



Chapter 1

Introduction

1.1 The central themes for the Review

1.1.1 Health inequalities are a matter of social justice

Inequalities are a matter of life and death, of health and sickness, of well-being and misery. The fact that in England today people from different socio-economic groups experience avoidable differences in health, well-being and length of life is, quite simply, unfair and unacceptable. The aim of this Review is to assemble the evidence to show how to put them right.

The healthiest people in England now enjoy remarkably good health. For example, in the wealthiest part of London, one ward in Kensington and Chelsea, a man now has a life expectancy of 88 years. But the contrast is stark. A few kilometres away in Tottenham Green, one of the capital's poorer wards, male life expectancy is 71. Similar differences are seen all over the country, for both men and women.

There will always be inequalities in society. However, the scale of these dramatic health inequalities, which are still a dominant feature of health in England, are not inevitable and can be prevented.

Globally, concern with inequalities in health is commonly focused on the health of the poorest. In low-income countries, high levels of infant mortality result from material deprivation: lack of access to food, clean water, sanitation and shelter. Such absolute poverty is now rare in this country. Yet we still have large inequalities in health. In the poorest neighbourhoods of England, life expectancy is 67, similar to the national average in Egypt or Thailand, and lower than the average in Ecuador, China and Belize, all countries that have a lower Gross Domestic Product and do not have a national health service.²⁶ The diseases that contribute to dramatically shortened lives and worse health of those in disadvantage in England are not those associated with absolute destitution. They are heart disease, cancers, diseases related to drugs, alcohol, smoking, poor nutrition and obesity, accidental and violent deaths and mental illness.

1.1.2 There is a social gradient in health and health inequalities

Not only are there dramatic differences between the best-off and worst-off in England, but the relationship between social circumstances and health is also a graded one: the higher a person's social position, the better his or her health is. Figure 1.1 illustrates the relationship between the gradient in neighbourhood income and life expectancy. In England, people

living in the poorest neighbourhoods will, on average, die seven years earlier than people living in the richest (the top curve in Figure 1.1). Even more disturbingly, there is a greater variation in the length of time people can expect to live in good health (their health expectancy). For example, the average difference in disability-free life expectancy is 17 years (the bottom curve in Figure 1.1). In other words, people in poorer areas not only die sooner, but spend more of their shorter lives with a disability. To illustrate the importance of the gradient, even excluding the poorest five per cent and the richest five per cent, the gap in life expectancy between low and high income is six years, and in disability-free life expectancy 13 years.

Such systematic differences in health do not arise by chance, and they cannot be attributed simply to genetic makeup, 'bad' behaviour, or difficulties in access to medical care, important as these factors may be. Social and economic differences in health status reflect, and are caused by, social and economic inequalities in society. The Commission on Social Determinants of Health (CSDH), set up by the World Health Organisation, concluded that social inequalities in health arise because of inequalities in the conditions of daily life – the conditions in which people are born, grow, live, work and age – and the fundamental drivers that give rise to them: inequities in power, money and resources.²⁷

1.1.3 Addressing health inequalities is a matter of fairness

The starting point for this Review is that health inequalities that are preventable by reasonable means are unfair. Putting them right is a matter of social justice. A debate about how to close the health gap has to be a debate about what sort of society people want to live in.

Most people in this country have a strong sense of fairness and most deem the inequalities in society that give rise to health inequalities as unfair. In the 2009 British Social Attitudes Survey, more than 90 per cent of respondents agreed with the proposition that 'in a fair society every person should have an equal opportunity'.²⁸ The public also thinks that differences in income in Britain are too large. Surveys have shown that the majority of people estimate that the chair of a large company earns 15 times as much as an unskilled factory worker (a gross underestimate of the actual differential), but thought that the ratio should be six times. This publicly acceptable difference in earnings between top and bottom earners has changed little in two decades: it was five times in 1987, and six times in 1999.

As this Review makes clear, we do not think inequalities in income are the sole reason for inequalities in health. But inequalities in income are linked to inequalities in life chances in a number of salient ways. As the economist Amartya Sen argues, income inequalities affect the lives people are able to lead. It is not just what you have but what you can do with what you have that is important. A fair society would give people more equal freedom to lead flourishing lives. The central ambition of this Review is to create the conditions for people to take control over their own lives. If the conditions of daily life are favourable, and more equitably distributed, then they will have more control over their lives in ways that will influence their and their families' health and health behaviours.

1.1.4 The economic context

We are aware that we are reporting into an adverse economic climate. Inevitably, the question will be raised: can our recommendations be afforded? Our case for action is principally a moral one. The fact that people on low incomes lose 17 years of disability-free life because they live in worse conditions than people on high incomes is reason enough to act. However, it would be naive to fail to recognise the challenges of the current economic environment.

The benefits of reducing health inequalities are economic as well as social. The cost of health inequalities can be measured in both human terms – lost years of life and active life, and in economic terms – the cost to the economy of additional illness.

This is discussed in more detail in Chapter 2 and on the Marmot Review website (www.ucl.ac.uk/gheg/marmotreview).

If everyone in England had the same death rates as the most advantaged, a total of between 1.3 and 2.5 million extra years of life would be enjoyed by those dying prematurely each year as a result of health inequalities.²⁹ They would, in addition, have had a further 2.8 million years free of limiting illness or disability.³⁰ The estimated costs of these illnesses accounts, per year, for productivity losses of £31–33 billion³¹ and lost taxes and higher welfare payments in the range of £20–32 billion.³² The additional NHS healthcare costs in England are well in excess of £5.5 billion.³³

As further illustration, we have drawn on Figure 1.1 a line at 68 years – the pensionable age to which England is moving. With the levels of disability shown, more than three-quarters of the population do not have disability-free life expectancy as long as 68. If society wishes to have a healthy population, working until 68 years, it is essential to take action to both raise the general level of health and flatten the social gradient.

Figure 1.1 Life expectancy and disability-free life expectancy (DFLE) at birth, persons by neighbourhood income level, England, 1999–2003



1.1.5 Tackling health inequalities involves tackling social inequalities

In recent years, understanding about the social determinants of ill health, or the causes of the causes of ill health, has deepened (see discussion in Chapter 2).³⁵ There is clear evidence that:

- The conditions in which people are born, grow, live, work, and age are responsible for health inequalities.
- Early childhood, in particular, impacts on health and disadvantage throughout life.
- The cumulative effects of hazards and disadvantage through life produce a finely graded social patterning of disease and ill health.
- Negative health outcomes are linked to the stress people experience and the levels of control people have over their lives and this stress and control is socially graded.
- Mental well-being has a profound role in shaping physical health and contributing to life chances, as well as being important to individuals and as a societal measure.

As the CSDH report showed, the distribution of health and well-being needs to be understood in relation to a range of factors that interact in complex ways. These factors include: material circumstances, for example whether you live in a decent house with enough money to live healthily; social cohesion, for example whether you live in a safe neighbourhood without fear of crime; psychosocial factors, for example whether you have good support from family and friends; behaviours, for example whether you smoke, eat healthily or take exercise; and biological factors, for example whether you have a history of particular illnesses in your family. In turn, these factors are influenced by social position, itself shaped by education, occupation, income, gender, ethnicity and race. All these influences are affected by the socio-political and cultural and social context in which they sit.³⁶

As shown in Chapter 2, there are persistent inequalities across many of these key determinants of health. It is therefore not a mystery why, despite significant overall improvements in health, there continue to be health inequalities. Efforts to reduce health inequalities must address the wider social and economic determinants of health – inequalities in society – and how these play out in the quality of early years experiences, of education, economic status, employment and quality of work, of housing and environment and effective systems for preventing ill health. Chapter 4 of this report outlines our recommendations for reducing inequalities in these social determinants of health.

Social inequalities exist across a wide range of domains: age, gender, race, ethnicity, religion, language, physical and mental health and sexual orientation. There are also some groups in society who are particularly disadvantaged: for example people who are homeless, refugees and asylum seekers, including those who receive no financial support and for whom absolute poverty remains a

reality. These inequalities interact in complex ways with socioeconomic position in shaping people's health status. For instance, people with physical and learning disabilities are more likely to suffer discrimination, poor access to some health services and worse employment prospects as a result of their disabilities, all of which impact negatively on their health.

While worse health outcomes for some ethnic groups are associated with their socioeconomic status, for others outcomes are worse than would be expected from their economic status.³⁷ There are also systematic gender differences in health outcomes. Many of the consultation responses submitted to the Review documented particular exposures and discriminatory practices that compound existing socioeconomic disadvantage.³⁸ Some of the evidence of these inequalities and their consequences are given in Chapter 2. For specific groups who face particular disadvantage and exclusion, additional efforts and investments and diversified provisions will be needed to reach them and to try to reduce the multiple disadvantages they experience.

1.1.6 Tackling health inequalities means tackling climate change

There is a close relationship between the challenges of climate change and the challenges of health inequalities: not least because both impact most on the poor and disadvantaged. Both health inequalities and the negative impacts of climate change give extra urgency to putting sustainable development at the heart of creating a fairer society. Just as steps necessary for sustainable development must take health inequalities into account, so recommendations that we make must be put into the context of sustainable development.

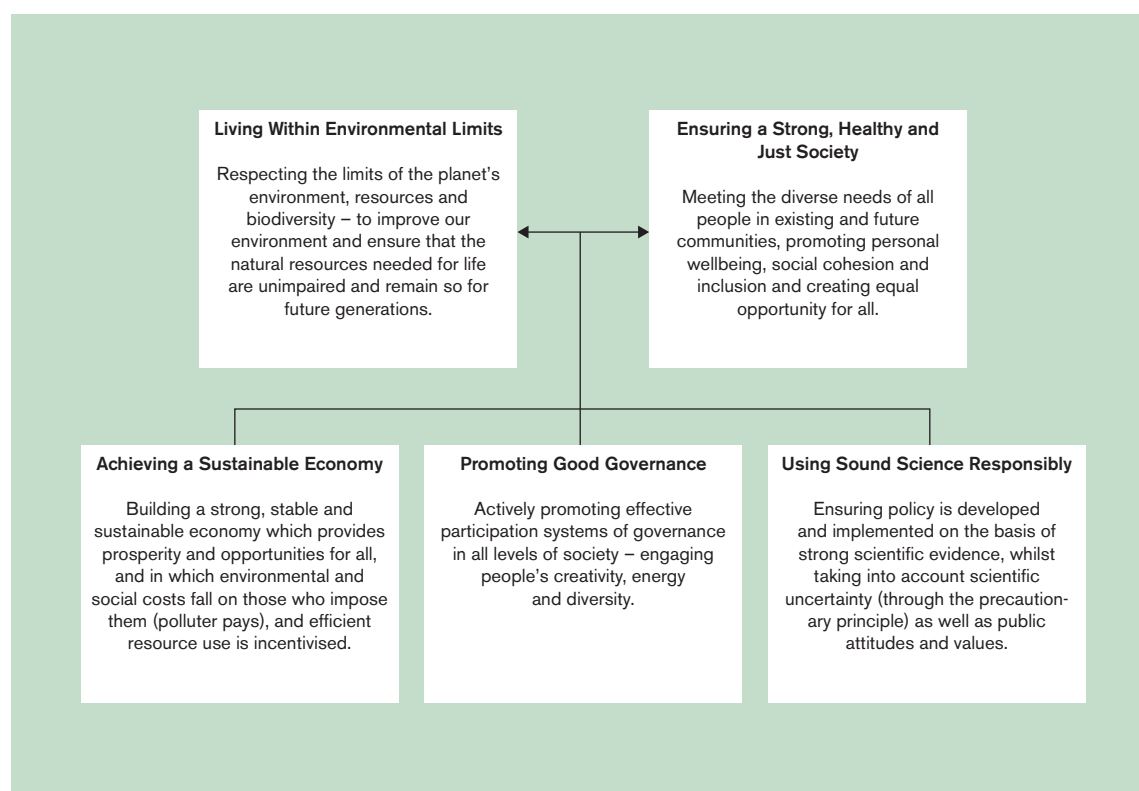
Our recommendations address the need for a sustainable economy, food system, transport systems, and use of green spaces. Many measures to address climate change also bring health benefits such as more active travel (for instance walking and cycling), which, in addition to reducing carbon emissions, also increases physical activity, and reduces air pollution and traffic accidents. These complementary recommendations are described in more detail in Chapter 4. Figure 1.2 depicts the guiding principles for sustainable development, which are reflected in the Review's conceptual framework, Figure 1.3.

1.2 Conceptual framework and action on the social determinants of health inequalities

1.2.1 A framework for the Review's recommendations

The CSDH developed a conceptual framework that showed how the causes of health inequalities operate at the societal as well as the individual level. In translating the CSDH framework and recommendations to England, we convened nine task groups, to cover these societal causes – the main social determinants – of health inequalities. The task groups began with the CSDH report and then reviewed the evidence

Figure 1.2 Guiding principles for sustainable development



Source: Department for Environment, Food and Rural Affairs for National Statistics⁴⁰

relevant to a high income country, such as England and other parts of the UK, about what could be done to take action on the social determinants of health. Based on these reports and a wide range of discussions and consultations, our framework for action was developed, as shown in Figure 1.3.

The framework sets out the overall aim of the Review – to reduce health inequalities and improve health and well being for all. To achieve this we have two overarching policy goals:

- 1 Create an enabling society that maximises individual and community potential.
- 2 Ensure social justice, health and sustainability are at the heart of all policy-making.

These two goals are the central principles which, the Review advocates, should guide policy interventions and approaches to reduce health inequalities throughout the life course and across the social gradient. Beneath the two policy goals are six policy objectives, relating to the main social determinants of health, outlined in more detail in Chapter 4. Underpinning these is the need for equality and effectiveness to be embedded in all policies and the development of delivery systems to deliver the policies and interventions advocated here (described in Chapter 5).

1.2.2 Policy objectives and the life course

The recommendations of the Review are set out in Chapter 4 under the six policy objectives as outlined in the framework above. These recommendations also need to be viewed in the context of a life course approach, Figures 1.4. A life course approach is needed because:

- 1 Individual development takes place from birth to death.
- Social and biological influences on development start at conception, or earlier, in terms of genetic effects.³⁹ These accumulate through pregnancy to influence the health of the child at birth. From the time of birth, the individual is exposed to a wide range of experiences – social, economic, psychological and environmental – and these change as they progress through the different stages of life – pre-school, school, employment/training, family-building and retirement.
- It is the accumulation of these influences, their effects and the interactions that ‘cast a long shadow’ over subsequent social development, behaviour, health and well-being of the individual. These effects may be either protective – increasing esteem, life skills, resilience and resistance to ill health and encouraging ‘healthy behaviours’ – or hazardous – destroying self-regard, undermining social skills and the ability to learn and creating the conditions for mental and physical ill health.

- 2 The logic that underpins the proposals in this report is to take action across each stage of the life course, as depicted in Figure 1.5, with two related purposes:
 - To affect the ways in which socially determined influences impact on the individual, with the aim of accentuating the positive effects and minimising negative effects. Some actions and factors (those affecting early years, work and employment) will be focused on specific stages of the life course. Others (skills development) will span several and others still (community, place and standard of living) will impact in different ways, but at every stage of life.
 - To prevent the risks to health that have already accumulated over previous stages of the life course. This is in recognition of the need to improve the health and well-being of existing generations, including the oldest, who have a lifetime of accumulated experience and risks to health.

1.2.3 Policy objectives and the social gradient

The social gradient in health has profound implications for understanding causes of inequalities but it also implies the need for different approaches to address them. As Figure 1.1 illustrates, everyone beneath the very best-off experiences some effect of health inequalities. If the focus were only on those most in need and social action were successful in

improving their plight, what about those just above the bottom or at the median, who have worse health than those above them? All must be included in actions to create a fairer society.

Many of the social policies implemented to address inequalities over recent years have been targeted at the most disadvantaged groups or areas. In our recommendations we propose actions of sufficient scale and intensity to be universal but also proportionately targeted to reduce the steepness of the gradient. We call this *proportionate universalism*.

The ambition of this Review is to take a new approach and reduce the gradient in health inequalities. Figure 1.6 depicts different steepness of gradients for life expectancy in two different regions of England. Flattening the gradient is the ambition of proportionate universalism and of the recommended policies that we outline in Chapters 4 and 5.

1.2.4 Health and well-being

The focus of much work on health inequalities in England, in particular the current Public Service Agreement (PSA) target, has been on inequalities in mortality. However, measures of mortality focus policy too narrowly on increased treatment of the disease-related causes of death, such as the late consequences of hypertension, at the expense of more upstream interventions that would prevent the onset of medical problems. They capture inequalities in life-threatening ill health, but not necessarily in the experience of good health and well-being across life.⁴¹

Figure 1.3 The conceptual framework

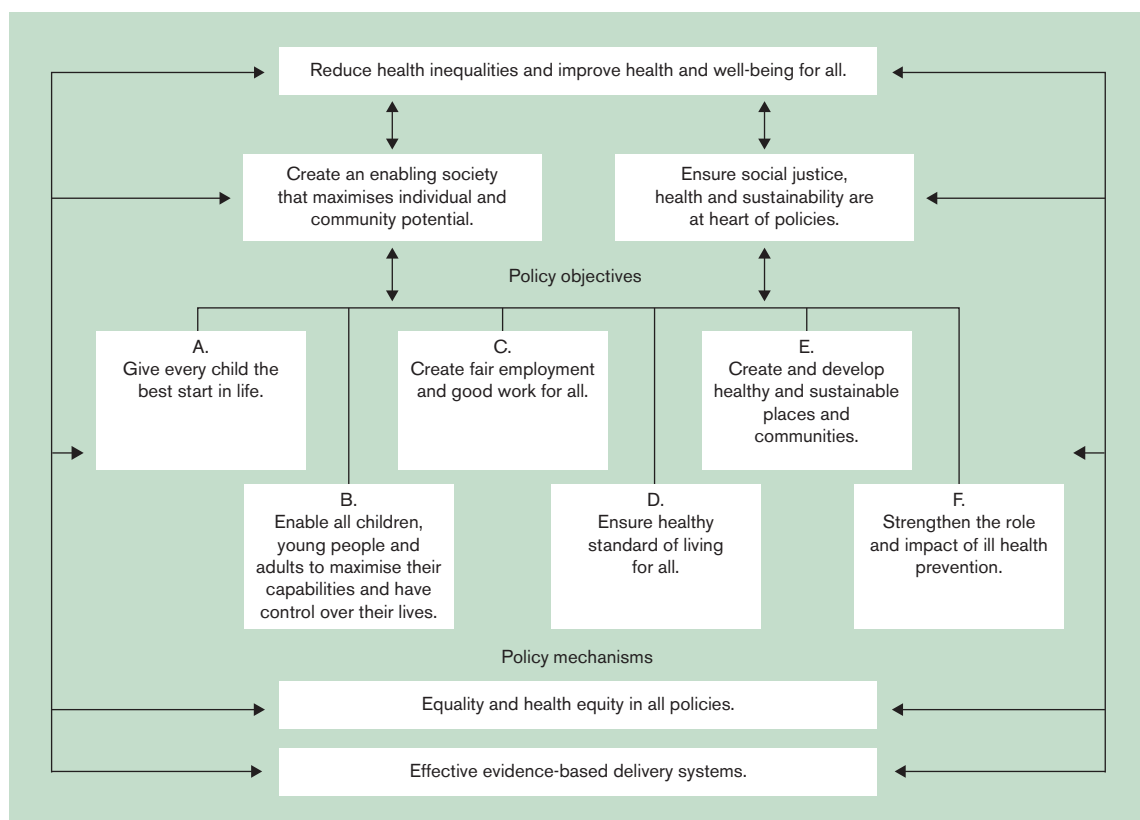


Figure 1.4 Stages of the life course and the accumulation of effects

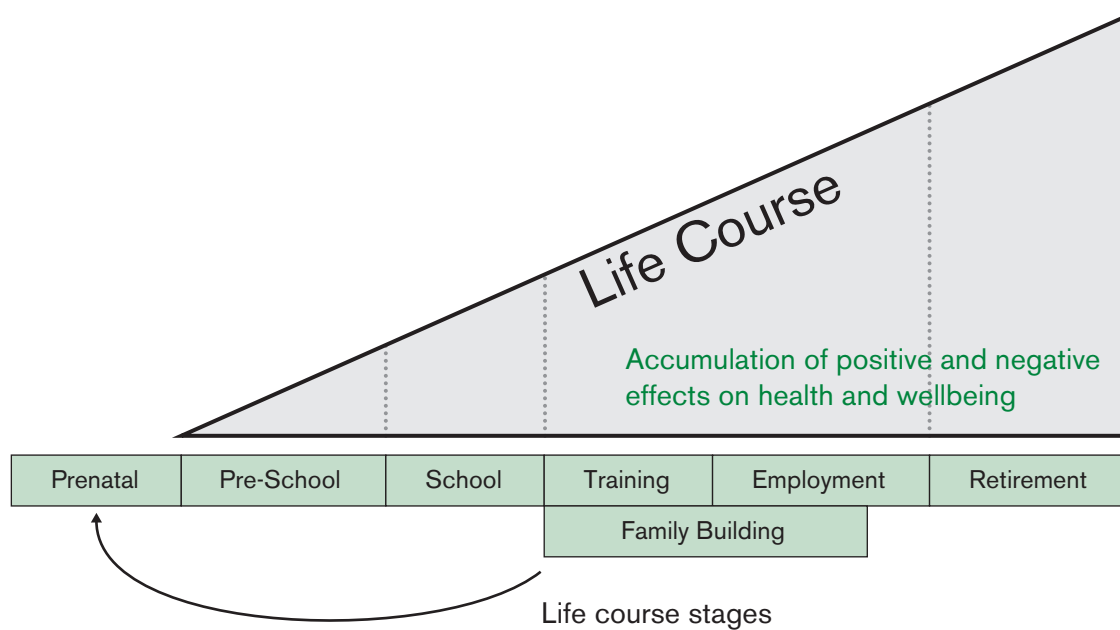
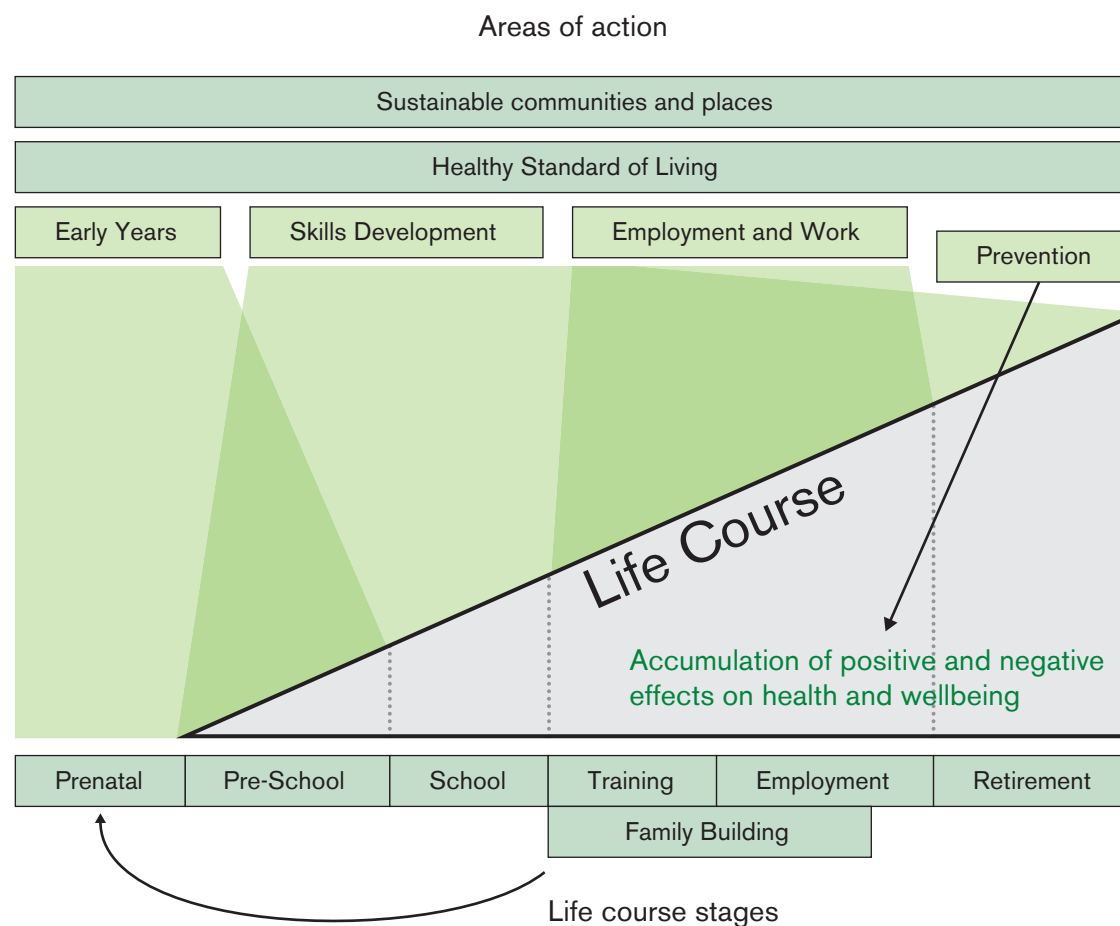


Figure 1.5 Actions across the life course



Physical and mental health are important indicators of well-being but there are other measures and part of our aim is to promote and sustain fair distribution of well-being as well as health. Our concern with health and well-being as ‘outcomes’ relates to a broader movement to evaluate societal performance using a richer array of measures than simply Gross Domestic Product. The Commission on the Measurement of Economic Performance and Social Progress, set up by President Sarkozy and chaired by Joseph Stiglitz, emphasised the need to measure social progress in other than narrow economic terms and to focus on well-being as a measure of social progress.⁴² In Chapter 5 we explore how new measures of well-being and adding years to life could galvanise action to reduce health inequalities.

1.2.5 Summary

It is sometimes difficult for many people to accept that serious and persistent health inequalities exist in England. We have a highly valued National Health Service and the overall health of the population has improved greatly over the past 50 years. Dramatic health inequalities are still a dominant feature of health in England. Chapter 2 describes in detail some of these inequalities in health and the inequalities in life chances that give rise to them.

All the major political parties express concern over health inequalities and the need to create a fairer society. The present government, in power for 12 years, has done much in the name of social justice

and there are few areas of social policy that have not been affected by concern to improve social justice and equity. While it is clear that progress has been made, the results have not met the level of ambition. This is partly due to powerful counteracting social and economic forces. But the nature, sustainability and intensity of policies pursued have also played their part. In Chapter 3, we outline lessons to be learned from recent health inequalities strategies, from the types of policies and interventions pursued, from how those policies have been developed, and how they have been delivered and measured. The recommendations in Chapters 4 and 5 attempt to learn from these lessons and advocate a new practical and conceptual approach to reducing health inequalities.

The economic, as well as the health and well-being of today’s children depends on us having the courage and imagination to rise to the challenge to do things differently, to put sustainability and well-being alongside economic growth and bring about a more equal and fair society.

Figure 1.6 Age standardised mortality rates by socioeconomic classification (NS-SEC) in the North East and South West regions, men aged 25–64, 2001–2003

