March 2004, unless in an emergency and even then for no longer than six weeks – action: ODPM Homelessness and Housing Support Directorate, local authorities

Commitment achieved

A total of 337, or 95% of, local authorities, including all London boroughs, met the bed and breakfast target. This reduction reflects the excellent achievement of local authorities working with ODPM.

Figures show a 99.3% reduction in the number of homeless families with children in bed and breakfast hotels for longer than six weeks over the two years since March 2002 when the target was set.

The Homelessness (Suitability of Accommodation)(England) Order 2003 came into force on 1 April 2004 to reinforce and sustain the bed and breakfast target.

Theme 3: Preventing illness and providing effective treatment and care

8. Increase participation in physical activity through the introduction of local exercise action pilots – action: DH with Sport England, Countryside Agency

Commitment achieved

Ten local exercise action pilots (LEAPs) are under way across England (jointly funded by DH, the Countryside Agency and Sport England). They will test the effectiveness of different PCT-led community approaches to increasing levels of, and access to, physical activity and make a significant contribution to the evidence base of what works. The tender for the LEAP schemes stated that individual pilots should aim to reach a minimum of 50,000 people, covering target groups of around 1,000 people.

9. The development of co-ordinated local action programmes that improve the health and well-being of older people as included in the NSF for Older People – action: DH

Insufficient data to determine progress to date

Routine information is not collected on progress in this area. A recent informal review of actions in a selection of SHAs indicates that plans to promote healthy ageing have been agreed in most areas. In some areas, a strong Healthy Living Strategy has been established, generally through the Local Strategic Partnership, with wide membership and a broad agenda. However, many areas still lack this strategic approach. More detailed information on the state of development will come from the forthcoming Healthcare Commission review of older people's services.

10. Establish 5 A DAY initiatives in the top 20% of most deprived areas – action: DH

Commitment achieved

The top 20% of most deprived PCTs all have PCT-based 5 A DAY community initiatives lasting two years with start dates ranging from late 2002 to late 2003, funded with £10 million from the former New Opportunities Fund (now the Big Lottery Fund) and covering projects such as food co-operatives. These projects and 5 A DAY work in all PCTs are supported by a £1 million a year communication budget targeted at individuals who eat the fewest portions of fruit and vegetables.

11. Promote rehabilitation and supported discharge from hospital with 150,000 additional people receiving intermediate care services – action: DH

Commitment achieved

333,821 people received intermediate care services during 2003/04 – this is an additional 200,000 people receiving such care compared to 1999/2000 and well in excess of the commitment given in *The NHS Plan* (2000).

Annex 4: Absolute and relative inequalities

Overview

This report focuses on monitoring inequalities in terms of the **gap** between disadvantaged groups and a chosen reference group (the least disadvantaged group or the population as a whole). The gap in performance on an indicator between a disadvantaged group and the reference group can be measured in absolute or relative terms. Both the **absolute** and **relative** gaps are important and relevant measures of inequality, and in this report we have used both measures to assess progress against the headline indicators.

The **relative gap** is the ratio of the indicator value in the disadvantaged group to the reference group (an alternative measure of the relative gap is the percentage difference between the two groups). Taking inequalities in health outcomes as an example, the relative gap measures how unequal the health experience between groups is, i.e. how much more likely someone from a disadvantaged group is to experience poor health (eg death from cancer) than, say, the national average.

The **absolute gap** is the difference between the indicator values for the disadvantaged group and the reference group. The absolute gap measures the impact of the unequal health experience in absolute terms, eg how many more cancer deaths (per 100,000 population) occur in the disadvantaged group than the national average as a result of the higher risk in the disadvantaged group.

It is important to consider both absolute and relative measures and to interpret these carefully when assessing the extent of inequality. For example, a large social class gradient in a rare cause of death may be less important in public health terms than a smaller social class gradient in a common cause of death (for which absolute differences between social classes, and so the overall impact of the inequality, are higher).

It is also important to assess trends in both absolute and relative measures of inequality when interpreting changes over time. For example, where indicator values are decreasing in the reference group, it is possible for a narrowing in the absolute gap between disadvantaged groups and the reference group to be accompanied by a static or increasing relative gap. Similarly, where indicator values are increasing in the reference group, it is possible for a narrowing in the relative gap to be accompanied by a static or increasing absolute gap.

For this report, we have presented information in relation to the headline indicators using both absolute and relative measures of inequality. We have used the indicator ratio (rather than the percentage difference) to measure relative inequality.

Table 7: Absolute and relative gap measures: formulae, interpretation and examples

Measure	Indicator difference	Indicator ratio	Percentage difference
Absolute or relative?	Absolute	Relative	Relative
Description	Difference in performance between the disadvantaged and reference groups	Performance in the disadvantaged group as a proportion of performance in the reference group	Difference in performance between the disadvantaged and reference groups as a proportion (measured as %) of performance in the reference group
Formula	$R_A - R_B$	R_A / R_B	$[(R_A - R_B) / R_B] \times 100$
R_A = indicator value for disadvantaged group (group A) R_B = indicator value for reference group (group B)			
Interpretation:			
Values	Greater than 0 if poorer performance corresponds to a higher indicator value (as for mortality rates) Less than 0 if poorer performance corresponds to a lower indicator value (as for educational attainment)	Greater than 1 if poorer performance corresponds to a higher indicator value (as for mortality rates) Less than 1 if poorer performance corresponds to a lower indicator value (as for educational attainment)	Greater than 0 if poorer performance corresponds to a higher indicator value (as for mortality rates) Less than 0 if poorer performance corresponds to a lower indicator value (as for educational attainment)
No inequality	Indicator difference = 0	Indicator ratio = 1	Percentage difference = 0
Size of inequality	Greater distance from 0 (positive or negative) = larger inequality	Greater distance from 1 (above or below 1) = larger inequality	Greater distance from 0 (positive or negative) = larger inequality
Examples:			
1) Suppose the death rate is 120 deaths per 100,000 population in the lowest social class, 80 deaths per 100,000 in the highest social class			
	The death rate difference is 40 deaths per 100,000 ie the death rate in the lowest social class is 40 deaths per 100,000 population greater than the death rate in the highest social class	The death rate ratio is 1.5 ie the death rate in the lowest social class is 1.5 times the death rate in the highest social class	The death rate percentage difference is 50% ie the death rate in the lowest social class is 50% higher than the death rate in the highest social class
2) Suppose the proportion achieving five GCSEs is 30% in the lowest social class, 50% in the highest social class			
	The GCSE attainment difference is -20 percentage points ie GCSE attainment in the lowest social class is 20 percentage points lower than in the highest social class	The GCSE attainment ratio is 0.6 ie GCSE attainment in the lowest social class is 0.6 times attainment in the highest social class	The GCSE attainment percentage difference is -40% ie GCSE attainment in the lowest social class is 40% lower than in the highest social class

Relationship between absolute and relative measures

The two relative gap measures (indicator ratio and percentage difference) are closely related. Since $R_A / R_B - 1 = (R_A - R_B) / R_B$, then

Percentage difference = (Indicator ratio – 1) x 100

For example, if the indicator ratio between groups A and B is 1.3, the percentage difference is 30% (the value for group A is 30% higher than that for group B). If the indicator ratio is 0.7, the percentage difference is -30% (the value for group A is 30% lower than that for group B).

The relative gap measures depend on the absolute gap (indicator difference) divided by the indicator value in the reference group (group B):

Percentage difference = 100 x indicator difference / R_B

Indicator ratio = 1 + indicator difference / R_B

One consequence of this is that a large indicator difference between two groups can occur with a small indicator ratio between the same groups, if the reference group indicator value is large. Similarly, a small indicator difference can occur with a large indicator ratio, if the reference group indicator value is small. So there may be a large inequality measured in absolute terms but a small inequality measured in relative terms, and vice versa.

Another consequence is that if the indicator value for the reference group is decreasing, it is possible for the absolute inequality to narrow over time while the relative inequality remains the same or increases over the same period. Similarly, if the indicator value for the reference group is increasing, it is possible for the relative inequality to narrow over time while the absolute inequality remains the same or increases over the same period (see Figure 30 overleaf).

Figure 30a: Trajectories for maintaining constant absolute and relative inequality between two groups, A and B, when reference group B trajectory is decreasing over time

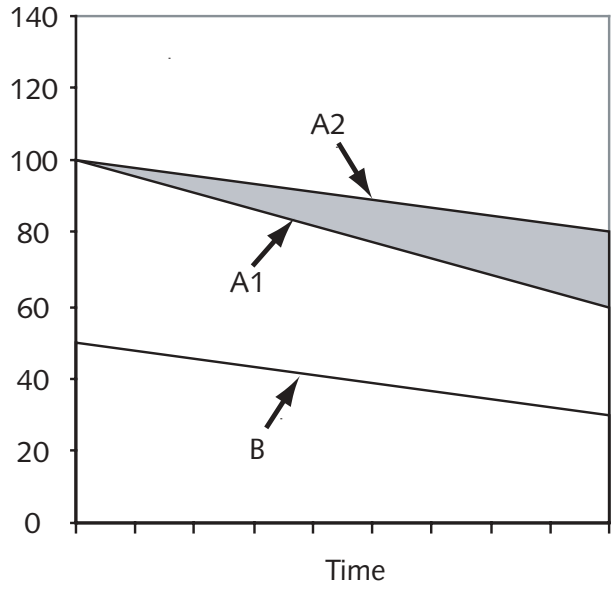
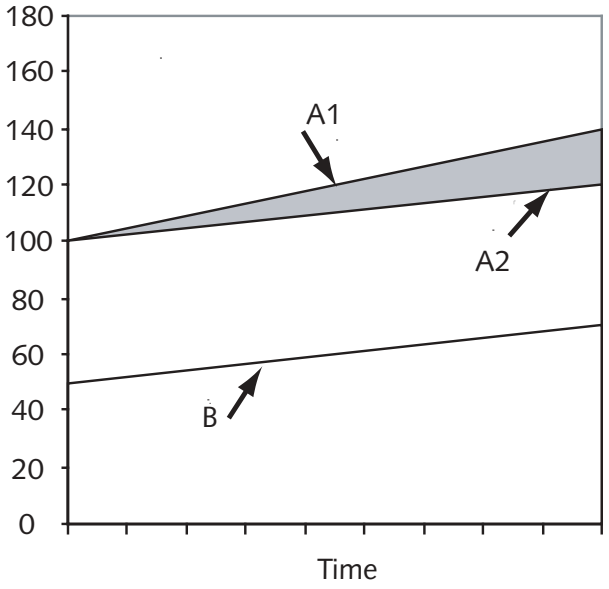


Figure 30b: Trajectories for maintaining constant absolute and relative inequality between two groups, A and B, when reference group B trajectory is increasing over time



KEY:
B = Trajectory of reference group B
A1 = Trajectory that group A must follow to maintain constant relative inequality with group B
A2 = Trajectory that group A must follow to maintain constant absolute inequality with group B

Figure 30a: If group A follows trajectory within shaded area, absolute inequality is narrowing but relative inequality is widening
Figure 30b: If group A follows trajectory within shaded area, relative inequality is narrowing but absolute inequality is widening

Annex 5: Changes in definitions of social class

Old Social Class and new National Statistics Socio-Economic Classification

Box 11

Registrar General's Social Class (based on occupation)

These are valid up to and including 2000.

Class description and examples of occupations:
Non-manual
I – Professional: doctors, chartered accountants, professionally qualified engineers
II – Managerial and technical/intermediate: managers, school teachers, journalists
IIIN – Skilled non-manual: clerks, cashiers, retail staff
Manual
IIIM – Skilled manual: supervisors of manual workers, plumbers, electricians, goods vehicle drivers
IV – Partly skilled: warehousemen, security guards, machine tool operators, care assistants, waiters and waitresses
V – Unskilled: labourers, cleaners and messengers

The Registrar General's Social Class (RGSC) was the principal classification of socio-economic status used in the UK since its first appearance in the Registrar General's Annual Report for 1911. Analysis by RGSC has consistently shown social gradients in health, and particularly in mortality at working ages, infant mortality and birthweight. From 2001, RGSC was replaced by the new National Statistics Socio-Economic Classification (NS SEC) in all official statistics. NS SEC also replaces Socio-Economic Group (SEG) which has also been used in official statistics.

These socio-economic classifications are based on occupation, in combination with employment status and, in some circumstances, size of workplace.

There is no direct mapping between the old and new classifications.

Table 22 illustrates the construction of the various analytical class breakdowns of the new NS SEC. The three-class version is the one used to define the Department of Health PSA target on infant mortality.

When NS SEC was introduced the target was reformulated in terms of 'routine and manual' occupations compared to the national average.

Table 8: NS SEC operational categories and analytical classes

Operational categories	Analytical classes			
	Nine-class version	Eight-class version	Five-class version	Three-class version
1 Employers in large establishments	1.1 Large employers and higher managerial occupations	1 Higher managerial and professional occupations	1 Managerial and professional occupations	1 Managerial and professional occupations
2 Higher managerial occupations				
3 Higher professional occupations	1.2 Higher professional occupations			
4 Lower professional and higher technical occupations	2 Lower managerial and professional occupations	2 Lower managerial and professional occupations		
5 Lower managerial occupations				
6 Higher supervisory occupations				
7 Intermediate occupations	3 Intermediate occupations	3 Intermediate occupations	2 Intermediate occupations	2 Intermediate occupations
8 Employers in small establishments	4 Small employers and own-account workers	4 Small employers and own-account workers	3 Small employers and own-account workers	
9 Own-account workers				
10 Lower supervisory occupations	5 Lower supervisory and technical occupations	5 Lower supervisory and technical occupations	4 Lower supervisory and technical occupations	3 Routine and manual occupations
11 Lower technical occupations				
12 Semi-routine occupations	6 Semi-routine occupations	6 Semi-routine occupations	5 Semi-routine and routine occupations	
13 Routine occupations	7 Routine occupations	7 Routine occupations		
14 Never worked and long-term unemployed	8 Never worked and long-term unemployed	8 Never worked and long-term unemployed	Never worked and long-term unemployed	Never worked and long-term unemployed

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