Health inequalities: A matter of life and death

What causes health inequalities? Have government policies been making them worse or reducing them and how does this impact on peoples' health?

Health inequalities are avoidable differences in health outcomes between different groups such as men and women, different ethnicities, people with different sexual orientations, or people living in different parts of England. These health outcomes may include risk of developing a disease, dying from an illness or disease such as cancer, or how old you are when you die (life expectancy).

Why do health inequalities matter?

England has some of the deepest and most ingrained spatial inequalities in Europe. Life expectancy for a baby boy born in Blackpool (North West of England) is 73.1 years old, compared to a baby boy born in Hart in Hampshire (South East of England) whose life expectancy is 83.4 years old - or 10.3 years longer! Women living in the North of England compared to the rest of England are more likely to have a severe mental health problem and women living in the North East, North West, and Yorkshire and Humber have the highest rates of death from alcohol related causes (Bambra et al. 2024).

As well as North/South inequalities, England also suffers from coastal and inland inequalities. People living in coastal areas in the UK are 11% more likely to suffer from poor mental health or to develop Chronic Pulmonary Obstructive Disease (COPD) then someone living inland (Chief Medical Officer's Annual Report 2021). Health inequalities matter because these differences in health could be avoided.

The Social Determinants of Health

In the UK, we have a national health system (NHS) where all people can access the health care they need, free at the point of use. So, you may be thinking, why do we see such big differences in health outcomes in different parts of the country? A key reason, as research shows, is that between 60-80% of our health is determined by non-medical factors which are called the *Social Determinants of Health (SDOH).*

SDOH are the conditions in which people are born, grow, live, work and age. These are shaped by economic policies and systems, social norms, social policies, and political systems. Examples of the social determinants of health include the welfare/benefit system, types of jobs available, wage rates (e.g. minimum wage legislation), access to affordable and quality housing, access to green space, social inclusion and non-discrimination, access to high-quality education, and access to health care. The effects of health inequalities are multiplied for those having more than one type of disadvantage.

A brief history of health inequalities in the UK

The industrial revolution, which gained momentum at the start of the Victorian era in the 1830s, is considered the baseline or starting point for modern health inequalities. In 1842, a report authored by Edwin Chadwick highlighted social differences in health and death. Overcrowded housing, poor working conditions, and lack of green space led to poor health and disease outbreaks, such as cholera and tuberculosis, which particularly affected large industrial cities such as those in the North, including Manchester, Liverpool, and Newcastle. These poor conditions

and stark health inequalities contributed to the development of the modern welfare state after World War 2.

The welfare state provided a social safety net, including affordable social housing and a minimum income, which resulted in a narrowing of health and income inequalities, peaking in the late 1970s. However, a period of de-industrialisation, beginning in the 1980s, led to rising inequalities, further entrenching the inequalities in Northern cities that stemmed from the Industrial Revolution. De-industrialisation, combined with political choices such as Margaret Thatcher's 'Right to Buy' policy for tenants in council houses, significantly reduced the social housing stock.

Moreover, the privatisation of infrastructure, such as railways and buses, resulted in chronic underinvestment and reductions in routes which negatively impacted on the social determinants of health. These negative impacts on the social determinants of health were worse in Northern towns and cities which were more affected by the closure of important industries for employment such as manufacturing and coal mining than other areas.

Health Inequalities continued to rise throughout the 1980s and 1990s in the UK which coincided with decreasing generosity of welfare benefits and the privatisation of services such as utilities. There was some evidence of a narrowing of health inequalities with the election of the Labour government in 1997. However, the change in government and the consequence of the 2008 financial crisis has led to rising inequalities from 2010 when a Conservative-led government

came to power. These were further worsened by the Covid-19 pandemic and the subsequent cost of living crisis.

Policy impact on health inequalities:

New Labour Government 1997-2010

The 'New' Labour Government elected in 1997 became the first recent European government to develop and implement a strategy explicitly to *reduce* health inequalities. The strategy started with the Acheson Independent Inquiry into Health Inequalities in 1998. The review focussed on three key areas:

1) Policies that were likely to impact on health should be evaluated in terms of their impact on health inequalities
2) High priority should be given to the health of children and families
3) Recommendations were provided to reduce income inequalities and improve living standards of the poor, such as increasing benefit levels for women of reproductive age, expectant mothers, young children and older people.

The Acheson Report influenced the Government White Paper, *Saving Lives 1999* and the associated Action Report on Health Inequalities. The key targets of the Labour government's health inequalities strategy were to: reduce the relative gap in life expectancy at birth between the most deprived local authorities and the English average by 10% by 2010; and cut relative inequalities by occupational class in infant mortality rates by 10%.

To achieve these targets, the Labour government implemented a comprehensive multi-faceted strategy. This included increases in levels of public spending on a

range of social programmes, the introduction of the national minimum wage, area-based interventions such as the Health Action Zones, and a substantial increase in expenditure on the NHS. The latter was targeted at more deprived neighbourhoods when, after 2001, a 'health inequalities weighting' was added to how NHS funds were geographically distributed, so that areas of higher deprivation received more funds per head to reflect higher health need.

There is a growing body of evidence to show that the strategy led to a reduction in health inequalities. Some of our research looking at the impact of the increase in pension income for pensioners via the *Minimum Income Guarantee* (1999-2002), showed that two million pensioners were lifted out of poverty. This policy also improved the mental health of men living in the most deprived areas (Albani et al. 2023). In another study, where we looked at New Labour's health inequality strategy and infant mortality, we found that infant mortality rates declined more quickly in the most deprived areas compared with the rest of England during this time (Robinson et al. 2019). However, there is a lack of evidence on whether the English health inequality strategy influenced *geographical* health inequalities, such as those between the North and South and coastal areas and inland areas.

Austerity Policies (post 2010-2017)

The 2008 financial crisis and a change of government in 2010, led to a change in approach to tackling health inequalities. The focus of this Conservative-Liberal Democrat government was on reducing the national deficit (the amount the government borrowed each year to cover the shortfall in its income), to be

achieved by reducing spending across Government departments. Services for young people have been particularly affected by reductions in funding. Every region of England saw funding cuts for youth services by at least 60%, with some areas such as the North West facing cuts of 74%, the North East 76% and the West Midlands 80%. Sunderland in the North East of England had the largest decrease in funding over this time at 84%.

The public health grant to local government to fund sexual health services, a service where the highest users are those between 16 and 25, was reduced by £1 billion (24%) between 2015/16 to 2020/2. Between 2009-2010 and 2019–20, spending per pupil , including on the day-to-day running of the school and funding for school buildings in England), fell by approximately 9%. Evidence shows that these reductions in funding affected health, particularly for those who were already vulnerable to poor health, leading to increased inequalities.

In our study on infant mortality rates (Robinson et al. 2019), we found that after the decline seen in infant mortality rates during the Labour health inequality strategy period (1999-2010), infant mortality rates began to rise again for those living in the most deprived areas.

In some of our research (Brown et al. 2024) we found that young people aged 16-25 living in parts of the country that had the largest funding cuts such as the North East, faced declines in their mental health compared to the New Labour period (1999-2010) when there had been a focus on reducing health inequalities. Some

of these declines in mental health may have been made worse, for example, because the North East is more reliant on government funding than the South East.

So, how can we reduce health inequalities?

Research tells us that health inequalities have been persistent in some areas compared to others, for example in the North of England, and in coastal areas compared to inland areas. Targeted well-funded approaches with a specific aim of reducing health inequalities may be effective at reducing health inequalities in the short term. However, research shows that once this funding is reduced, health inequalities worsen, particularly for areas that are more reliant on this funding.

There is a growing understanding that if we really want to reduce health inequalities between places and people, we need to think about how we can tackle the root causes of health inequalities. A **place-based approach**, for example, is where communities, the NHS, local government, and charities work together to create places that promote good health in the community, rather than focusing on individual challenges or issues. This approach is widely viewed as the best way to sustainably tackle health inequalities, especially if there is not much funding available.

Place-based approaches focus on planning policies that are responsive to the unique challenges and assets of that place. They rely upon collective control for all of those who may be affected by a policy decision in the community. This means giving residents a stronger voice and more influence in shaping the decisions that are made that affect their everyday lives. By focussing on the unique circumstances

and needs of local communities, place-based approaches aim to tackle the root causes of health inequalities, such as access to green space, employment opportunities and creating lasting change rather than short term fixes.

One example of a place-based approach is from Sport England, who are currently investing £250 million into 90 Place Partnerships. Their aim is to collaborate with local people who live and work in their communities to build a picture of the system from their perspective and reflect on their needs and circumstances to create meaningful change in their communities.

By working *with* communities, rather than *for* them, it is recognised that people are the experts on their own lives. The belief is that when people feel they have a sense of *ownership* of their environment, it can lead to increased social cohesion, a sense of belonging and, consequently, improved health outcomes. The success of place-based approaches relies on investment and the ability to engage across diverse groups in the community. Without this, it risks reinforcing existing health inequalities. Place-based approaches offer a promising alternative to focussing on individuals.

Some conclusions

We have highlighted above some of the factors that contribute to the persistent geographical health inequalities we see in England. We give examples, drawing

from our own research, of how political decisions have influenced underlying trends in health inequalities.

The challenge is how we can try and create places that are resilient to the political winds of the day. Place-based approaches, a form of partnership working bringing together people living in the community with local government, the health and care service, and the voluntary sector may be one approach best able to tackle the root causes of health inequalities.

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Biographical Notes