HOUSE OF COMMONS LIBRARY

DEBATE PACK

Number CDP 2016/0225, 23 November 2016

Reducing health inequality

Dr Sarah Barber
Nikki Sutherland

This pack has been prepared ahead of the debate to be held in the Commons Chamber on Thursday 24 November 2016 on the motion:

'That this House calls on the Government to introduce and support effective policy measures to reduce health inequality'

The subject for this debate has been selected by the Backbench Business Committee. The debate will be opened by Dr Sarah Wollaston MP.

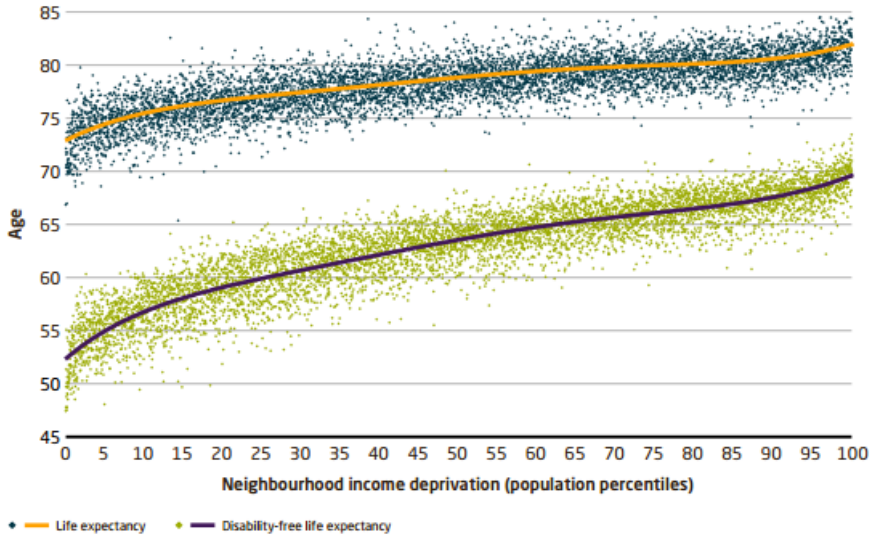
Contents

1. Reducing health inequality

As well as improving the health of the population in general it has been a long-standing objective of public health policy in the UK to reduce health inequalities. There have been a series of major reports into public health in the UK focusing on inequalities in health access and outcomes, starting with the Black Report,[1] which was published in 1979. The report investigated the inequality of healthcare such as the differences between the social classes in the usage of medical services, infant mortality rates and life expectancy. The Whitehead report in 1987, the Acheson report in 1998 and the Marmot review in 2010 investigated similar concerns.

Fair Society, Healthy Lives, the 2010 report of the Marmot Review reported that people who lived in poorer areas die sooner, and spend more of their lives with disabilities. The review highlighted a social gradient of health inequalities (see Box 1), in simple terms -the higher a person's social position, the better their health is likely to be.

Box 1: Social gradient of health inequalities (Marmot Review 2010)



The review stated that reducing these inequalities would require work across all determinants of health and recommended action in the following 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

[1] Working Group on Inequalities in Health, *Inequalities in health: report of a research working group [Black Report]* (chaired by Douglas Black), DHSS, 1980

- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill-health prevention.[2]

The *Healthy Lives, Healthy People* White Paper, published on 30 November 2010, responded to the Marmot review and set out the Coalition government's long-term vision for the future of public health in England. It took the view that the balance of responsibility and action should shift from central government to local communities, and that people should be supported to take on more responsibility for their health. The *Healthy Lives* White Paper reported that changing adults' behaviour could reduce premature death, illness and costs to society, avoiding a substantial proportion of cancers, vascular dementias and over 30% of circulatory disease; saving the NHS much of the estimated £3.5 billion cost of alcohol misuse; and saving £13.9 billion a year, the societal costs related to drug-fuelled crime.

The *Health and Social Care Act 2012* transferred responsibility for commissioning the majority of public health services in England from primary care trusts (PCTs) to local authorities and established Public Health England, which took on responsibilities to oversee the local delivery of public health services. There is a Commons Library Standard Note (SN/SP/6844) on local authorities' duties to improve public health.

An Office of National Statistics report published in November 2015 (looking at the 2009-2013 period) showed that wide inequality in health still exists, not only between different parts of the country but even within local authority areas. The report concluded that there had been little change in inequality over the last decade.[3]

Persisting health inequality in the UK has been a subject raised in a recent House of Commons Health Select Committee Inquiry on public health. The September 2016 report states that, as well as focusing on public health, reducing health inequality will require that wider determinants of health, such as housing and education will need to be addressed. The Report also states that cuts to public health are a false economy, and the funding provided needs to match the commitment to public health in the *NHS Five Year Forward View*. The Report calls for the embedding of health in all policies, including making it a material consideration in planning and licencing decisions. The Government response to the Committee's report has not been published yet.

In response to a PQ in July 2016, the then Minister for Public Health Jane Ellison set out that reducing health inequalities is a priority for the Government:

> Reducing health inequalities is a priority for this Government.
>
> The Department takes a comprehensive and strategic approach to tackling health inequalities that addresses the wider social causes of ill health, promotes healthier lifestyles for all, tackles differences in both access to, and outcomes from, health and public health

2 Professor Sir Michael Marmot, *Fair Society, Healthy Lives. The Marmot Review* (2010)
3 https://www.gov.uk/government/news/inequalities-in-health-and-life-expectancies-persist

services. Action is led locally to ensure that the solutions put in place reflect the needs of individual communities.

Achieving measureable and sustained reductions in health inequalities is integral to the Department's *Shared Delivery Plan 2015-20*, and reflected in the Government's mandate to NHS England, Public Health England's (PHE's) *Evidence into Action* and supporting strategic and business plans at national and local level. NHS England's Business Plan for 2016/17 prioritises closing the gap for groups experiencing poorer health outcomes, a poorer experience of, and access to, healthcare. PHE is supporting local and national efforts to address health inequalities by providing knowledge and intelligence, and evidence-informed tools and advice.

To support this, the Department has published *Improving outcomes and supporting transparency: A public health outcomes framework for England 2013-16.* The framework's vision is to improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest. It is focused on the two high-level outcomes we want to achieve across the public health system and beyond. The first is increased healthy life expectancy; the second is reduced differences in life expectancy and healthy life expectancy between communities through greater improvements in more disadvantaged communities. [4]

[4] PQ 42294, 14 July 2016

2. Health inequality in England – statistics

The following tables highlight some health equalities between local authorities in England. In each case, the highest and lowest ten local authority areas on the relevant indicators are highlighted. Further indicators can be explored on the Public Health Outcomes Framework website.

Because many of these estimates have a level of uncertainty built in, you should be cautious about drawing conclusions from small differences between local authority areas.

Life expectancy at birth, men, 2012-2014

Highest	Years	Lowest	Years
Kensington and Chelsea	83.3	Blackpool	74.7
Harrow	82.7	Manchester	75.8
Richmond upon Thames	82.4	Middlesbrough	76.2
Westminster	82.3	Liverpool	76.4
Barnet	82.1	Kingston upon Hull	76.6
Kingston upon Thames	82.0	Stoke-on-Trent	76.6
Wokingham	81.8	Blackburn with Darwen	76.7
Camden	81.8	Salford	76.7
Surrey	81.7	Knowsley	76.9
South Gloucestershire	81.5	Sandwell	77.0

Life expectancy at birth, women, 2012-2014

Highest ten local areas	Years	Lowest ten local areas	Years
Camden	86.7	Middlesbrough	79.8
Kensington and Chelsea	86.4	Blackpool	79.9
Westminster	86.3	Manchester	79.9
Harrow	86.1	Halton	80.5
Richmond upon Thames	86.0	Kingston upon Hull	80.5
Rutland	85.9	Knowsley	80.5
Barnet	85.1	Liverpool	80.5
Brent	85.1	Tameside	80.6
Bracknell Forest	85.0	Oldham	80.7
Buckinghamshire	85.0	Salford	80.7

Life expectancy is highest in London and the South East, and lowest in the North West and the North East. The highest life expectancy in the North of England is found in North Yorkshire. The lowest in the South of England is found in Tower Hamlets, Barking & Dagenham, Southampton and Portsmouth.

Excess weight in adults, 2013-2015

Highest ten local areas	%	Lowest ten local areas	%
Rotherham	76.2	Camden	46.5
Doncaster	74.8	Kensington and Chelsea	47.3
Halton	74.7	City of London	47.9
Blackpool	73.9	Lambeth	51.1
Hartlepool	73.3	Hammersmith and Fulham	51.6
Barnsley	72.4	Tower Hamlets	52.5
Stockton-on-Tees	72.1	Brighton and Hove	52.6
South Tyneside	71.3	Islington	52.8
East Riding of Yorkshire	71.3	Richmond upon Thames	53.0
St. Helens	71.2	Hackney	53.2

Levels of excess weight (obese and overweight adults) are higher in the North of England than the South. The highest rates in the South of England are found in Peterborough and Swindon. The lowest rates in the North of England are found in York.

Rates in the most deprived local authorities are only slightly higher than rates in the least deprived local authorities. This is in contrast to childhood obesity, where there is a clear link to deprivation.

Avoidable mortality rate per 100,000, 2013-15

Highest ten local areas	Rate	Lowest ten local areas	Rate
Manchester	409	Bracknell Forest	101
Blackpool	387	Kingston upon Thames	101
Salford	348	Barnet	102
Liverpool	344	Westminster	102
Tameside	335	Redbridge	102
Middlesbrough	329	Wokingham	103
Nottingham	326	Buckinghamshire	103
Kingston upon Hull	326	Harrow	103
Stoke-on-Trent	326	Windsor and Maidenhead	104
Manchester	320	Richmond upon Thames	105

This indicator measures the number of people who die from causes that are considered preventable (e.g. cancers, cardiovascular diseases, injuries, respiratory diseases), relative to the size and age structure of the population. Rates are higher in the North of England. The lowest rates in the North are found in North Yorkshire & York. The highest rates in the South are found in Portsmouth, Tower Hamlets & Southampton.

Rates in the 10% most deprived local authorities are around 75% higher than rates in the 10% least deprived local authorities.

Under 75 mortality from cancer per 100,000, 2013-15

Highest ten local areas	Rate	Lowest ten local areas	Rate
Manchester	219	Westminster	90
Blackpool	215	Bracknell Forest	96
Knowsley	213	Barnet	97
Kingston upon Hull	212	Bromley	97
Liverpool	212	Richmond upon Thames	98
Salford	209	Brent	99
Nottingham	203	Rutland	99
Hartlepool	203	Harrow	100
Stoke-on-Trent	202	Redbridge	102
Barking and Dagenham	202	Buckinghamshire	102

This indicator measures the number of people aged under 75 who die from cancer, relative to the size and age structure of the population. All of the top ten rates are in the North, except for Barking & Dagenham and Stoke-on-Trent. Elsewhere in the South, higher rates are found in Portsmouth, Lewisham and Islington. In the North, lower rates are found in York, North Yorkshire and Cheshire East.

Rates in the 10% most deprived local authorities are almost 50% higher than rates in the 10% least deprived local authorities.

Admissions for alcohol-related conditions per 100,000, 2014/15

Highest ten local areas	Rate	Lowest ten local areas	Rate
Blackpool	1,223	Wokingham	379
North Tyneside	1,028	Kensington and Chelsea	421
Stoke-on-Trent	991	West Berkshire	424
Wolverhampton	935	Havering	430
Middlesbrough	930	Kingston upon Thames	430
Nottingham	928	Richmond upon Thames	430
Gateshead	927	City of London	431
Salford	924	Medway	434
Liverpool	903	Redbridge	440
Wakefield	885	Croydon	455

This indicator measures the number of people admitted to hospital for alcohol-related conditions, relative to the size of the population. The highest rates are in the North and the Midlands, and the lowest are in London and the South East. In the North, lower rates are found in Cheshire West & Chester and East Riding of Yorkshire. In the South, higher rates are found in Bristol, Islington and Torbay.

Rates in the 10% most deprived local authorities are around 60% higher than rates in the 10% least deprived local authorities.

Adults meeting recommended '5 a day' fruit & veg, 2015

Highest ten local areas	%	Lowest ten local areas	%
Rutland	62.8	Liverpool	36.5
Cornwall	62.1	Thurrock	40.1
Devon	61.5	Birmingham	40.4
Isle of Wight	60.8	Tameside	41.2
Brighton and Hove	60.8	Brent	41.2
Bournemouth	60.5	Manchester	41.4
Somerset	60.1	Newham	41.8
Wokingham	60.1	Middlesbrough	42.1
Buckinghamshire	59.9	Havering	42.1
Norfolk	59.8	Wakefield	42.7

Rutland and Cornwall have the highest percentage of adults meeting the recommendation to eat five portions of fruit and veg per day. Liverpool and Thurrock have the lowest percentage.

Rates are highest in the least deprived local authorities.

3. News Articles

BBC News Online

Unequal Scotland? - How being poor can cut short your life

Douglas Fraser 17 November 2016

http://www.bbc.co.uk/news/uk-scotland-38003373

Guardian

Figures reveal huge inequalities in health and longevity across UK

Patrick Collinson 11 October 2016

https://www.theguardian.com/society/2016/oct/11/figures-reveal-huge-inequalities-in-health-and-longevity-across-uk

Guardian

MPs say cuts are 'false economy' in drive to improve poor people's health

Health select committee says government must fulfil health pledges and take on big industry interests to tackle childhood obesity and diabetes

Sarah Boseley 1 September 2016

https://www.theguardian.com/society/2016/sep/01/mps-say-cuts-are-false-economy-in-drive-to-improve-poor-peoples-health

Guardian

NHS success in tackling health inequality varies hugely across England

Sarah Boseley 20 August 2016

https://www.theguardian.com/society/2016/aug/20/poor-healthcare-leading-to-hospital-admissions-shows-no-social-divide

Lancet

Child poverty continues to rise in the UK

20 August 2016http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)31416-7/fulltext?rss=yes

Independent

Worse treatment of poor people by GPs costs the NHS £4.8bn a year, study finds;

'It seems that people living in poorer areas, who are typically more likely to get sick, aren't getting the same benefits from primary care as people living in richer areas'

Shehab Khan 20 August 2016

http://www.independent.co.uk/life-style/health-and-families/health-news/nhs-gps-poverty-healthcare-costs-48bn-study-york-university-a7201306.html

Guardian

London: fatal lung conditions 'more likely' in deprived boroughs

British Lung Foundation research finds those in poorer areas up to twice as affected as those in rich boroughs

Fiona Harvey 6 June 2016

https://www.theguardian.com/environment/2016/jun/06/london-fatal-lung-conditions-more-likely-in-deprived-boroughs

Independent

Global report finds 2008 recession led to spike in cancer deaths – but not in countries with universal healthcare

Researchers examined the link between unemployment, public health care spending and cancer mortality in more than 70 countries over a 20-year period from 1990 to 2010

Ian Johnston 25 May 2016

http://www.independent.co.uk/life-style/health-and-families/health-news/nhs-universal-healthcare-cancer-deaths-recession-austerity-lancet-a7048991.html

BBC News Online

Lifespan gap 'widening between rich and poor'

Judith Burns 3 May 2016

http://www.bbc.co.uk/news/education-36170289

4. Press releases

House of Commons Health Select Committee

Cuts to public health risks widening health inequalities

01 September 2016

After taking on responsibility for public health, local authorities were dealt an in-year cut of £200 million last year and now face further real terms cuts to public health budgets. Cuts to public health and the front line services they deliver are a false economy as they not only add to the future costs of health and social care but risk widening health inequalities, says the Health Committee in its report on Public health post-2013.

- Read the report summary
- Read the report conclusions and recommendations
- Read the full report: Public health post-2013

Whole life course approach required

In her first speech as Prime Minister, Theresa May put reducing health inequalities at the top of her list for action, highlighting the 'burning injustice' that if you are poor you will die on average nine years earlier than if you are rich.

The government must recognise that tackling health inequalities and improving public health will not primarily happen in hospitals, even though hospitals receive the lion's share of health funding. Rather, it requires a whole life course approach, tackling the wider determinants of health in local communities, effective action on prevention and early intervention, and through joined-up policy making at a national level.

There is a growing mismatch between spending on public health and the significance attached to prevention in the NHS 5 Year Forward View.

Call for bold and brave action

To support this agenda at a national level, the Committee wants to see a Cabinet Office minister given specific responsibility for embedding health across all areas of Government policy at national level.

The report concludes that while there is evidence of progress locally, there is less evidence of such an approach becoming embedded across Government departments. It calls for the Government to take bold and brave action through its life chances and childhood obesity strategies in order to improve public health and reduce health inequalities.

Chair's comments

Health Committee Chair, Dr Sarah Wollaston adds:

"The disappointing watering down of the childhood obesity strategy, published in August, demonstrates the gap in joined-up evidence-based

policy to improve health and wellbeing. Government must match the rhetoric on reducing health inequality with a resolve to take on big industry interests and will need to be prepared to go further if it is serious about achieving its stated aims."

Public health does not primarily take place in hospitals but within local communities and the committee heard general but not universal support for the move of public health to local authorities but also concerns about the resulting fragmentation of some services and issues that have arisen over the transition.

Government policy

The Committee urges the Government to make good on its commitment to health in all policies by enshrining health as a material consideration in planning and licensing law.

The Committee heard evidence that this would help local government to directly improve the health of their local communities and reduce health inequalities. Local authorities need the levers to be able to take effective action to protect local communities and this is especially important given the cuts to their budgets.

Public health system progress

The Committee found that in some local authorities good progress has been made, with modest positive impact on public health outcomes already being seen, but in others, less headway has been made. The new public health system is designed to be locally driven, and therefore a degree of variation between areas is to be expected. However, the Committee is concerned that robust systems to address unacceptable variation are not yet in place.

The current system of sector-led improvement needs to be more clearly linked to comparable, comprehensible and transparent information on local priorities and performance on public health. Changes to local government funding, especially the removal of ring-fencing of the public health grant, must be managed so as not to further disadvantage areas with high deprivation and poor health outcomes.

Health protection

Health protection—encompassing prevention, preparedness and response to outbreaks and other health threats—is a critical public health function. Despite several sets of guidance on responsibilities the Committee heard that confusion, duplication and lack of clarity persist in some local areas.

Public Health England must ensure that local areas are clear about their responsibilities and equipped to deliver a seamless and effective response to outbreaks and other health protection incidents.

Public Health England

Inequalities in health and life expectancies persist

20 November 2015

Inequalities in health and life expectancies persist in England and its local authority areas.

A new ONS report produced in conjunction with PHE has been published revealing the scale of inequalities in life expectancy and healthy life expectancy across England, but also within local authority areas.

The data shows that wide inequalities exist not only between the most and least deprived areas of the country; but between the most and least deprived areas within local councils across the country.

This is the first time such an analysis has been done and it will help health professionals, both nationally and within local authority areas, assess, down to very small geographies, where they need to focus their efforts.

The number of years an individual could expect to live in good health (healthy life expectancy) in 2009 to 2013 in England was 63.5 years for males and 64.8 years for females.

Compared with the most deprived areas, the figures for those living in the least deprived areas were higher by 16.7 years for males and 16.8 years for females. This difference was much greater for healthy life expectancy than it was for life expectancy.

The report also concludes that there has been little change in this inequality over the last decade.

Professor John Newton, Chief Knowledge Officer at Public Health England, said:

The findings reinforce the need to address health inequality through public health and prevention as all the evidence shows that the root causes of health inequalities like these lie largely outside the health service.

The other big issue is that inequalities are greater for years of life lived in ill health. People are living longer with one or more diseases like diabetes or cancer that might in the past have been fatal. This is a new situation for care services and has implications for how and where the resources those services need to be allocated in future.

Dr Ann Marie Connolly, Deputy Director, Health Equity and Mental Health, at Public Health England, said:

We know that inequalities in life expectancy emerge from inequalities in the conditions of daily life including people's incomes, living standards, educational attainment and access to services. These in turn can drive unhealthy behaviours like smoking, poor diet and physical inactivity. Although we've seen improvements in physical activity and smoking rates, these have not been enjoyed by all sections of society and so we

continue to see these stark differences in outcomes for different communities across England.

See Health Expectancies at birth by Middle Layer Super Output Areas, England, Inequality in Health and Life Expectancies within Upper Tier Local Authorities: 2009 to 2013

Kings Fund

Gap in life expectancy between rich and poor shrinks, new report finds

11 August 2015

The gap in life expectancy between the richest 10 per cent and the poorest 10 per cent shrank by 2.5 years between 1999 and 2010, finds a new report by The King's Fund published today. The report, which builds on Professor Sir Michael Marmot's ground-breaking research into health inequalities, is the first time that the relationship between life expectancy and income has been analysed over time at this level of detail.

Populations in poorer areas tend to have worse health than populations in richer ones, but our research suggests that the gap in life expectancy narrowed from 6.9 years in 1999–2003 to 4.4 years in 2006–10. Average life expectancy across the whole of England increased during this period, but the fastest improvement was in areas with the highest levels of income deprivation.

The reasons behind this are complex. From the late 1990s to 2010, the Department of Health focused on reducing inequalities in health by targeting areas with particularly low life expectancy, providing additional support to their local NHS and encouraging greater uptake of treatments for conditions like diabetes and high cholesterol. However, wider factors impacting life expectancy also changed during this period: poverty in older people improved; unemployment remained low during most of this period; and, there were improvements in housing quality, particularly in the social rented sector.

The research also showed that life expectancy in some areas was unexpectedly high or low, even when accounting for other factors. For example, average life expectancy is higher in West London and lower in urban areas of the North West than the levels of deprivation and lifestyles in those parts of the country would predict.

Commenting on the findings, David Buck, Senior Fellow at The King's Fund, said:

'It is welcome news that differences in life expectancy between rich and poor areas improved in the period up to 2010. The relationship between poverty and poor life expectancy has been known for some time. But how this relationship changes over time, and the role of other factors are less well understood. This period saw significant improvements in

inequalities in general with low unemployment and improved housing, which are likely to have been factors in this improvement.

'While the changes in the relationship between income and life expectancy is good news, it remains to be seen how the gap in life expectancy between the richest and the poorest will have been affected by the economic downturn, and the policy reaction to it, following the 2008 financial crisis. We believe our findings support and reinforce the case for a true cross-government approach to reducing inequalities in health, with NHS, local authority and central government policy more aligned than they currently are.'

Notes to editors:

The report, Inequalities in life expectancy: changes over time and implications for policy, is available at: www.kingsfund.org.uk/publications/inequalities-life-expectancy

The original Marmot Review, Fair society, healthy lives, was published in 2010. The report is available at: www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

The King's Fund is an independent charity working to improve health and health care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

Care Quality Commission

'Too much' inequality across health and social care, finds CQC

13 March 2015

Today, we have published our annual equality information report, Equal Measures, which summarises what we have learned about equality and diversity, both across health and social care and internally last year.

In this, we have found that while seeing some improvements, there is still too much variation in people's access, experience and outcomes in many health and social care services. For example, the fact that more ethnic groups seem to use certain hospital services more than other groups suggests that access could be an issue. Also, we have found that people with dementia have poorer outcomes in hospitals than those without dementia going into hospital for the same health conditions; and, that the needs of people with visual impairment and hearing loss within care homes are sometimes overlooked.

As well as this, we have found that there is too much variation in equality for staff who work within these services, with increasing evidence showing that there is a link between the discrimination experienced by staff and the quality of care provided. We have used

these findings to set our equality objectives for the year ahead and beyond.

David Behan, Chief Executive of the Care Quality Commission said:

"People expect to receive health and social care services which provide them with safe, effective, compassionate, and high-quality care – no matter who they are.

"We know that when providers ensure equality for their staff, this improves the quality of care that they provide to their communities.

"This is an important characteristic of a well-led service and we will assess it during our inspections. The objectives that we have outlined in our report centre on tackling equality variation in services and within our organisation. They will help us to go further in achieving change for people use health and social care and our own staff.

Our equality objectives for 2015-17 as an employer are to:

1. Deliver learning and development for all of our staff by March 2016, to address 'unconscious bias'.
2. Work towards having no difference in the employment outcomes for our staff or potential recruits because of age, disability, ethnicity, gender, gender reassignment, religion or belief, or sexual orientation.

Our equality objectives for 2015-17 that CQC will deliver in our work are to:

1. Include race equality for staff as a factor in our judgements about whether hospitals are well-led (using the NHS workforce race equality standard, published this week).
2. Improve our regulatory insight and action about the safety and quality of mainstream health services for people with a learning disability or dementia, or those experiencing mental ill-health.
3. Help our inspectors to make consistent and robust judgements about particular aspects of equality, such as by looking at the transition of young disabled people into adult services, and a focus on whether adult social care services are meeting the needs of lesbian, gay and bisexual people and people with a sensory impairment.

5. Parliamentary Questions

Health Services: Expenditure

Asked by: Cox, Mr Geoffrey

To ask the Secretary of State for Health, what steps he has taken to reduce health spending inequalities between (a) the UK and other European countries and (b) UK health authority districts.

Answering member: Mr Philip Dunne | Department: Department of Health

Based on the latest internationally comparable Organisation for Economic Co-operation and Development (OECD) data, total health spending in the United Kingdom, as set out by the OECD for 2014 (published 30 June 2016), and which includes public (Government) and private spend, is at 9.9% of Gross Domestic Product (GDP), above the OECD average1 of 9.0% and the EU-15 average of 9.8%.

Reducing health spending inequalities is part of the core formula that is used to determine the funding that is allocated to clinical commissioning groups (CCGs), which are the equivalent of UK health authority districts in England. Responsibility for CCG allocations rests with NHS England. NHS England also has a duty to reduce health inequalities.

The formula includes an adjustment for unmet need and health inequalities, which has been refined for 2016-17 to 2020-21 allocations.

The unmet need and health inequalities adjustment continues to be based on the standardised mortality ratio for those aged under 75 years. The latest data has been used and the adjustment refined to give a higher weight per head to the areas with the worst standardised mortality ratio for those aged under 75 years and to be based on the size of each CCG's registered lists in place of Office for National Statistics populations, on which it was previously based.

NHS England has published a technical guide to allocations which sets out all the individual factors used in determining the allocation levels. The guide is available here:

https://www.england.nhs.uk/2016/04/allocations-tech-guide-16-17/#

Funding for other parts of the UK is a matter for the devolved administrations.

Note:

[1]The reported averages reflect the simple average of countries' figures without weighting that for population or GDP of the respective countries.

HC Deb 18 November 2016 | PQ 52023

Health Services

Asked by: Lord Kennedy of Southwark

To ask Her Majesty's Government what are the reasons for geographical health inequalities in the UK.

Answering member: Lord Prior of Brampton | Department: Department of Health

Health inequalities are the result of numerous factors that shape health such as education, employment, housing and living standards, abetted by the effects of unhealthy behaviours. These differences in the 'social determinants of health' are highlighted in *Fair Society, Health Lives: The Marmot Review*. A copy of the review has been placed in the Library.

HL Deb 17 November 2016 | PQ HL3056

[Deposited Paper 2016-0664, Fair society, healthy lives. The Marmot review. Strategic review of health inequalities in England post-2010 https://depositedpapers.parliament.uk/depositedpaper/view/2277146]

Health: Poverty

Asked by: Baroness Hollins

To ask Her Majesty's Government what estimate they have made, or are planning to make, of the cost to the health service of poverty-related ill health.

Answering member: Lord Prior of Brampton | Department: Department of Health

The Department has not made, and is not planning to make, an estimate of the cost to the health service of poverty related ill health. However, in 2008 the Department commissioned Professor Michael Marmot of University College London to chair an independent strategic review of health inequalities in England from 2010. The Review, *Fair Society, Healthy Lives*, estimated that, in 2010, direct NHS healthcare costs in England associated with treating the consequences of inequality amounted to £5.5 billion per year for treating acute illness, mental illness and prescriptions. This estimate does not cover all health service activity, including primary care costs.

The review also estimated the wider costs of health inequalities, with £31-33 billion worth of productivity losses resulting from inequalities in illness, and between £20-32 billion in lost taxes and higher welfare payments. A copy of the review has been placed in the Library.

HL Deb 26 July 2016 | PQ HL1172

[Deposited Paper 2016-0664, Fair society, healthy lives. The Marmot review. Strategic review of health inequalities in England post-2010 https://depositedpapers.parliament.uk/depositedpaper/view/2277146]

Health: Equality

Asked by: De Piero, Gloria

To ask the Secretary of State for Health, what steps his Department is taking to reduce health inequalities in areas of high deprivation.

Answering member: Jane Ellison | Department: Department of Health

Reducing health inequalities is a priority for this Government.

The Department takes a comprehensive and strategic approach to tackling health inequalities that addresses the wider social causes of ill health, promotes healthier lifestyles for all, tackles differences in both access to, and outcomes from, health and public health services. Action is led locally to ensure that the solutions put in place reflect the needs of individual communities.

Achieving measureable and sustained reductions in health inequalities is integral to the Department's *Shared Delivery Plan 2015-20*, and reflected in the Government's mandate to NHS England, Public Health England's (PHE's) *Evidence into Action* and supporting strategic and business plans at national and local level. NHS England's Business Plan for 2016/17 prioritises closing the gap for groups experiencing poorer health outcomes, a poorer experience of, and access to, healthcare. PHE is supporting local and national efforts to address health inequalities by providing knowledge and intelligence, and evidence-informed tools and advice.

To support this, the Department has published *Improving outcomes and supporting transparency: A public health outcomes framework for England 2013-16.* The framework's vision is to improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest. It is focused on the two high-level outcomes we want to achieve across the public health system and beyond. The first is increased healthy life expectancy; the second is reduced differences in life expectancy and healthy life expectancy between communities through greater improvements in more disadvantaged communities.

HC Deb 14 July 2016 | PQ 42294

Health Services

Asked by: Berger, Luciana

To ask the Secretary of State for Health, what assessment he has made of in which type of healthcare there is greatest geographical disparity of treatment (a) availability, (b) choice and (c) outcomes across England.

Answering member: Jane Ellison | Department: Department of Health

No such assessment has been made. However, the Right Care programme actively uses variation between clinical commissioning groups to help identify those diseases or conditions that have the

potential for greatest improvement. Indicators used include prevalence, treatment and outcomes.

The NHS Atlas of Variation, Commissioning for Value Packs and indicators in the National Health Service Outcomes Framework and Public Health Outcomes Framework provide publicly accessible resources to compare geographical areas and highlight health inequalities and other variation across a wide variety of indicators.

HC Deb 29 February 2016 | PQ 28312

Health Inequality

Asked by: Mr Philip Hollobone (Kettering) (Con)

If she will discuss with the Secretary of State for Health ways to address the relative inequality of health outcomes for men and women.

Answered by: The Parliamentary Under-Secretary of State for Women and Equalities and Family Justice (Caroline Dinenage) | Department: Women and Equalities

There are gender differences across a range of health outcomes. Women live longer than men, but that gap is closing. The Government are tackling health inequalities by addressing the social causes of ill health and promoting healthier lifestyles, all now underpinned by legal duties. Action is led locally to ensure that there are solutions to local gender and other health inequalities.

Mr Hollobone: Over the past 30 years, female suicide rates have declined from 11 per 1,000 to five per 1,000, but male suicide rates have remained stubbornly high, at 19 to 20 per 1,000, and in that period 130,000 men have committed suicide. What will the Minister do, together with the Department of Health, to tackle that very serious problem?

Caroline Dinenage: My hon. Friend makes an excellent point. The Under-Secretary of State for Health, my hon. Friend the Member for Battersea (Jane Ellison), was keen to be here today, but she is at an LGBT conference. Suicide is the largest cause of death of men under 50, so this is a really important issue. That is why the Prime Minister's commitment earlier this week to investing in mental health services will be so important in this space.

HC Deb14 January 2016 | PQ 903019 | Vol 604 cc994-1112

Health Problems (Poverty)

Asked by: Tommy Sheppard (Edinburgh East) (SNP)

What assessment he has made of the effect of poverty on the incidence of health problems.

Answering member: The Parliamentary Under-Secretary of State for Health (Jane Ellison) | Department: Health

Across Government we are working to improve the life chances of children, and that is at the heart of our efforts to tackle the real causes of child poverty and improve the prospects for the next generation. That involves taking a broad approach to improving poor health and tackling health inequalities which the last Government embedded in the law. The wider causes of ill health, such as worklessness and unhealthy lifestyles, are all being addressed at the moment. I welcome the fact that we have record numbers of people in work and a dramatic drop in the number of children living in workless households. That goes to the heart of some of the broader drivers of ill health and poverty.

Tommy Sheppard: I am pleased that the Government accept that there is a causal link between poverty and poor health outcomes. They will also know of the widespread concern that the proposed changes to the tax credits regime will result in greater poverty, which will in itself cause poorer health outcomes and may put great pressure on the NHS. Will the Department consider putting in place mechanisms to monitor the effect of the tax credit changes on demands on the national health service?

Jane Ellison: We do far more than monitor health inequalities; we are taking action to deal with them. The heart of my portfolio is comprised entirely of tackling health inequalities in our nation. Let me give just a couple of examples: the expanded troubled families programme, on which the Department of Health is working closely with other Departments; and the family nurse partnership, where we support some of the most vulnerable young parents in the earliest years of their children's lives. Those programmes have the greatest impact on our most disadvantaged communities. The matters that the hon. Gentleman raises are for other Departments, but I assure the House that improving the life chances of all our children is core business for the Government.

Peter Grant: Interesting answer, but unfortunately it was not the answer to the question that was asked. No doubt my hon. Friend will follow that up later. Is the Minister aware of work produced by, for example, Sir Harry Burns, the former chief medical officer of Scotland, which clearly indicates that although there is a very strong link between poverty and poor health, that link is not inevitable and should not be allowed to become inevitable? What are the Government doing to change policy, so that that link can be broken?

Jane Ellison: I have already given some examples of the work the Government are doing to tackle health inequalities in our nation. Let me give the hon. Gentleman another practical example. The burden of disease that tobacco brings falls disproportionately on poor

communities. As well as the action that we have taken on standardised packaging and on smoking in cars with children, we are committed to a new tobacco strategy. I have said publicly that at the heart of the strategy there must be effective action to look at the areas in which the effect of tobacco falls most heavily—disadvantaged communities. We are taking practical action to close gaps in health outcomes in a range of ways.

HC Deb 17 November 2015 | Vol | 602 c513

6. Useful links and further reading

House of Commons Health Select Committee *Public Health Post-2013* HC140 published 1 September 2016

http://www.publications.parliament.uk/pa/cm201617/cmselect/cmhealth/140/140.pdf?utm_source=140&utm_medium=module&utm_campaign=modulereports

Kings Fund Kings Fund *Inequalities in life expectancy :Changes over time and implications for policy* August 2015

https://www.kingsfund.org.uk/publications/inequalities-life-expectancy?gclid=CILWvYa0stACFRMz0wodSpYCGg

Royal College of Nursing Policy Briefing *Health Inequalities and the Social Determinants of Health* January 2012

https://www2.rcn.org.uk/__data/assets/pdf_file/0007/438838/01.12_Health_inequalities_and_the_social_determinants_of_health.pdf

NICE Local Government Briefing *Health inequalities and population health* October 2012

https://www.nice.org.uk/advice/lgb4/chapter/introduction

The King's Fund *Public health and inequalities*

https://www.kingsfund.org.uk/topics/public-health-and-inequalities

Royal College of General Practitioners *Health Inequalities* May 2015

http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=10&cad=rja&uact=8&ved=0ahUKEwjH0f2EwrLQAhUEfxoKHVi8CEEQFgiAATAJ&url=http%3A%2F%2Fwww.rcgp.org.uk%2F-%2Fmedia%2FFiles%2FPolicy%2FA-Z-policy%2F2015%2FHealth-Inequalities.ashx%3Fla%3Den&usg=AFQjCNGva815jUinCHZLYk4dnoTgBWKQTw

Public Health England *Reducing health inequalities - key resources* October 2014

https://publichealthmatters.blog.gov.uk/2014/10/03/reducing-health-inequalities-key-resources/

UCL Institute of Health Equity *'Fair Society Healthy Lives' (The Marmot Review)* 2010

http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

Marmot Indicators 2014 - Local Authority Profiles

http://www.instituteofhealthequity.org/uk/marmot-indicators-2014-supporting-documents

Public Health England *National Conversation on Health Inequalities*

https://www.gov.uk/government/collections/national-conversation-on-health-inequalities

Department of Health *Improving outcomes and supporting transparency*

Part 1A: A public health outcomes framework for England, 2013-2016 November 2013

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/263658/2901502_PHOF_Improving_Outcomes_PT1A_v1_1.pdf

About the Library

The House of Commons Library research service provides MPs and their staff with the impartial briefing and evidence base they need to do their work in scrutinising Government, proposing legislation, and supporting constituents.

As well as providing MPs with a confidential service we publish open briefing papers, which are available on the Parliament website.

Every effort is made to ensure that the information contained in these publically available research briefings is correct at the time of publication. Readers should be aware however that briefings are not necessarily updated or otherwise amended to reflect subsequent changes.

If you have any comments on our briefings please email papers@parliament.uk. Authors are available to discuss the content of this briefing only with Members and their staff.

If you have any general questions about the work of the House of Commons you can email hcinfo@parliament.uk.

Disclaimer

DEBATE PACK
CDP 2016/0225
23 November 2016