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Dr Janice Thompson

Health Inequalities – Review by Committee for HSSPS

1. Background

On 4 July 2012 the Committee held an evidence session with Public Health Agency on the issue of health inequalities. This revealed that although the general health of the population has been improving, the rate of improvement is not equal across the population and that health outcomes are worse in the most deprived areas of Northern Ireland than in the region generally. There are continuing large differences across various measures, for example – life expectancy, drug and alcohol related mortality, suicide, teenage pregnancy, respiratory and cancer mortality.

At that meeting the Committee agreed to undertake a short review to identify effective interventions to address health inequalities. The findings of the review would then be used to feed into the Department's consultation and continued development of the new DHSSPS 10-Year Public Health Strategy, *Fit and Well: Changing Lives 2012 – 2022*, which was published in August for public consultation until 31 October 2012.

RaISe had previously prepared two papers on the issue of health inequalities (which were included in the Committee pack for the meeting of 12th September 2012), entitled "*Health Inequalities in Northern Ireland*" and "*Health Inequalities in Northern Ireland by Constituency*". These provide useful background on the issue in Northern Ireland.

This paper has been prepared specifically in relation to the Committee's review and is to assist the Committee to identify on which areas of health inequalities it wishes to focus.

2. Introduction to Health Inequalities

The Institute of Public Health in Ireland (IPH) refers to health inequalities as:

Preventable and unjust differences in health status experienced by certain population groups. People in lower socio-economic groups are more likely to experience chronic ill-health and die earlier than those who are more advantaged.¹

The Marmot Review (2010) – *Strategic Review of Health Inequalities In England post-2010* - carried out by Sir Michael Marmot and his team at University College London (UCL), noted that inequalities in health arise because of inequalities in society,

In the conditions in which people are born, grow, live, work and age. So close is the link between particular social and economic features of society and the distribution of health among the population, that the magnitude of health inequalities is a good marker of progress towards creating a fairer society.²

The causes of health inequalities are complex but are strongly driven by the social, economic and environmental conditions in which people live and work. These conditions are known as the **social determinants of health** and are thought to be largely the result of public policy.³

From birth, people are exposed to a wide range of social, economic, psychological and environmental experiences which change as they go through the different stages of life. Each of life's transitions can affect health. However, people who are disadvantaged are at greater risk. Disadvantages tend to congregate among the same people, accumulate through life and can be passed on from generation to generation.⁴

Prior to the Marmot Review the House of Commons Health Committee published its Health Inequalities Inquiry (2009) and found that although the health of all groups in England is improving, over the previous decade the "*health of the rich is improving*

¹ Social Determinants and Health Inequalities, Institute of Public Health in Ireland, www.publichealth.ie/service/social-determinants-health-inequalities

² Fair Society, Healthy Lives, The Marmot Review, Strategic Review of Health Inequalities in England post-2010, Executive Summary, page 10, <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review>

³ Social Determinants and Health Inequalities, Institute of Public Health in Ireland, www.publichealth.ie/service/social-determinants-health-inequalities

⁴ The Annual Report of the Chief Medical Officer for the Northern Ireland 2010, Deprivation and health inequalities, page 5, <http://www.dhsspsni.gov.uk/cmoo-annual-report-2010.pdf>

more quickly than that of the poor".⁵ The Inquiry highlighted several reasons why the poorest in society are less likely to adopt beneficial health behaviours including⁶:

- Lack of information;
- Lack of material resources to live healthily;
- Environments in which they live may make it difficult, for example smoking tends to be more "*heavily entrenched in those from lower socio-economic groups which makes positive change harder*"; and
- More difficult lives including problems such as low income, lack of employment or personal safety concerns – these may mean that changing health behaviour is unlikely to be a major priority.

The Inquiry also highlighted that socioeconomic factors appear to go beyond the "*direct influence socio-economic circumstances may have on lifestyle aspeople from high socioeconomic classes who smoke live longer than those from lower socioeconomic classes who smoke.*"⁷

The Marmot Review highlighted that variation in health status is not only evident at the extreme ends of the socioeconomic spectrum but follows a gradient, with overall health tending to improve with each step up the socioeconomic ladder. The **social gradient of health** runs across society and although the greatest health differences are seen between the most and the least deprived, the gradient exists across the population.⁸

According to the Marmot Review, it is unlikely that that the social gradient in health will be eliminated completely but it should be possible to have a shallower social gradient than at present,

*To reduce the steepness of the gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage....**proportionate universalism**. Greater intensity of action is likely to be needed for those with greater social and economic disadvantage, but focusing solely on the most disadvantaged will not reduce the health gradient, and will only tackle a small part of the problem*⁹

Many of the key health behaviours significant to the development of chronic disease follow the social gradient, for example, smoking, obesity, lack of physical activity, poor nutrition, abuse of drugs and alcohol; along with other factors such as mental illness, low breastfeeding rates and poor oral and sexual health.¹⁰

⁵ House of Commons Health Committee, Health Inequalities, Third Report of Session 2008-09 Volume I, March 2009, page 5

⁶ House of Commons Health Committee, Health Inequalities, Third Report of Session 2008-09 Volume I, March 2009, page 23-24

⁷ House of Commons Health Committee, Health Inequalities, Third Report of Session 2008-09 Volume I, March 2009, page 24

⁸ Fit and Well, Changing Lives – 2012-2022, A 10-Year Public Health Strategic Framework for Northern Ireland, A Consultation Document, DHSSPS, August 2012, paragraph 2.11

⁹ Fair Society, Healthy Lives, The Marmot Review, Strategic Review of Health Inequalities in England post-2010, Executive Summary, page 10

¹⁰ Make Healthier Choices Easier, HSC Public Health Agency, <http://www.publichealth.hscni.net/directorate-public-health/health-and-social-wellbeing-improvement/make-healthier-choices-easier>

In Northern Ireland (NI), the key strategy for tackling health inequalities will now be the new 10-Year cross-departmental public health strategic framework ***Fit and Well: Changing Lives 2012 – 2022*** (August 2012). It is a cross-government, outcome-based strategic framework and takes account of social, economic and legislative changes since the previous 10-year strategy, *Investing for Health*, was published in 2002.

Fit and Well will continue to focus on improving the overall health and well-being of the NI population whilst aiming to reduce evident health inequalities. It will adopt a life-course approach and will focus on those determinants which evidence shows are the most powerful in reducing health inequalities, for example, early years interventions. It takes particular notice of the findings of the Marmot Review.¹¹ The new strategy is further discussed in section 5.

To better monitor health inequalities in NI, the DHSSPS has established the **Health and Social Care Inequalities Monitoring System (HSCIMS)**. Using particular indicators, the HSCIMS produces regular annual updates on the extent of inequality experienced by those living in the 20% most deprived areas and that experienced by those living in rural areas when compared with the regional average. Information from the Fourth Update Bulletin of the HSCIMS is included in section 3 below.

3. Health Inequalities in Northern Ireland

The following information is extracted from the *NI Health and Social Care Inequalities Monitoring System, Fourth Update Bulletin* (June 2012).¹²

Health inequality gaps are the largest between the most and least deprived areas of NI. Although the inequality gaps follow similar trends to those gaps seen between the most deprived areas and NI as a whole, the observed gaps are much larger and males and females in the most deprived areas could expect to live on average, almost 8 years and 5 years less respectively than their counterparts in the least deprived areas in NI.

The largest gaps between the most and least deprived areas of NI occurred in alcohol related hospital admissions (457%), alcohol related mortality (440%), self-harm admissions (368%), hospital admissions for drug related mental health and behavioural disorders (368%), teenage births (341%), drug related mortality (334%), smoking during pregnancy (247%) and suicide (234%).

¹¹ Developing a new Public Health Strategy for Northern Ireland- Update September 2011, <http://www.dhsspsni.gov.uk/newsletter-public-health-strategy.pdf>

¹² DHSSPS, *NI Health and Social Care Inequalities Monitoring System, Fourth Update Bulletin* (June 2012), Executive Summary, http://www.dhsspsni.gov.uk/inequalities_monitoring_update4-2.pdf

The most noticeable improvements in health gaps over time between the most and least deprived areas of NI have occurred for drug related mortality, self-harm admissions, teenage births, smoking during pregnancy and infant mortality.

Some gaps have widened over time, the most evident increases occurred in hospital admissions for drug related mental health and behavioural disorders, alcohol related mortality, suicide and both respiratory and circulatory death rates.

Health outcomes are also generally worse in the most deprived areas in NI when compared with those measured generally in NI overall and large differences continue to exist for a number of different health measures:

- Hospital admissions for drug related mental health and behavioural disorders and drug related mortality showed similar inequality gaps with rates in deprived areas for both more than double the regional figure (138% and 123% higher respectively).
- Alcohol related hospital admissions was 130% higher in the most deprived areas compared to NI overall. The figures for alcohol related mortality were 124% higher; for self-harm admissions, 116% higher and for suicide 82% higher.
- Sizeable gaps also exist for teenage births (93%), smoking during pregnancy (73%) and respiratory mortality (72%).

Comparing the change in health inequalities over time shows that there have been a **number of reductions in inequality gaps over time between the most deprived areas and NI overall**, such as for infant mortality where rates in the most deprived areas reduced relatively from being two-fifths higher to being almost identical to that in the wider region. Other notable improvements occurred in all cancer and lung cancer incidence rates, teenage births, smoking during pregnancy, emergency hospital admission rates and dental registration rates. However the DHSSPS noted that despite these relative improvements, many of these observed health gaps still remain sizeable.

Some gaps increased despite improvements in health outcomes in the most deprived areas as they occurred at a slower pace than in NI overall, for example, in mortality rates for respiratory diseases, circulatory diseases and smoking related causes.

Gaps also widened where health problems grew in deprived areas faster than elsewhere such as in hospital admissions for drug related mental health and behavioural disorders, drug related mortality, suicide and childhood obesity.

Health outcomes are generally better in rural areas when compared with those in the region generally. Males in rural areas could expect to live 1.6 years, and females, 1.7 years on average, longer than their counterparts in NI as a whole.

4. The Marmot Review

In the UK it is the Marmot Review (2010) that has set the direction of travel for tackling health inequalities that require action across all the social determinants of health. It has been described as “*the most comprehensive effort to date to review evidence regarding policies and interventions to address the socio-economic gradient in health*”.¹³ The key messages from this Review are as follows¹⁴:

1. Reducing health inequalities is a matter of fairness and social justice.
2. There is a **social gradient in health** – the lower a person’s social position, the worse his or her health. Action should focus on reducing the gradient in health.
3. **Health inequalities result from social inequalities.** Action on health inequalities requires action across all the social determinants of health.
4. Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. This is called ‘**proportionate universalism**’.
5. Action taken to reduce health inequalities will benefit society in many ways. It will have economic benefits in reducing losses from illness associated with health inequalities. These currently account for productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs.
6. Economic growth is not the most important measure of our country’s success. The fair distribution of health, well-being and sustainability are important social goals. Tackling social inequalities in health and tackling climate change must go together.
7. Reducing health inequalities will require action on six policy objectives: **Give every child the best start in life**; Enable all children, young people and adults to maximise their capabilities and have control over their lives; Create fair employment and good work for all; Ensure healthy standard of living for all; Create and develop healthy and sustainable places and communities; and Strengthen the role and impact of ill-health prevention.
8. Delivering these policy objectives will require action by central and local government, the NHS, the third and private sectors and community groups.
9. Effective local delivery requires effective participatory decision-making at local level. This can only happen by empowering individuals and local communities.

¹³ The Right Start to a Healthy Life, Levelling-up the Health Gradient Among Children, Young People and Families in the European Union – What Works? EuroHealthNet, Edited by I. Stegeman and C Costongs, March 2012, <http://www.sante.public.lu/publications/sante-fil-vie/petite-enfance/right-start-healthy-life-levelling-up-health-gradient-children/right-start-healthy-life-levelling-up-health-gradient-children.pdf>

¹⁴ Extracted from: Fair Society, Healthy Lives, The Marmot Review, Strategic Review of Health Inequalities in England post-2010, Executive Summary, page 9, <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review>

The Marmot Review clearly highlighted that central to the Review was a life course perspective as,

*“disadvantage starts before birth and accumulates throughout life ... Action to reduce health inequalities must start before birth and be followed through the life of the child... For this reason **giving every child the best start in life (Policy Objective A) is our highest priority recommendation**”¹⁵*

The DHSSPS has taken particular note of the findings and recommendations of the Marmot Review in the new proposals for the 10-Year Public Health Strategy, *Fit and Well*, outlined in more detail in the next section.

5. New 10-Year Public Health Strategic Framework for NI, *Fit and Well, Changing Lives – 2012-2022*

Investing for Health (2002) was the Department’s first 10-year cross-cutting public health strategy and contained a framework for action based on partnership working and a number of lifestyle strategies. The key aims were to improve life expectancy across the population and to reduce health inequalities.

The strategy was reviewed in 2009 and whilst progress has been made, challenges relating to health inequalities still remain. There was mixed success in terms of evidence of health improvement outcomes (although this is no different to the experience of the rest of the UK and beyond) but a key area of success is noted as the commitment by local stakeholders to local delivery through cross-sectoral partnerships.¹⁶ The review of *Investing for Health* concluded that there was a need for a new updated strategic direction to build on the previous strategy and *Fit and Well* is that successor and is now published for consultation.

In developing the consultation document, *Fit and Well*, the DHSSPS gave due consideration to the Marmot Review and the prominence it gave to the impact of the determinants of health across the life course and its six cross-cutting policy recommendations (listed above in section 4), with the highest priority being given by Marmot to giving every child the best start in life.¹⁷ The DHSSPS also noted the importance that Marmot placed on tackling the social gradient of health inequalities with ‘**proportionate universalism**’. The DHSSPS also noted that policies to date that have achieved overall improvements in key determinants such as living standards or smoking,

¹⁵ Fair Society, Healthy Lives, The Marmot Review, Strategic Review of Health Inequalities in England post-2010, Executive Summary, page 14, <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review>

¹⁶ Fit and Well, Changing Lives – 2012-2022, A 10-Year Public Health Strategic Framework for Northern Ireland, A Consultation Document, DHSSPS, August 2012, paragraph 1.10

¹⁷ Fit and Well, Changing Lives – 2012-2022, A 10-Year Public Health Strategic Framework for Northern Ireland, A Consultation Document, DHSSPS, August 2012, paragraph 2.10

“have often increased inequalities in these major influences on health. Therefore it is important to distinguish between the overall level and the social distribution of health determinants and interventions.”¹⁸

Chapter 5 of *Fit and Well* describes the ‘whole systems’ approach that the DHSSPS is advocating acknowledging that many of the social determinants of health lie outside the direct influence of the health system. There is a growing recognition across government of the importance of the life course approach and the need for cross-government collaboration, for example, Child Poverty Action Plan and the Children and Young People Strategy.¹⁹

The DHSSPS highlights that the proposed *Fit and Well* framework sets out a wide range of life course and population outcomes, the emphasis is on the most disadvantaged in society and that *“actions must take account of the social gradient and the need for more focused effort or ‘proportionate universalism’ (ie to reduce the gradient there is a need for universal actions, but with additional provision for additional need) to tackle the health inequalities that exist in our society”*.²⁰

To take this direction forward the DHSSPS have proposed two strategic priorities for *Fit and Well*²¹:

1. **Early Years** – there is overwhelming evidence that children’s life chances are heavily based on their development in the first years of life and *“it is vital that children are given the best possible start in life in order to break the cycle of disadvantage that correlates to poor outcomes throughout life and across generations.”* Early years generally refers to programmes and service that intervene and support early in a child’s life (aged between 0 and 5 years of age, including prenatal care).²²

The need for this priority is underlined by the fact that in NI has high levels of child deprivation - 21% of children in NI live in relative income poverty and Sure Start caters for 34,000 children aged 0–4 in particularly disadvantaged areas (almost 30% of the 0–4 population).²³

¹⁸ Fit and Well, Changing Lives – 2012-2022, A 10-Year Public Health Strategic Framework for Northern Ireland, A Consultation Document, DHSSPS, August 2012, paragraph 2.13

¹⁹ Fit and Well, Changing Lives – 2012-2022, A 10-Year Public Health Strategic Framework for Northern Ireland, A Consultation Document, DHSSPS, August 2012, paragraphs 5.1, 5.4, 5.5

²⁰ Fit and Well, Changing Lives – 2012-2022, A 10-Year Public Health Strategic Framework for Northern Ireland, A Consultation Document, DHSSPS, August 2012, paragraph 6.9

²¹ Fit and Well, Changing Lives – 2012-2022, A 10-Year Public Health Strategic Framework for Northern Ireland, A Consultation Document, DHSSPS, August 2012, paragraph 6.9

²² Early years interventions to address health inequalities in London – the economic case, Greater London Authority GLAEconomics, mayor of London, January 2011, Executive Summary, page 5
<http://www.london.gov.uk/sites/default/files/Early%20Years%20report%20OPT.pdf>

²³ Fit and Well, Changing Lives – 2012-2022, A 10-Year Public Health Strategic Framework for Northern Ireland, A Consultation Document, DHSSPS, August 2012, paragraph 7.1

It has been commented that improving the health outcomes for children and young people can only be achieved by enhancing the quality of their environments, particularly their family environments and the communities in which they live.²⁴

2. **Supporting Vulnerable People and Communities** – the DHSSPS proposes more focus to reduce the health inequalities experienced by vulnerable people within NI including - vulnerable children who experience learning or physical disabilities, neglect and other adverse social and environmental factors; people with disabilities; travellers; migrant populations; the homeless; prisoners; refugees; immigrants; and people living in areas of deprivation.

The DHSSPS considers these two broad areas as priorities as they are “*reflective of demographic trends and the evidence base in relation to addressing health inequalities*”.²⁵

As already discussed in section 4, the Marmot Review also considered that the highest priority should be “*giving every child the best start in life*”.²⁶

6. Taking Forward the Committee Review

The HSSPS Committee wish to undertake a short review to identify effective interventions to address health inequalities. The findings of the review would then be used to feed into the Department’s consultation and continued development of the new 10-Year Public Health Strategy, *Fit and Well*. To take this forward the Committee may wish to focus its review on a specific area, for example either a relevant key policy area highlighted by the Marmot Review, where giving every child the best start in life is the highest priority recommendation, or focus on an area of priority for the DHSSPS from *Fit and Well* where the two key priorities are also the Early Years and Supporting Vulnerable People and Communities.

It is beyond the scope of this paper to look into a full range of examples of good practice in all the specific areas highlighted above. However, to further assist the Committee’s consideration it may be useful to consider the recommendations of the recent review carried out on the social determinants of health for the World Health Organisation (WHO) led by Michael Marmot of the Institute of Health Equity, University College London, “*the results of the review are clear: with the right choice of policies, progress can be made across all countries, including those with low incomes*”.²⁷ The

²⁴ The Right Start to a Healthy Life, Levelling-up the Health Gradient Among Children, Young People and Families in the European Union – What Works? EuroHealthNet, Edited by I. Stegeman and C Costongs, March 2012, <http://www.sante.public.lu/publications/sante-fil-vie/petite-enfance/right-start-healthy-life-levelling-up-health-gradient-children/right-start-healthy-life-levelling-up-health-gradient-children.pdf>

²⁵ Fit and Well, Changing Lives – 2012-2022, A 10-Year Public Health Strategic Framework for Northern Ireland, A Consultation Document, DHSSPS, August 2012, paragraph 6.10

²⁶ Fit and Well, Changing Lives – 2012-2022, A 10-Year Public Health Strategic Framework for Northern Ireland, A Consultation Document, DHSSPS, August 2012, paragraph 2.10

²⁷ Report on social determinants of health and the health divide in the WHO European Region (September 2012), WHO, Regional Office for Europe, Executive Summary, page 1,

final review report was presented to the 62nd Session of the WHO Regional Committee for Europe (10-13 September 2012). This WHO EU Review highlighted the highest priorities for action to be²⁸:

- **The Life Course** – within the life course the highest priority is for countries to ensure a good start to life for every child (as highlighted by the Marmot Review for England and the DHSSPS *Fit for Life* document);
- **Wider Society** – actions that create or reassert societal cohesion and mutual responsibility;
- **Macro-level context** – the wider influences that shape lives, health and rights, including the priority to address the health effects of the current economic crisis; and
- **Systems** – refocusing delivery systems to whole of government and whole of society approaches which requires greater coherence of action across all sectors, (the whole systems approach is advocated in the DHSSPS *Fit and Well* document).

The Review team of this WHO EU Review has been contacted by RaISe to source further detail for the Committee on good practice in tackling health inequalities referred to for various EU countries (including evidence from Denmark, Norway, Poland, Slovenia, Spain, Sweden and others) with regard to both action at a national level and other evidence at a subnational level including the WHO European Healthy Cities Network.²⁹

In the UK there is much work on going to tackle health inequalities, including the work of the Public Health Agency in NI, particularly in connection with interventions in the early years, which was highlighted in a previous RaISe paper (in Committee pack for meeting of 12th September), entitled *Health Inequalities in Northern Ireland* (NIAR 308-12, May 2012).

As one of the key policy areas highlighted by Marmot and by the DHSSPS is a focus on giving every child the best start in life, so as an example of possible directions that could be considered in that area, this paper takes an initial look at some research work that has been published in this area in the EU, Scotland and London.

Tackling the Gradient (2009-2012) was a collaborative EU research project involving 12 institutions from nine countries³⁰ in Europe. The Gradient project had the overall

http://www.euro.who.int/_data/assets/pdf_file/0004/171337/RC62BD05-Executive-summary-Report-on-social-determinants-of-health-and-the-health-divide-in-the-WHO-European-Region.pdf

²⁸ Report on social determinants of health and the health divide in the WHO European Region (September 2012), WHO, Regional Office for Europe, Executive Summary, pages 5-6,

http://www.euro.who.int/_data/assets/pdf_file/0004/171337/RC62BD05-Executive-summary-Report-on-social-determinants-of-health-and-the-health-divide-in-the-WHO-European-Region.pdf

²⁹ <http://www.euro.who.int/en/what-we-do/health-topics/environment-and-health/urban-health/activities/healthy-cities/who-european-healthy-cities-network>

³⁰ Belgium, Czech Republic, Germany, Iceland, Norway, Spain, Slovenia, Sweden and UK,

goal of identifying what measures could be taken to level-up the socio-economic gradients in health among children and young people in the EU.³¹

The project discovered that a critical step in levelling-up the health gradient is to look at policies through a “Gradient Evaluation Lens” and the project developed such a tool which highlights key factors that policy makers and practitioners must consider to ensure measures are ‘gradient friendly’.

Another Gradient outcome is insight into the fact that community social capital matters to the health of children and young people and that this was a previously understudied area.

Gradient outcomes also support the premise that the nature of welfare state matters and countries that invest most in family friendly policies have more level socio-economic gradients. The project highlighted that the evidence base of what works to level-up the health gradient in children “*is thin*”, examples of policies and interventions cited include:

- Social protection policies – linked to the need to improve living standards and conditions - including active labour market interventions, social assistance through child benefits, income supports, scale and quality of early childcare services and the education system generally. These are all areas where governments can take measures to ensure greater equity among children. The project highlighted that social systems must place strong emphasis on family policies that support parent’s capacity to care for their children (“*income and job security are, for example, a precondition of positive parenting*”);
- Policies that encourage maternal employment – it is mostly well-educated mothers in high socioeconomic groups that are in paid employment, “*any active labour market policy to enhance maternal employment must be paired with provision of high quality day-care centres, with subsidised fees based on ability to pay*”;
- Educational interventions – there is a strong correlation between educational status and health status. Equity issues in schools manifest in early school leaving and gaps in outcomes. The project cites Dutch and Swedish policy to tackle truancy and early school leaving;
- Health policies and interventions – several health interventions were identified in the seven EU member states that took part in this part of the Gradient project that directly contributed to levelling-up the health gradient (although the project acknowledged that the evidence was not strong) – including a preventative dental care project in all kindergarten and schools in Germany; A French Mother and Child Protection Programme and an obesity prevention study in North Western Germany.

³¹ Tackling the Gradient: Applying Public Health Policies to Effectively Reduce Health Inequalities amongst Families and Children, Drivers for Health Equity, EuroHealthNet, <http://health-gradient.eu/other-research/gradient/>

In 2010, **the Scottish Government** published *Growing up in Scotland: Health inequalities in the early years*. The analysis by the Scottish Centre for Social Research³² looked at a wide range of outcome measures such as birth weight, experience of long-term health problems, accidents and wider developmental problems. It also looked at risk factors such as maternal smoking, diet and physical activity levels.

Among the findings were that inequalities in exposure to risk factors were generally larger than was evident for the outcomes, however within the outcomes looked at – behavioural, psychosocial and linguistic problems showed much starker inequalities than physical ones such as poor general health.

The work reinforced the evidence that there are strong associations between child outcomes and maternal health and behaviours such as smoking, disability and parenting ability. How disadvantaged children avoided negative outcomes in some cases through ‘resilience’ was also investigated, for example social support and neighbourhoods provided an important source of resilience. Other factors within households also were associated with avoiding negative outcomes, despite disadvantage, including consumption of fruit and vegetables and higher levels of physical activity.

Overall the analysis concluded that although the focus on early years was important, policy making needs to be “*alive to the fact that tackling health inequalities in children also requires action to address the health inequalities experienced by their parents and wider families*”.

In **London**, the case for improving health inequalities across the social gradient is highlighted by data showing that a greater proportion of people in London live in deprived areas and the health of children is generally worse compared to the rest of England. The Mayor of London’s Health Inequalities Strategy sets out “*an ambitious and long-term commitment to promote effective parenting, early years development and readiness for learning...and to promote evidence-based programmes in family support early interventions and mainstream delivery in London*”.

As part of this strategy, Greater London Authority (GLA) Economics have developed an economic case for early years interventions in London. The GLA believe that the evidence shows that “*well designed and implemented early years programmes can have significant benefits in terms of life-long health, educational attainment, social, emotional and economic wellbeing and reduced involvement in crime that far outweigh their costs*”.³³

³² Growing up in Scotland: Health inequalities in the early years, Scottish Government, 2010, <http://www.scotland.gov.uk/Publications/2010/04/26103009/0>

³³ Early Years Interventions to address Health Inequalities in London - the Economics Case, GLAEconomics, January 2011, <http://www.london.gov.uk/sites/default/files/Early%20Years%20report%20OPT.pdf>

GLA Economics highlight that the most robust evidence of costs and benefits of early years programmes comes from the US and show that some home visiting programmes and pre-school programmes are particularly effective, especially for disadvantaged groups.³⁴ These include the Nurse Family Partnership (a voluntary preventative programme for teenage mothers), which is being already being tested in certain places across England, Scotland and NI, and was referred to in the previous RaISe paper *Health Inequalities in Northern Ireland* (NIAR 308-12, May 2012).

³⁴ Early Years Interventions to address Health Inequalities in London - the Economics Case, GLAEconomics, January 2011, <http://www.london.gov.uk/sites/default/files/Early%20Years%20report%20OPT.pdf>