

Health inequalities in Northern

It is possible to improve public health and reduce the gap between rich and poor but we are clearly not doing enough to tackle the underlying causes, argues *Jane Wilde*, director of the Institute of Public Health. The Programme for Government needs to be toughened across all sectors to tackle the causes of poverty and ill-health and we need to focus on social development as well as economic growth.

The latest figures from the DHSSPS on health inequalities give us a chance to reassess thinking. As Paul McGill explains on pages 14-15 there are improvements in some areas but the gap between rich and poor and the consequent loss of life and health is a cause for serious concern. There is little point in having the data and saying we have a problem if we fail to do all we can to try and change things for the better.

Our first challenge is to convince a very wide range of stakeholders that change for the better can happen. Health inequalities vary over time and between societies. International data show rapid improvements in some countries and lack of improvement in others. It is clear that changes in the social and economic environment alongside public health action can do much to improve things. For example the gap in life expectancy between the bottom and top social groups in England and Wales grew from 5.5 years to 9.5 years in the two decades to the mid-1990s and then started to narrow.)

To make progress we need to understand the causes of health inequalities. The circumstances in which we live and work are of fundamental importance to our health. These circumstances are sometimes termed the social determinants of health and include income, housing, education, employment, transport and so on.

Researchers are coming up with new understanding of how social determinants affect health and particularly how they cause inequalities in health. It is the unfair and systematic distribution of these determinants that is causing persistent and profound differences in health. In other words the causes of health inequalities are inequalities in the social and economic determinants of health.

In a recent seminar arranged by Belfast Healthy Cities, Northern Ireland's chief medical officer, Michael McBride, highlighted the ways in which social circumstances have such a profound effect on health. Scotland's CMO, Harry Burns, told a compelling story of research linking the long term stress associated with deprivation with diseases such as heart disease and diabetes. We are beginning to see clearer evidence of how social circumstances affect disease mechanisms and this is important because it points to the actions and policy choices which are likely to be most effective.

A balanced Programme for Government?

There is a general political desire to improve health and well-being in Northern Ireland. So how does the draft Programme for Government shape up?

Evidence shows that we are clearly not doing enough to tackle health inequalities and the underlying problems of poverty. We need to make the case much more strongly to politicians and policy makers that a successful modern society is one which puts an emphasis on equitable social, environmental and health development.

There seems to be a view that policy is a zero sum game and that we have to choose between a focus on economic growth or social development. This is patently not true. Of course economic development is important but it is a means to an end rather than an end in itself. As many leading international economists have said, economic growth alone will not bring improvements in health and education. We need policies across all sectors that are health and equity oriented.

This includes action on eradicating fuel poverty, improving social housing, protecting and promoting a sustainable environment

There is a widespread assumption that efforts to improve health will automatically reduce health inequalities. This is not the case. Improving health is not the same as reducing health inequalities. In fact if living standards continue to rise, effective policies will have to meet two criteria; improvements in health available to all AND a rate of improvement that increases all the way down the social ladder.

Opportunity in whose lifetime?

The publication of the anti-poverty strategy Lifetime Opportunities was welcome but in the absence of the long awaited action plan and no dedicated budget it seems as though this has fallen off the ladder.

World Development Reports have consistently shown that poverty is about opportunity, empowerment and dignity. People feel poor if they can't do the things that are reasonable to expect in a society. Both poverty and inequality are strongly linked to poor health. As well as reducing absolute levels of poverty Lifetime Opportunities appeared to recognise that poverty is about more than money. The lack of action and apparent lack of commitment to this policy is deeply disappointing and will hamper any effort to reduce health inequalities.

Perhaps the most important area in which we can act to reduce inequalities is improving the life chances and opportunities of children. Evidence suggests so. This makes the recent rise in the level of child poverty all the more disturbing. The current inquiry into child poverty is a chance to

Ireland: are we failing?

make sure that politicians and policy makers know that there is wide support to end the appalling level of child poverty.

Shockingly, a recent Unicef report which assembled 40 indicators of child wellbeing in rich countries concluded that children in Britain and the US fared less well than the other 21 countries studied. Close analysis of this data (Pickett and Wilkinson 2007) shows that measures of child wellbeing are related to income inequality. What makes a difference to the wellbeing of children seems to depend more on reducing levels of inequality and reducing relative poverty than concentrating on further economic growth

Investing for health

The cross cutting public health strategy Investing for Health (IfH) will be reviewed in 2008. This is an important opportunity to raise the bar and show that we are seriously committed to improving public health in Northern Ireland. We will not do so without radical action to tackle inequalities. Whatever plans are made for this review we need to make sure that there is active involvement in decisions by communities and groups whose health and lives are most affected.

Fragmented and short-term approaches are ineffective and IfH needs to be more strongly linked to primary care. There is no question that the provision of comprehensive primary care is a key part of any successful effort to improve health. The worry is that financial pressure will lead to damaging cuts in planned expenditure on preventive services. We need to hold on to the principle of universal access to high quality care.

The recent Northern Ireland data show disturbingly poor levels of mental health among unskilled workers. We need to challenge the myth of the highly stressed wealthy executive. In fact it is far more stressful to be in a low paid job or to be out of work and to experience the loss of control and autonomy this brings. Calls for better support and funding for mental health services are welcome and need to be tailored to ensure equity and to take into account the important impact on prevention and treatment of social circumstances.

We need to acknowledge local successes and the many organisations and initiatives which have tried to develop new ways of working, but must also recognise that setting up structures and partnerships is not enough without clearly articulated policies and their full implementation. We need a co-ordinated and comprehensive countrywide response.

Information matters

Much of the debate about health inequalities is vague. Too often we aren't clear about which inequality we are trying to change. Different dimensions of inequalities eg age, gender, socio-economic, disability need different responses.

We also need more research. The emphasis in much health



Dr Jane Wilde at last year's Action for Equity conference organised by the Institute of Public Health, with Dermot Ahern, Irish Foreign Minister, Paul Goggins, then Minister of Health in Northern Ireland and Owen Metcalfe, IPH

research is on biological mechanisms. Vital as this is, we also need to research the social mechanisms that affect these biological processes. Investing in one without the other simply does not make sense. We need more multidisciplinary research, clearer reviews and dissemination of what works and better measures of both health and inequality

As Paul McGill has shown we need to examine the data carefully. Looking at area data is one thing, we also need to look at socio-economic groups. And there is a clear need to think about data and research on other forms of inequalities such as age, gender, ethnicity and disability. We need to look at absolute improvements or lack of improvement as well as summary figures. Not taking a wide and careful view means we can often miss the point.

Perhaps it would be clearer if rather than talking about reducing health inequalities we called for action to level up. We are fortunate in Northern Ireland to have systems that allow national data to be disaggregated by social group.

Health in an unequal society

Health inequalities are inhumane. In the end we all die but we should be indignant that those who are most disadvantaged are dying unnecessarily. The standards of health enjoyed by the best off should be attainable to all. And that is why I believe we must try to convince everyone in society that reducing health inequalities should be at the top of the agenda.

The driving force for action to level up health is social justice. Evidence and calls for action are not enough. We need political will and commitment for change – cross party support for health equity.

Huge social class gap continues

THERE HAS BEEN a modest improvement in some aspects of health for people in deprived areas in recent years but they still fall far behind the Northern Ireland average. In a few aspects of health the gap has grown even wider. *Paul McGill* has been poring over a new set of statistics.

Although the Department of Health, Social Services and Public Safety aims to reduce health inequalities and has had strategies to meet this aim for more than a decade, the latest figures show it has had very little success.

Detailed comparisons are made in *Health and Social Care Inequalities Monitoring System: Second Update Bulletin 2007*, issued recently by the Department to build on a huge statistical bulletin published early in 2004.

In addition SCOPE has obtained statistics showing some indicators of health by social class groupings; these too show that there is hardly any change in the general picture – middle class people have much better health and life expectancy than working class people.

Statistics in the official bulletin use 'deprived' to mean the worst 20% of super output areas as defined by the Northern Ireland Statistics and Research Agency (NISRA). These areas are compared with the Northern Ireland average or with the 80% 'non-disadvantaged areas. If the one-fifth of deprived areas were matched instead against the 20% best off areas, the contrast would be more striking still.

Figures about areas are inevitably rough and ready since they do not define the people inside those areas. We know that most people in deprived areas are themselves deprived but not all of them are; some better off people also live there. Likewise many disadvantaged people live in better-off areas. So we don't have any definitive information about the health of the most deprived people.

This is where figures about socio-economic groups are better, since people are assigned to the appropriate group on the basis of their own characteristics.

Despite this reservation, there is a consistent pattern under which people in deprived areas have worse physical and mental health than people in better-off areas on almost every indicator – and the picture has not changed much in the last decade despite government's best efforts.

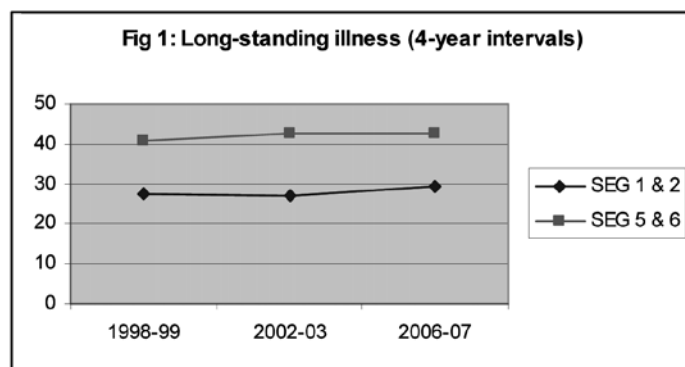
DHSS targets

This can be seen in two key DHSS targets. It aims to halve the life expectancy gap between the 20% most deprived areas and the NI average in the period 2000-2010 for both men and women. However its update to the official statistics show that the gap for men has gone down from 3.9 years to 3.8 years and for women from 2.7 years to 2.5 years between 2001 and 2006. A dramatic shift will be needed in the next four years to meet the target; at the present rate of progress it will take 70 years for men.

DHSS also aims to reduce the gap in long-standing illness between the two highest socio-economic groups (professionals, employers and managers) and the two lowest (semi-skilled and unskilled manual workers) by one fifth in

the same period. In this case some progress has been made but the extent of ill-health has increased across the board in the last eight years – hardly what DHSS wanted. As Figure 1 shows, the extent of ill-health among manual workers has increased slightly over the last few years but the health of professional workers has got worse at an even faster rate.

The government and any others concerned with health will clearly have to work very hard to reverse the trend and it seems clear that any substantial improvement for manual workers will require radical new policies.

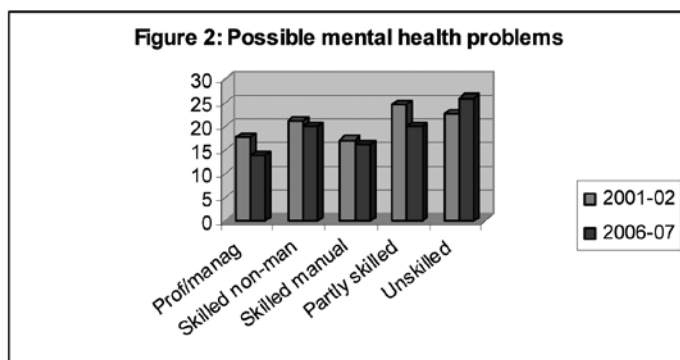


Mental health

Much greater emphasis has been placed in recent years on mental health since there is evidence that its extent has not been properly recognised. It is clear from Figure 2 that mental health problems are much more likely to face semi-skilled and unskilled manual workers than others groups.

Having said that, the risk of mental health problems among semi-skilled workers has decreased in recent years but that among unskilled workers has gone up by more than three percentage points. The other three groups have also shown an improvement, especially professionals and managers, whose risk of mental health has fallen by more than three percentage points.

In short, this means that the gap between the highest and lowest social group has widened alarmingly. Whereas five years ago unskilled workers were five percentage points worse



Note: this refers to four or more items in a selection of 12 indicators.

in health in Northern Ireland

off than professional workers on mental health measures, they are now 12 points behind – 26% as opposed to 14%.

Self-harm and suicide

The most alarming gap between the 20% most deprived areas and the rest of Northern Ireland lies in the admission rates for self-harm. Girls in disadvantaged areas are nearly two and a half times more likely to be taken to hospital for self-harm than girls elsewhere; boys are three times more likely. Overall, people in deprived areas are 2.7 times more likely to self-harm than in other places.

Some good news is that the self-harm rate in deprived areas has fallen slightly in the last five years but the rate elsewhere has risen fractionally, so the gap has narrowed a little bit. Nonetheless this indicator of poor health is overwhelmingly to be found in deprived areas.

Suicide has been a major issue in recent years because the overall rate in Northern Ireland has risen from 9.4 per thousand to 11.4 in the last five years and it has gone up for both males and females in deprived and other areas alike.

As with self-harm there has been a small narrowing of the gap between deprived areas and the Northern Ireland average but the problem is still far worse in the former; the latest suicide rate in the worst 20% of areas is 16.8, far ahead of the overall rate of 11.4.

Progress

One important indicator of poverty throughout the world is infant mortality. Some progress has been made in cutting the rate in Northern Ireland as a whole and especially in deprived areas, though the rate has fluctuated over the years and may rise again.

To even out fluctuations a bit, the DHSS statistics are based on four-year averages. In the period up to 2001, the infant mortality rate in deprived areas was 7.5 per 1,000 live births, about one third higher than the average of 5.7. By last year the rate in disadvantaged areas had declined to 6.5, about one fifth above the new average of 5.3.

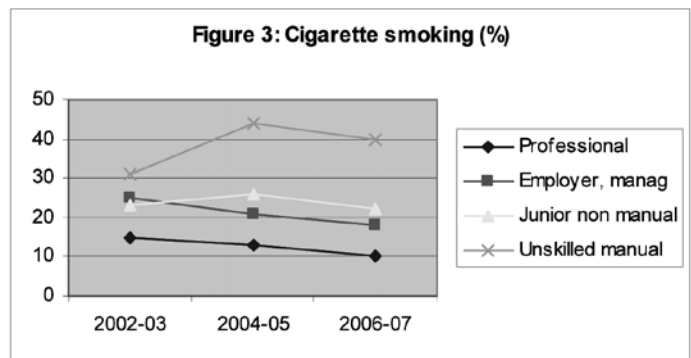
Among people in deprived areas under the age of 75, the rate of deaths from respiratory diseases has gone down from 69 per 100,000 population to 48, an encouraging trend but still far above the Northern Ireland average of 30.

Likewise with cancer, the death rate in the 20% poorest areas has fallen from 176 to 158 but it is still worse than the Northern Ireland average of 127, which has improved only very slightly in the last five years.

Smoking

A crucial cause of deaths from both cancer and respiratory illnesses is cigarette smoking and it will be interesting to see what effect the smoking ban in enclosed public places will have on health outcomes in Northern Ireland.

Meanwhile Figure 3 paints an alarming picture in recent years. Professional and managerial staff, who were already the least likely to smoke four years ago, have cut down on smoking even more; there has also been a tiny improvement for lower-level non-manual workers. In sharp contrast, smoking among unskilled workers has jumped up from 31% to 40%. Excluded from the graph are skilled and semi-skilled manual workers, whose pattern of smoking has not changed and remains high.



However, there is another important dimension to the discussion of smoking, namely sex differences. In the longer six year period from 2000 to 2006, the rate of smoking among men fell in every socio-economic group.

Among women, by contrast, the rate fell in three groups: lower level non-manual workers and skilled and semi-skilled manual workers. Surprisingly more professional women are smoking now than six years ago and among female employers and managers the smoking rate has shot up from 17% to 24%. The smoking rate has also risen among unskilled women.

One issue about women smoking is the impact on their babies if they are pregnant. In this case there are clear social class differences, though the latest data are for the year 2000. Among women in the highest socio-economic group 11% smoked throughout pregnancy but the rate was nearly three times worse in the lowest group (29%). Among women who had never worked, an alarming 46% had smoked throughout their pregnancy.

The 2000 data show another big social class difference: that 87% of professional and two thirds of other non-manual women breastfed their babies. Among semi-skilled mothers the rate was much lower at 51% and far lower again among unskilled women (38%).

Some of the data were supplied specifically to SCOPE but very many statistics are published in Health and Social Care Inequalities Monitoring System: Second Update Bulletin 2007 on www.dhsspsni.gov.uk; click on 'Statistics & Research' and then on 'Health Inequalities'.