Royal College of Nursing

Health inequalities and the social determinants of health

Policy Briefing

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Introduction

Health outcomes such as life expectancy continue to improve in the UK[1] thanks to improved social conditions, advancing medical and scientific knowledge, a highly trained professional workforce and massive investment in the healthcare system. However, these improvements mask a widening gap between the health outcomes of the wealthiest and the most deprived communities. A baby born into a home with parents that are well educated and financially prosperous has a better chance of living longer (and without disease and disability) than a baby born to parents who are not. This is, in a large part, because the social and economic inequalities in our society are reflected in, and help to determine, our health outcomes.

Definitions of health inequalities and health inequities

Health *inequalities* are the 'differences in health status or in the distribution of health determinants between different population groups'[2]. Those differences are *inequitable* when they can be determined as being unfair or avoidable.

What are the social determinants of health?

The social determinants of health are the collective set of conditions in which people are born, grow up, live and work. These include housing, education, financial security, and the built environment as well as the health system. The World Health Organisation (WHO) notes that in turn, these conditions are shaped by a powerful over riding set of forces: economics, social policies and politics[3].

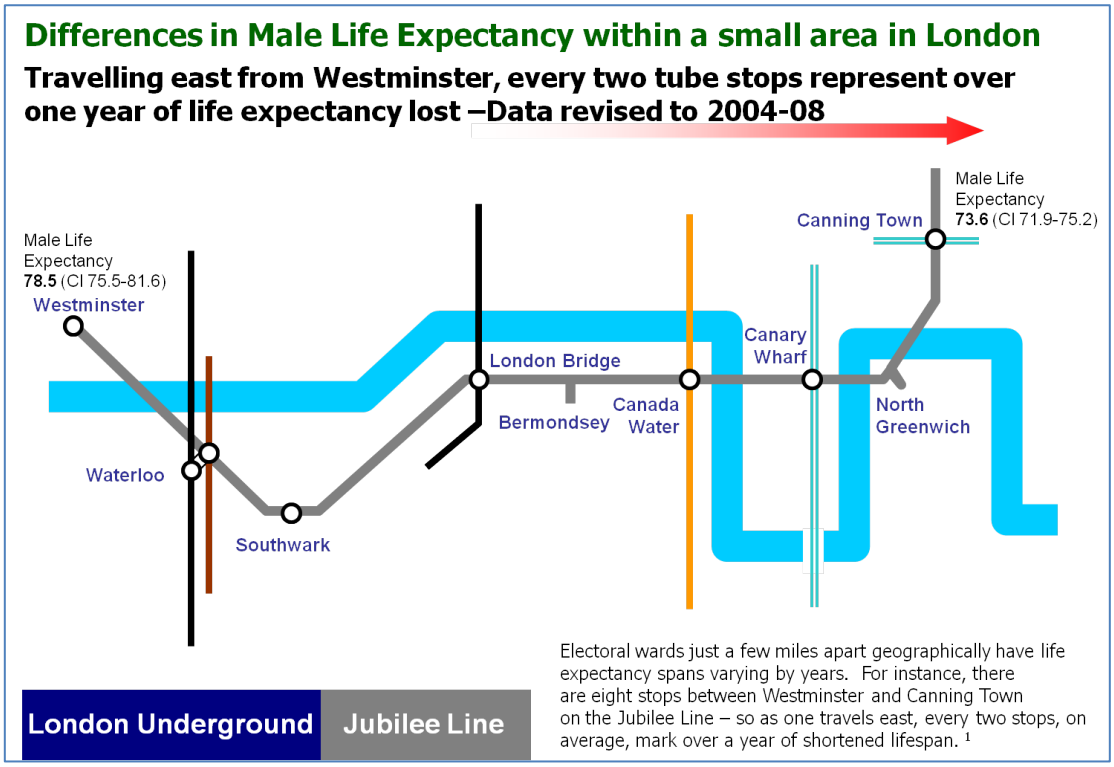
It is now widely accepted that these social determinants are responsible for significant levels of unfair health 'inequities'. So whilst some health inequalities are the result of natural biological differences or free choice, others are beyond the control of individuals or groups and could be avoided.

Illustrative statistics

- In England people living in the poorest areas will die an average of 7 years earlier than those living in the richest areas[4]
- In England, the average difference in disability free life expectancy between the poorest and richest areas is 17 years[5]
- In Scotland men living in the most deprived areas will, on average, die nearly 11 years earlier than those in the least deprived areas.
- There is an 18.5 year difference in the number of years Scottish men will, on average, live in good health between the least and most deprived areas[6].
- Unskilled workers are twice as likely to die from cancer as professionals[7].
- In Northern Ireland, men living in the poorest areas will die an average 8 years earlier than those living in the richest areas[8]

[1] http://www.statistics.gov.uk/cci/nugget.asp?id=168
[2] http://www.who.int/social_determinants/en/
[3] http://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/index.html
[4] Office of National Statistics (2009) *life expectancy at birth*
[5] As above
[6] http://www.isdscotland.org/Health-Topics/Public-Health/Publications/2011-12-20/2011-12-20-HLE-Summary.pdf?53040713072
[7] http://info.cancerresearchuk.org/prod_consump/groups/cr_common/@nre/@pol/documents/generalcontent/crukmig_1000ast-3347.pdf

The diagram below demonstrates how for every two stops travelled east from Westminster on the tube, one year of life expectancy is lost.



Source: Analysis by London Health Observatory of ONS and GLA data for 2004-08. Diagram produced by Department of Health

Evidence on the social determinants of health

In the last thirty years a succession of high profile reports have demonstrated the links between social or 'wider' determinants and health outcomes and inequalities:

- In 1980 an expert committee chaired by Sir Douglas Black determined that the main cause of health inequalities was economic inequality. Fairer re-distribution of resources and action to end child poverty were recommended.

- In 1998 Donald Acheson conducted an inquiry into inequalities in health. The priority recommendations were for all relevant policies to be evaluated for their health inequality impact; giving a high priority to the health of families with children; and taking steps to reduce income inequalities and improve the living standards of poor households[9].

- In 2008 the WHO published the Sir Michael Marmot led Global Commission on the Social Determinants of Health Report[10].

- In 2008 the Scottish Government's ministerial task force into health inequalities published its *Equally Well* report, which included a number of key support papers

[8] http://www.dhsspsni.gov.uk/hscims_life_expectancy_decomposition_2011.pdf
[9] http://www.archive.official-documents.co.uk/document/doh/ih/contents.htm
[10] World Health Organisation (2008) *Closing the gap in a generation: health equity through action on the social determinants of health: final report of the commission on social determinants of health.*

investigating the evidence of links between health inequalities and socio-economic deprivation. This has become the basis of Scottish Government policy in this field.

- Sir Michael Marmot was tasked by the UK government to review the current inequality challenges facing the UK. This report - *Fair Society, Healthy Lives*[11] - was published in early 2010 and received support from across the political spectrum. *Fair Society, Healthy Lives* stressed that tackling health inequalities was a matter of social justice, with real economic benefits and savings, and called for action to tackle the social gradient in health outcomes.

- Also in 2010, the UK Parliament's Committee of Public Accounts[12] confirmed that the gap in life expectancy between people in deprived areas and the general population has continued to widen. The Committee noted that whilst the National Health Service (NHS) in England spends around 4 per cent of its funding on prevention that individual PCTs' spending on prevention is not readily identifiable and that the extent of the NHS' contribution in tackling inequalities is unclear.

Government policy

England

In 1997 the Labour Government put tackling health inequalities at the heart of its health agenda and issued a number of policy documents and related targets. For example in 2004 the Department of Health (DH) set a target to reduce the gap in life expectancy in local authorities with high deprivation and the population as a whole by 10 per cent by 2010[13]. The administration also recognised the importance of improving the life chances of children in order to tackle inequalities – for example the *Every Child Matters* agenda, which included improving economic wellbeing as one of five key goals[14], and a commitment was made to halve child poverty within a decade. Yet despite the good intentions and investment neither target – to reduce the life expectancy gap or to halve child poverty – was met.

The current coalition Government has expressed a commitment to reduce health inequalities and voiced support for the Marmot review. Within public health policy, great emphasis has been placed on finding new ways to change behaviour by encouraging personal responsibility for health, the transfer of responsibility for public health to local authorities, and incentivising positive outcomes (details of which can be found in the public health white paper *Healthy Lives, Healthy People*[15]). Under these plans, direct responsibility for delivering improvements in health inequalities has therefore been placed with Local Authorities and Health and Wellbeing Boards.

Policies set by departments other than the DH also have a significant impact on health outcomes, for example those relating to transport, education, the environment, and economic security.

[11] http://www.marmotreview.org/AssetLibrary/pdfs/Reports/FairSocietyHealthyLivesExecSummary.pdf
[12] http://www.publications.parliament.uk/pa/cm201011/cmselect/cmpubacc/470/47002.htm
[13] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107609
[14] https://www.education.gov.uk/publications/standard/publicationdetail/page1/DfES/1081/2004
[15] http://www.dh.gov.uk/en/Publichealth/Healthylivineshealthypeople/index.htm

Scotland

The National Performance Framework in Scotland has set the reduction of inequality as a core goal for the public sector. Key performance indicators, such as "Increase the proportion of babies with a healthy birth weight" are intended to give practical measures for those areas of improvement deemed most likely to have long-term effect. However, although records are improving, Scotland still has some of the worst life expectancy and healthy life expectancy statistics in western Europe.

In 2008 the Scottish Government published *Equally Well: report of the ministerial task force on health inequalities*[16], which focused largely, but not exclusively, on socio-economic deprivation. In its conclusions it set out 4 priority areas for action to reduce inequality in Scotland: very early years' intervention; mental illness; the "big killer" diseases, and drug alcohol problems, particularly affecting young men. A number of test sites have been piloting new approaches to the reduction of health inequalities. In addition, the Scottish Government has promoted linked activity, such as the development of the "Keep Well" project to deliver targeted health checks in the areas of highest deprivation and increased investment in the Family Nurse Partnership model.

However, Scotland's health inequities remain stubborn. In response, the Chief Medical Officer for Scotland is championing a new way of improving public health - , which he has described as an "asset-based" approach - intended to build community capacity, resources and control to improve health. Linked to this is a significant shift in political support, across all parties, to back increased spending on preventative activity to drive a significant step change in Scotland's poor health record.

Northern Ireland

Reducing the gap in life expectancy between the most and least advantaged remains a key priority for the Northern Ireland Executive and is reflected in its Programme for Government. Investing for Health, Northern Ireland's current public health strategy, is largely built on the concept of the social determinants of health. It embraces a number of approaches to address issues such as smoking, obesity, alcohol and drug misuse, suicide and sexual health. A new public health strategy will be launched in 2012, which is expected to have an emphasis on addressing health inequalities across the whole life course with a clear focus on addressing the social determinants of health. The recent Review of Health and Social Care also identified the need for a renewed focus on public health and social well-being to tackle health inequalities and underpin a refocusing of care provision away from acute setting and towards a greater emphasis on caring for people in their own homes and communities.

Financial security and health in the current economic context

Poverty and low living standards are powerful causes of poor health and health inequalities[17]. The impact of the recent recession is therefore having significant implications for the health status of the less well off in society. Unemployment is high (8.3% of the working population, with youth unemployment alone now over one

[16] http://www.scotland.gov.uk/Topics/Health/health/Inequalities/inequalitiestaskforce/Q/editmode/on/forceupdate/on
[17] http://www.who.int/social_determinants/thecommission/finalreport/en/index.html

million[18]) and earnings and savings are being devalued by high levels of inflation which are pushing up the cost of necessities such as food, fuel and transport.

Evidence shows that the impact of rising inflation is felt disproportionately by people on lower incomes with a recent report from the Institute for Fiscal Studies finding that inflation rates have been particularly high for goods which make up a large proportion of lower income households' spending[19].

The Coalition Government's approach to reducing the national budget deficit and climbing out of recession relies on a combination of public spending cuts, public sector and welfare reform, and the belief that the private sector must stimulate wider economic growth.

For example, around £17billion is being cut from welfare spending[20] and proposals for reforming the system include:

- a new Universal Credit with a benefit cap of £500 a week.
- a cap on housing benefit; pegging tenants to the cheapest third of rents in an area; and cutting housing benefit by 10% a year of unemployment benefits.
- the Disability Living Allowance will become the Personal Independence Payment, with funding cuts of 20% proposed.
- a freeze in child benefit

Given the current levels of unemployment and the reduction in living standards, the welfare system offers an important social protection to many lower income households. Concern has been expressed that the proposals listed above may place already vulnerable groups at risk of worsening poverty and inequalities[21] and that disincentives around the benefit of obtaining work for certain groups (e.g. single parents) will still remain. Food distribution charity FareShare have recently provided an example of the fall in basic living standards being experienced by vulnerable families. A recent report revealed the charity has seen a 20% rise in the demand for its services from families who are unable to regularly feed themselves, and 54% of respondents to a survey revealed they had gone without food for a day or more in the past year[22].

Unintended consequences from ongoing changes to UK benefits policy are also beginning to appear. Significant concerns have been raised about the tensions arising between those policies handled separately in the four countries, such as health and housing, and changes to UK welfare benefits policies that are reserved to Westminster. The Scottish Parliament and Scottish Government, and Northern Ireland Assembly and Executive, for example, have detailed areas of conflict in the potential operation of UK benefits reform in Scotland and Northern Ireland, along with friction in the different devolved political approaches taken to reducing poverty, unemployment and inequality[23].

[18] http://www.ons.gov.uk/ons/rel/lms/labour-market-statistics/december-2011/index.html
[19] http://www.ifs.org.uk/comms/comm119.pdf
[20] http://www.nao.org.uk/publications/1012/reducing_cost_in_the_dwp.aspx
[21] http://www.disabilityalliance.org/whatsnew.htm#campaigns
http://www.housing.org.uk/campaigns/welfare_action_week.aspx
[22] http://www.fareshare.org.uk/wordpress/wp-content/uploads/2011/10/NIS-2011key-findings-01.10.11.pdf
[23] http://www.scottish.parliament.uk/parliamentarybusiness/CurrentCommittees/45099.aspx

Example of health impacts: housing

This section briefly considers the complex associations between housing and health inequalities, as there is longstanding acknowledgement of the connection between bad housing and poor health.

The quality of the housing (e.g. insulated, dry, safe from hazards), the accessibility to local services and amenities, (e.g. transport, work, shops) as well as the security of housing arrangements are all important for good physical and mental well being. Poor quality housing can be the cause of numerous physical and mental health problems which can result in unnecessary hospital admissions, force longer than necessary hospital stays (e.g. if homes are not fit to return to) and ultimately cause death. In recent years a wealth of evidence has been collected to demonstrate specific links between poor housing and a number of mortality and morbidity indicators. Impacts on physical and mental health include:

- Excess Winter Deaths are almost three times higher in the coldest quarter of housing than in the warmest quarter
- Children living in cold homes are more than twice as likely to suffer from a variety of respiratory problems than children living in warm homes.
- One in four adolescents living in cold homes is at risk of multiple mental health problems compared to one in twenty living in warm homes[24].

RCN Position

Nursing and population health

Nursing presence at every stage of the life course means they are engaged across the spectrum of public health interventions; ranging from the 'teachable moments' which occur when a patient requires acute care as a result of alcohol misuse to delivering the Family Nurse Partnership programme. Nurses are able to view individuals' needs and circumstances holistically, to understand the full package of support and care required, often by working closely with other agencies outside the NHS, to help address underlying causes of illness. The RCN has previously set out the aims of nursing services in the delivery of public health[25]. These include to:

- Increase life by influencing healthy behaviours
- Reduce health inequalities – for example targeting vulnerable populations to improve health outcomes and access to services
- Improve population health – for example reducing obesity
- Increase awareness of positive, healthy behaviours in communities
- Promote and develop social capital
- Engage with individuals, families and communities to influence the design and delivery of services

Public health is therefore absolutely the core business of all nurses, but these duties are not performed in a vacuum. Nurses reach deep into the heart of families and communities. They are confronted daily with the consequences of social conditions

[24] Marmot review team for Friends of the Earth (2011) *The health impacts of cold homes and fuel poverty*
[25] http://www.rcn.org.uk/__data/assets/pdf_file/0011/78734/003114.pdf

on the health and well-being of the communities they are caring for. This frequently results in a complex work environment. For example, trying to promote positive physical and mental health where the social and physical environment – anything from high unemployment, a lack of green spaces, or areas which are high in crime - makes this very difficult.

Because nurses witness the impact of social determinants on the health of both patients they are providing care to and the wider population, they have a clear stake in the direct and underlying causes of bad health. Nurses recognise that until the root causes of illness and poor health behaviours are tackled, the NHS will constantly be required to deal with the consequences.

Nurses can influence the health of communities in many ways. They can carry out direct interventions for individuals and families; assess needs and help ensure that the right services are commissioned; make sure vulnerable groups are prioritised; provide leadership; support community empowerment; and advocate for change. In 2002, the RCN published *The Community Approach to improving public health: community development for community nurses*[26], which recognised the importance of working with people to identify and find solutions for issues affecting their community. The community development approach takes a 'broad based positive' view of health, rather than focusing on illness and includes an assessment of the social features which underpin health and well-being including housing, poverty and the ability of local people to influence local decisions. Empowering people to take control of their lives will help people to take control of their health and the nursing presence across communities can support this. For an example of a nurse led project to support community empowerment, see Appendix 1.

Action to improve the social determinants of health

The RCN is committed to diminishing health inequalities and therefore fully endorses the six key policy objectives cited in *Fair Society, Health Lives*, which are:

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention

The current health reforms in England must ensure that local Health and Wellbeing Boards, Clinical Commissioning Groups and Public Health England are held accountable for closing the inequality gap.

Strategies for reducing health inequalities will never be effective if they fail to address the endemic social and economic inequality in the UK. In our response to the public health white paper for England, the RCN called on the Westminster government to recognise the links between low incomes (amongst both the employed and unemployed) and poor physical and mental health. The RCN also signalled concern that proposed welfare reforms such as cuts to housing benefit and incapacity benefit,

[26] http://www.rcn.org.uk/__data/assets/pdf_file/0005/78512/001445.pdf

may be counterproductive for the health and wellbeing of vulnerable members of society who genuinely depend on the welfare system to maintain a minimum standard of life and ensure a minimum standard of health. We agree that helping people enter and stay in work is of critical importance to health and well-being. Substantial investment is required however, as the occupational health services currently available to individuals and employers do not have capacity to provide appropriate support to everyone.

In Scotland the RCN has continued to campaign on the reduction of Scotland's significant health inequalities, including calls for the Scottish Government to audit and report on the socio-economic impact of its budget and spending decisions.[27]

The RCN undertakes a range of activities to tackle health inequalities, ensuring that the nursing voice is heard by responding to government initiatives and helping to shape policy and practice programmes. For example we are supporting the DH's Health Visitors Programme (England) and are engaged in the Scottish Government's Modernising Nursing in the Community board; and have responded to consultations on topics including (but not limited to) Public Health and NHS reform, the Child Poverty Review, and the Disability Living Allowance[28]. In Northern Ireland, the RCN campaigned for measures to promote public health during the 2011 Assembly elections and submitted written evience to the Review of Health and Social Care, calling for the link between social deprivation and health inequality to be addressed, and highlighting the key role of nursing.

The RCN also offers support and guidance to members on issues such as state benefits, ill health and disability, debt advice and housing problems[29].

In April 2011 at RCN Congress, members expressed collective concern about the impact of welfare reform on health and wellbeing. Following a proposal for discussion submitted by the RCN's London Board, members conceded that welfare reform may be necessary but raised a number of concerns about the current proposals – that they would further disadvantage people at the bottom of society; that the deterioration in the health of people whose benefits are cut would increase pressure on acute care services; as well as the impact of cuts to public sector and voluntary organisations which provide essential support[30].

Contact us

The RCN would welcome comments and feedback on this important issue. If you are in England, please contact us at policycontacts@rcn.org.uk. If you are in Scotland, please contact policyscotland@rcn.org.uk. If you are in Northern Ireland please contact John.knape@rcn.org.uk.

[27] http://scottishelections.rcn.org.uk/page/-/uploads/Inequalities1.pdf and http://scottishelections.rcn.org.uk/page/-/uploads/vulnerable_communities.pdf
[28] http://www.rcn.org.uk/support/consultations
[29] http://www.rcn.org.uk/support/services/welfare_rights_and_guidance
[30] http://www.rcn.org.uk/newsevents/congress/congress_2011/congress_2011_agenda/5._proposed_welfare_reforms

Appendix 1

The RCN's UK position on health visiting in the early years (2011)

http://www.rcn.org.uk/__data/assets/pdf_file/0004/391837/004125.pdf

Health visiting on the Beacon Estate in Falmouth, Cornwall during the 1990s

This estate scored highly on deprivation measures in the early 1990s and its people lived in a climate of deep despair. The normal health visiting service could not possibly meet the demands as crime and vandalism were rampant, with far too many child protection registrations and large-scale health problems, such as postnatal depression and asthma.

The two allotted health visitors were certain that the community had the strengths to lead positive change, if given the appropriate support from front line services like the police and the local authority. A residents' association was set up and the authorities promised to listen to the many concerns raised by the residents.

In 1995 the Beacon Community Regeneration Partnership started to tackle the many problems that blighted the estate.

In 1999 an audit revealed dramatic improvements:

- Crime rate down by 50 per cent • 900 properties were installed with central heating
- Unemployment down by 71 per cent
- Postnatal depression down 70 per cent
- Number of children on the child protection register down 60 per cent
- Childhood asthma down 50 per cent
- Education: 10/11 year old boys SATs scores improved 100 per cent, girls 25 per cent.

The Beacon partnership is still going strong and has itself generated over a £1 million for further improvements. Health outcomes continue to improve and in 2004 not one teenager became pregnant.

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