United Kingdom Health Inequities Project
Health Promotion

Section I: Summary

In 2003, the Government in the United Kingdom announced health inequalities targets, to be met by 2010, around infant mortality rates and life expectancy figures. The purpose of these targets is to narrow the differences in 'health' levels by 10% between the poorest socio-economic classes and the least performing regions of the country and the national population averages. To achieve targets, the government has employed a broad set of National Health Service (NHS) initiatives, as well as other social and fiscal policies. While overall health in the United kingdom has improved for the population as a whole, the health of these targeted groups have improved at a slower rate.

Section II: Statement of purpose

In 2003, the UK Government announced the following specific health inequalities targets:

1. By 2010, to reduce by at least 10% the gap in infant mortality between routine and manual groups and the population as a whole.

2. By 2010, to reduce by at least 10% the gap between the worst fifth of local authority areas in terms of at birth life expectancy and the population as a whole.

The Government intends to reach these targets through a range of NHS and other social and fiscal policies, many of which have been in place for some time. The NHS policies include reducing inequalities in access to health care and tackling the chronic diseases such as heart disease and cancer, from which those on lower incomes disproportionately suffer. Policies outside of health include introducing and increasing the minimum wage, improving employment opportunities for the long-term unemployed, improving adult education opportunities and early learning opportunities for the children of vulnerable groups (Sure Start), and urban renewal policies.

The government is working with local authorities from the communities that have the worst health indicators. These areas represent approximately 28% of the population of England. Local authorities known as “spearheads” have been charged with improving their region’s health. They are provided with web-based tools to conduct community health assessments and to compare their progress against other spearhead authorities across various health indicators. In theory, competition between local authorities will serve as a non-financial incentive system, spurring each authority to improve its performance against its closest competitors.

The program uses competition among spearheads as leverage to drive community health improvement – a strategy that has worked other health improvement project. For example, the Veterans Health Administration in the United States improved various process quality indicators through similar means, and the UK NHS has seemingly achieved some success around reducing hospital waiting times and ambulance response rates when using this type of mechanism. In terms of health inequalities, it appears that the Government's logic is that if the authorities with the worst population health levels can be encouraged to compete against each other to improve the health of their populations, then collectively they will close the gap on the population average for the country as a whole.

Section III: Outcomes

While this strategy may work in theory, it has not been as effective in this practice. Between 1999 and 2006, the health of all socio-economic groups in the United Kingdom improved, but the health of the lower classes improved at a slower rate than the rest of the population widening health inequalities:

- From 1999 to 2006, the infant mortality rate for the lowest socio-economic class fell from 6.3 to 5.6 per 1,000 live births; however during that same time period, the average infant mortality rate dropped from 5.6 to 4.8 per 1,000 live births. As of 2006, the infant mortality rate for lowest class remained higher than the population at-large – by 17%.

- In 1997, the life expectancy for men in 'spearhead' areas was 72.7 years, while the population average was 74.6 years. By 2006, life expectancy rates had improved to 75.3 years and 77.3 years, respectively. However, while both groups experienced increases in life expectancy rates, the population average remains 2.63% higher than that of the spearhead group.

While the overall health improvement efforts have resulted in health gains for the entire population, as illustrated above, the health of the lowest socio-economic classes has improved at a slower rate than the population average – further expanding the health disparities gap.

Experts have expressed concerns as to whether the health attainment goals can be met by 2010 or whether additional incentives are required to try to encourage local leaders to work harder to implement programs. Additionally, as with many top down policies, experts have suggested local leaders need not concrete recommendations on how best to implement health improvement programs.

Section IV: Contact Information and References

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Other Sources of Information

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