Briefing paper

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Health inequalities: concepts, frameworks and policy

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INTRODUCTION

At the heart of public health in contemporary Britain is a paradox. Britain is now collectively healthier than it has ever been in its history. Life expectancy improves and some of the great killer diseases are in retreat as the benefits of both a preventive approach to public health and advances in treatment bear fruit.[1] Yet at the same time, the problem of health inequalities remains stubbornly ubiquitous. While the health of the population as a whole may be improving, the health of the least and less well off either improves more slowly than the rest of the population or in some cases gets worse in absolute terms. This is a challenge to policy makers and practitioners. It suggests that while some of our policy and interventions undoubtedly work they also manifestly fail some sections of the population. To sharpen the tools for policy making in this arena, this paper reviews some of the important conceptual problems associated with discussions of health inequalities.

There is a large literature on health inequalities, although a very much smaller literature on how to reduce health inequalities.[2] The Health Development Agency (HDA) has the task of developing the evidence base in public health to inform policy and practice to reduce inequalities. Since 2000 the HDA has been reviewing the evidence on health inequalities and on the effectiveness of interventions. Reviews have been undertaken of the evidence dealing with the prevention of low birth weight,[3] social support in pregnancy,[4] the prevention of drug misuse,[5] sexually transmitted infections and HIV,[6] the promotion of physical activity,[7] accidental injury prevention,[8] the management of obesity and overweight,[9] the prevention of alcohol misuse[10] and smoking,[11] the promotion of breastfeeding,[12] and the prevention of teenage pregnancy.[13] The full results of these reviews are at: www.hda.nhs.uk/evidence. The problems attached to the review processes and the difficulties of getting evidence into practice are described elsewhere.[14] Without exception, though, the reviews demonstrate an underlying problem of health inequalities in all of these areas.

The HDA's review work has uncovered a number of major gaps in the evidence on health inequalities.[15] Among these gaps, we found that the conceptual apparatus to describe inequalities in health is surprisingly limited. For example, the HDA reviews found that dimensions of social position and social difference such as ethnicity, gender, disability, place, age and geography, while never explicitly denied as important, are under-developed empirically and theoretically. The question of social position, in other words, requires much more prominence in research and in policy making than it has hitherto received. In addition, the conceptual distinction between the determinants of health and the determinants of inequalities in health is frequently obscured, and therefore has little purchase on the policy making process.

The purpose of this paper is to highlight some of the conceptual issues relating to socioeconomic inequalities in health. The first section discusses how people have been classified in the UK, and how, using the traditional measure of socioeconomic position, the challenge of health inequalities is being addressed. The second section focuses on 'determinants', a core term in the drive to reduce health inequalities, and discusses the difference between determinants of health and determinants of inequalities in health. The distinction between the idea of health disadvantage, health gaps and health gradients is explored in the third section. The paper therefore makes explicit some of the key terms used in the debates about health inequalities to help inform the process of policy development.

MEASURING INEQUALITIES, SOCIAL GRADIENTS AND SOCIAL EXCLUSION

Measuring social inequalities

In Britain, inequalities between people have been measured primarily through occupation, using measures of occupation originally developed to construct the census in 1911. Occupations were categorised within a five tier system, running from social class 1 at the top to social class V at the bottom. The occupation of the male head of household was used to determine the social class membership of all the members of the household. This classification meant that women were therefore not accorded their own social class position. It also meant that occupation as a measure was placed at the centre of researchers' and policy makers' thinking about social inequality, with little allowance for kinds of social difference other than occupation.[16] It is noteworthy that the bottom social class group in the original census was very large as it included labourers, farm workers and domestic servants. In early 20th century Britain, the classification probably reflected the characteristics of the population well enough from the point of view of those putting the census together.

It does less well in today's Britain. Economic and social changes, including the decline of manual work, the increase in women's employment, patterns of immigration and changes in family composition have fundamentally altered the nature of the population.[17] Nevertheless, the old schema has continued, in modified form, to be used until very recently to describe data about health. This is because, while in many ways outdated and inappropriate, the occupation-based classification continues to capture important features of social inequality in Britain. Not only do living standards (like housing tenure and income) improve at each step up the class ladder, but also so do a range of other important drivers of people's wellbeing, including educational attainment, employment opportunities and health.

But today's researchers recognise that there are a number of axes of social differentiation in a complex contemporary society like Britain, including ethnicity, gender, sexuality, age, area, community and religion.[18] These represent linked but separate dimensions of inequality. For example, research suggests that socioeconomic disadvantage is a major contributor to the poorer health of African-Caribbean, Bangladeshi and Pakistani groups – and exposure to racism is an important part of why they are more disadvantaged than the wider population.[19] In addition, there is evidence that the experience of discrimination takes an additional toll on the health of black and Asian communities.[20]

What these different and variable axes of differentiation have in common is that they result in differences in life chances. These differences are literal: there are marked social variations in the chances of living a healthy life. This has been most systematically captured in occupation-based measures of socioeconomic position – but differences in people's health experiences and their patterns of mortality are observed across other dimensions of social differentiation. It is an important challenge to develop measures of inequality that embrace these differences. If, as the evidence suggests, dimensions of disadvantage interlock and take a cumulative toll on health, these dimensions need to be summed to map and understand the health penalty of social inequality.

Social gradients and social exclusion

When researchers talk about inequalities in health they are drawing on data which show that, when measured by occupation, there are marked differences in health from top to bottom of the occupational hierarchy.[21] Similar differences are captured in measures of people's socioeconomic circumstances, which are based on education, income and housing tenure. Evidence on the scale of socioeconomic inequalities in health has helped to drive forward policies to reduce them.

The evidence on the links between people's socioeconomic circumstances and their health has generated two kinds of policy responses. The first focuses on those in the poorest circumstances and the poorest health: on the most socially excluded, those with most risk factors and those most difficult to reach. This focus has been important in linking health inequalities to the social exclusion agenda, and in focusing policies at local and community level. In policy and intervention terms, this leads to approaches that attempt to lift the worst off out of the extreme situation in which they find themselves. If effective, such interventions help only a relatively small part of the population.

The second approach recognises that, while those in the poorest circumstances are in the poorest health, this is part of a broader social gradient in health. This means that it is not only the poorest groups and communities who have poorer health than those in the most advantaged circumstances. In addition, there are large numbers of people who, while they could not be described as socially excluded, are relatively disadvantaged in health terms. Preventive and other interventions could produce major improvements in their health and proportionate savings for the healthcare system.

THE DETERMINANTS OF HEALTH AND THE DETERMINANTS OF HEALTH INEQUALITIES

For the first time in Britain's history, health equity has been placed alongside health gain as a core objective of public health policy. Today's goals are to improve health and to reduce health differences between groups occupying unequal positions in society.[22] Tackling determinants is central to the achievement of the two goals, providing a way of simultaneously promoting health and addressing health inequalities (Box 1).

Box 1: Tackling determinants

'Cross-government action will address the root causes of ill-health and health inequalities… The government's aim is to reduce health inequalities by tackling the wider determinants of health inequalities.' (Department of Health, 2003)[23]

But what it means to tackle the root causes of health and health inequalities is not always clear. There are three related questions:

- What are determinants?
- How do they connect up with each other and with the individual whose health is being determined?
- Is there a difference between the determinants of health and health inequalities?

To examine these questions, we focus on socioeconomic inequalities, as manifested in health differences between advantaged and disadvantaged socioeconomic groups, and between richer and poorer areas. But the issues raised apply to other dimensions of health inequality, including gender and ethnic inequalities.

What are determinants?

'Determinants of health' is a term introduced in the 1970s as part of a wider critique of public health research and policy. It was argued that too much research attention and too much health expenditure were being devoted to individuals and their illnesses, and too little invested in populations and their health. Backing up the critique was evidence that medical care had played a relatively minor role in the dramatic improvements in health through the late 19th and early 20th century. Public health, it was concluded, should be more concerned with social policies and social determinants than with health services and disease outcomes.

In today's debates, the determinants of health include all the major non-genetic and non-biological influences on health. The term therefore covers individual risk factors, such as smoking, and what are often called 'wider determinants' (Box 2). Healthcare services are also usually included. This is because of evidence that, since the mid-20th century, timely and effective interventions have made an important contribution to the decline in mortality from major diseases such as coronary heart disease and cancer.

Box 2: Listing determinants

'Health and wellbeing are influenced by many factors including past and present behaviour, healthcare provision and "wider determinants", including social, cultural and environmental factors.' (Wanless, 2004)[24]

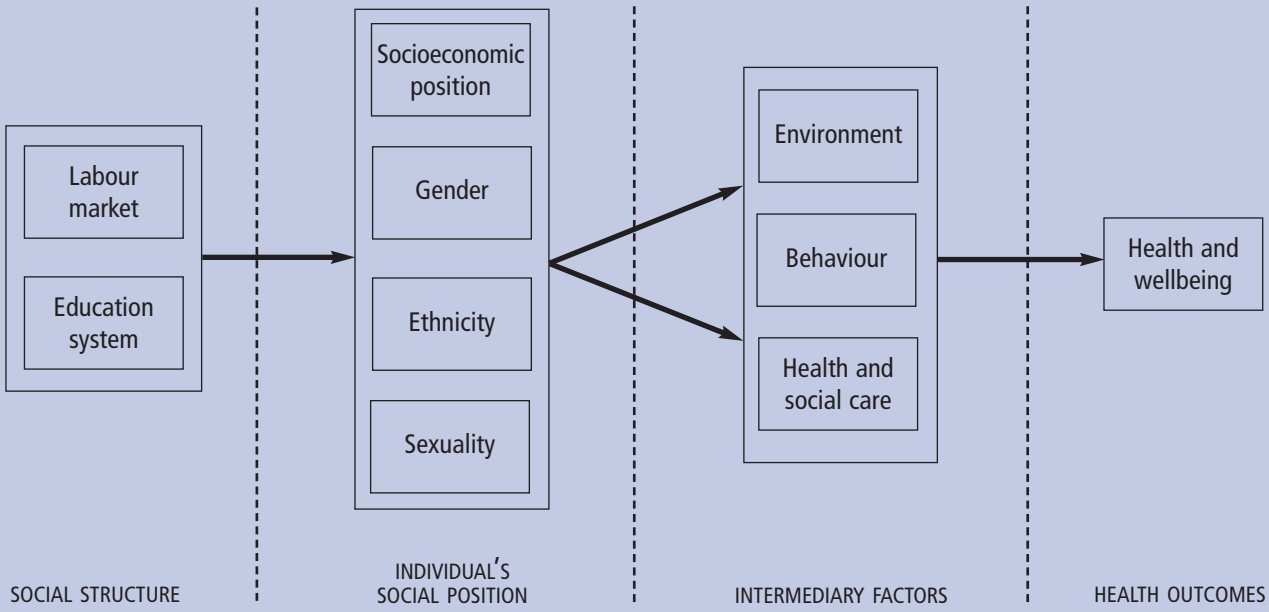
'Public health policy has recognised the growing importance of the wider determinants of health, such as income, education, employment, housing and the environment, as well as their effect on lifestyle. Highlighted by the Black report and the Acheson report, much of government policy now seeks to address these issues that have traditionally been outside the health domain.' (Wanless, 2004)[24]

How do determinants connect to people's lives?

Lists are helpful in identifying the important influences on population health (Box 2). But they are less helpful in explaining how wider determinants and individual risk factors link together and connect with people's lives. To understand the links, we need to include a determinant that is often left out of the lists and models. This is social position, a shorthand term for a person's position in the social hierarchies, the axes of differentiation, around which society is built. Because there is a range of (interlocking) structures of inequality, everyone occupies multiple social positions: for example, a white, gay man in a manual occupation or a heterosexual, Indian woman in a managerial occupation.

Many health researchers regard social position as the fundamental cause of health. This is because it is the pivotal link in the causal chain through which social determinants connect up to influence people's health. It marks the point at which societal-level factors – such as the structure of the labour market and education system – enter and shape people's lives, influencing the extent to which they are exposed to risk factors that directly affect their health, such as workplace hazards, damp housing and a poor diet.

Box 3: How key health determinants connect up[25]



Box 3 illustrates this important pathway, giving examples of determinants operating at different points along it. The pathway runs from the *social structure* to health and wellbeing. Structural determinants such as the education system impact on people's health and wellbeing via their *social position* and the *intermediary factors* associated with it. Examples of social positions are listed, as are a range of intermediary factors which influence health. Along with environmental and behavioural factors, such as housing quality and exposure to smoking, the figure includes health and social services among the intermediary determinants. In addition to their role in preventive care, these welfare services make an important contribution to reducing the impact of illness and injury on health (by treating illness and injuries, and providing care and support for those with disabling conditions, for example).

It needs to be emphasised that the figure gives examples from one key set of pathways: it does not provide a complete picture. For example, poor health and disability exert a downward drag on an individual's socioeconomic circumstances – signalling a line of influence running from health and back to social position.

Because an individual's social position (their socioeconomic position, for example) mediates both their access to societal resources (such as educational and job opportunities) and their exposure to risks, it has an enduring association with health, over time and across different diseases. Over the centuries, socioeconomic position has continued to predict health and longevity, despite major changes in the killer diseases and the risk factors through which they take their toll on health. Environmentally transmitted infectious diseases have given way to chronic diseases in which behavioural factors play the larger role, but the socioeconomic gradient has endured. Today, deaths with very different causes and age profiles, such as accidents and coronary heart disease, continue to display this gradient. Box 4 gives examples of this enduring association between socioeconomic position and health.

To date, socioeconomic position has been singled out for attention. Studies have highlighted how an adult's socioeconomic position (as an accountant or an unskilled

Box 4: Socioeconomic position and health, England and Wales[26 27 28]

Infant mortality by father's occupation, 1911 (per 1,000 births):

Higher non-manual (doctors, teachers etc)	42
Semi- and unskilled manual (labourers, navvies etc)	171

Death rates from suicide by social class, 1959-63, men aged 15-64 (standardised mortality rates per 100,000):

Social class I	91	Social class V	184

Death rates from ischaemic heart disease by social class, 1997-9, men and women aged 35-64 (age-standardised rates per 100,000 person years):

	Men	Women
I and II	90	22
IV and V	167	50

worker, for example) is powerfully shaped by the socioeconomic position of their parents,[29] with evidence that family background has become a more, not less, important influence on the future socioeconomic position of children.[30] Studies are highlighting, too, how a person's socioeconomic position is shaped by their position in other structures of inequality. For example, while education is linked to higher living standards, it confers greater benefits to some ethnic groups than others. The starkest contrast is between white and Bangladeshi groups: a Bangladeshi with a degree has the same risk of poverty as a white person with no qualifications.[31]

Is there a difference between the determinants of health and health inequalities?

The commitment to addressing underlying causes is often summed up in the phrase 'tackling the determinants of health and health inequalities'. Such phrases can create the impression that policies aimed at tackling the determinants of health are also and automatically tackling the determinants of health inequalities. What is obscured is that tackling the determinants of health inequalities is about tackling the *unequal distribution* of health determinants.

Focusing on the unequal distribution of determinants is important for thinking about policy. This is because policies that have achieved overall improvements in key determinants such as living standards and smoking have not reduced inequalities in these major influences on health. As the examples given in Box 5 indicate, positive trends in health determinants can go hand-in-hand with widening inequalities in their social distribution.

As these examples suggest, distinguishing between the overall level and the social distribution of health determinants is essential for policy development. When health equity is the goal, the priority of a determinants-oriented strategy is to reduce inequalities in the major influences on people's health. Tackling inequalities in social position is likely to be at the heart of such a strategy. It is the pivotal point in the causal chain linking broad ('wider') determinants to the risk factors that directly damage people's health.

Box 5: Health determinants – overall improvements but widening inequalities

From 1970-2000, there was a sustained improvement in the constituents of socioeconomic position. The proportion of the population with educational qualifications and in higher non-manual occupations rose; so too did average income. But the policies that produced these positive trends did not reduce inequalities in socioeconomic position. Instead, social differentials in participation in higher education, in access to secure and well-paid occupations, and in income all widened across this period.[32 33 34]

From 1970-2000, the proportion of adult smokers declined sharply. But policies associated with this overall improvement failed to dent the socioeconomic differentials in smoking. Instead, the gap in prevalence between manual and non-manual groups widened, in both absolute terms (the difference in the prevalence rate of non-manual and manual groups) and relative terms (the difference in the risk of smoking between the two groups).[35]

Tackling inequalities in health determinants

The 2004 Wanless report[36] recommends that objectives are set for major determinants of health and health inequalities (Box 6). Setting objectives depends on clarity about how determinants link up to influence both overall health and its unequal distribution – a clarity needed to guide analyses of how changes in the level and distribution of different determinants could work through into positive changes in health and health inequalities.

Box 6: Objectives for determinants

'The government should seek advice about what quantifiable objectives it should set for progress in tackling all the major determinants of health and health inequalities.'[36]

Objectives for health determinants are likely to focus on reducing overall exposure to health-damaging factors along the causal pathway identified in Box 3. These objectives are being taken forward by a range of current national and local targets: for example, to raise educational standards and living standards (important constituents of socioeconomic position) and to reduce rates of smoking (a major intermediary risk factor).

Objectives for health inequality determinants are likely to focus on levelling up the distribution of major health determinants. How these objectives are framed will

depend on the health inequalities goals that are being pursued. For example, if the goal is to narrow the health gap, the key policies will be those which bring standards of living and diet, housing and local services in the poorest groups closer to those enjoyed by the majority of the population. If the health inequalities goal is to reduce the wider socioeconomic gradient in health, then the policy objective will be to lift the level of health determinants across society towards the levels in the highest socioeconomic group.

Taking socioeconomic position as the example, Box 7 illustrates how national policies have contributed to both objectives: combining overall improvements in people's circumstances with a faster rate of improvement in disadvantaged groups.

To date, policy evaluation and health equity audit has been primarily concerned with the impact of new interventions targeted at the poorest communities (including Health Action Zones, smoking cessation services and Sure Start). The impact of these important initiatives will be influenced by the wider policy environment, with other policies either amplifying or moderating their progressive effects. For example, the post-1997 welfare reforms have been 'pro-poor', levelling up living standards between poorer and richer households (Box 7). But their redistributive effects have been blunted by broader and more powerful trends in earnings and incomes. The overall effect of social and policy changes since 1997 has therefore been to increase inequalities in living standards.[37] Such widening inequalities will make it harder to achieve sustained reductions in inequalities in intermediary risk factors such as smoking – and beyond these risk factors, to reduce health inequalities.

Box 7: Policies tackling health determinants and health inequality determinants[38 39]

- Changes to the tax and social security system since 1997 have raised average living standards. In addition, the reforms have been progressive. The rate of increase has been highest in the poorest households, tapering away to zero for higher income households. The reforms have left the richest households worst off.
- Increased investment in welfare services that directly support people's lives, such as health, education and housing, means that welfare services make a more substantial contribution to overall living standards in 2000/1 than they did in 1996/7. This investment has also had a differential effect, lifting living standards more in poorer than richer households.

This suggests that an important part of objective-setting for determinants is a baseline of knowledge about how established and mainstream policies may be contributing to the inequalities that the new interventions are seeking to redress.

Summary

Tackling the determinants of health inequality is central to the government's commitment to reduce health inequalities. A key feature of the determinants captured in Box 3 is that they are themselves socially determined. The labour market and education system which structure access to employment and income are powerfully influenced by the wider society. So, too, are the inequalities associated with socioeconomic position, gender, ethnicity and sexuality. National policies, regional strategies and services at local and community level also act directly on the environments to which we are exposed, the habits we develop, and the healthcare system to which we turn in times of need.

This suggests that the scope for policy intervention is considerable. It suggests, too, quantifiable objectives to reduce the unequal distribution of health determinants will be important in driving forward Britain's public health policy.

TACKLING HEALTH INEQUALITIES: HEALTH DISADVANTAGES, HEALTH GAPS AND HEALTH GRADIENTS

National policy documents suggest that the goal of greater equality in health is being interpreted in a number of different ways (Box 8). Tackling health inequalities variously means improving the health of poor groups, reducing the health differences between poorer and better-off groups, and lifting levels of health across the socioeconomic hierarchy closer to those at the top.[40] These different meanings are explored with reference to socioeconomic inequalities in health. But similar issues arise when thinking about policies to address other and interlocking structures of inequality, including those linked to ethnicity.

Box 8: What are health inequalities?

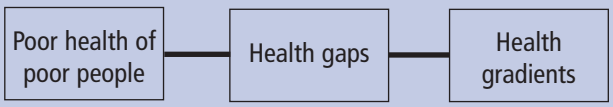
'The link between poverty and ill health'[41] and 'the health of the worst off'[42]

'The disparity in health status between rich and poor'[43] and 'the health gap between the worst off in society and the better off'[44]

'Exists between social classes'[45] 'right across the spectrum of advantage and disadvantage'[46]

These different understandings can be placed on a continuum, according to the degree to which they focus on the absolute levels of health in the poorest groups and communities, their relative health disadvantage or the wider socioeconomic gradient in health (Box 9). Tackling these different dimensions of health inequalities are complementary goals – improving the health of the poorest is the first stage in narrowing the health gap, which in turn contributes to reducing the health gradient. But there are also important differences between them.

Box 9: A range of meanings of health inequalities



Improving the health of poor people

At the left of the continuum in Box 9, health inequality is the link between social disadvantage and poor health (Box 8, quotes 1 and 2). The health inequality goal is therefore to achieve positive changes in the poorest groups: in their social conditions and life chances, in their risk behaviours and, as the longer-term outcome, in their health.

Defining health inequalities as the poor health of poor people has important policy advantages:

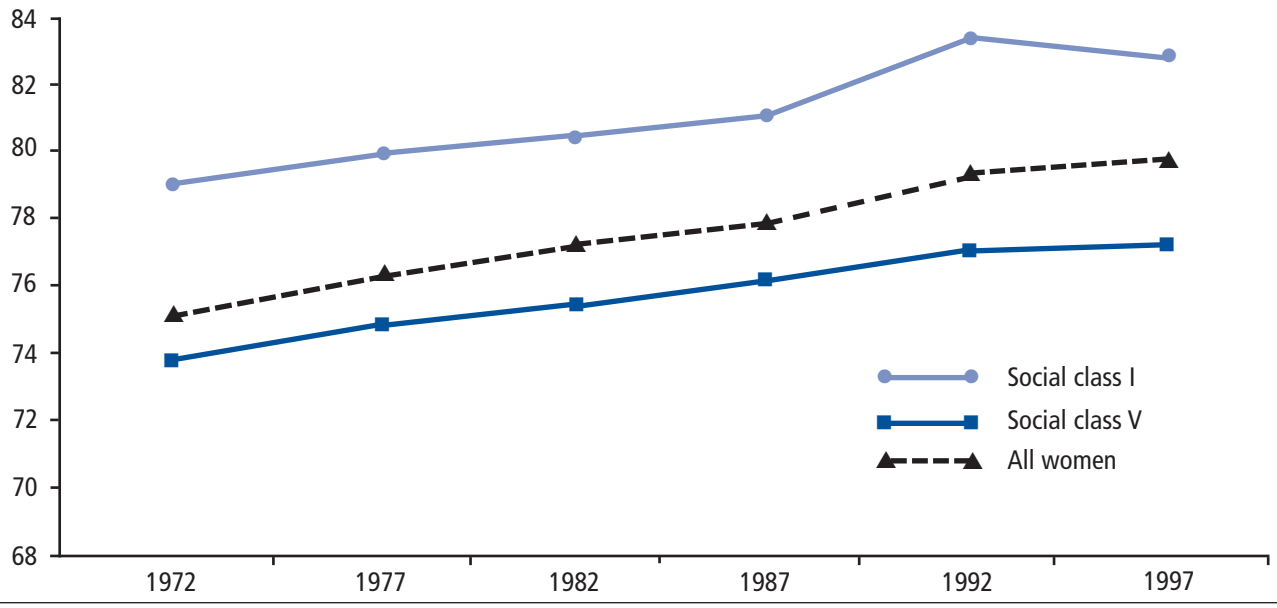
- It directs attention to the groups and communities who have lost out in the general rise in living standards and life expectancy: the unskilled manual groups where life expectancy has yet to reach the level achieved by professional groups three decades ago[47] and the wards where death rates are still above the rates reached by the country as a whole in the 1950s[48]
- It sets clear goals and clear criteria for monitoring and evaluation (Box 10)
- It aligns health equity policies with policies to promote social inclusion and to regenerate communities, steering them towards interventions to improve the life chances and health opportunities of poor groups. The targeted groups can be defined in spatial terms, using area-based measures of disadvantage, by their household circumstances (for example, unskilled manual head of households, claimant families) or through markers of individual vulnerability, like being a care leaver or a teenage mother.

Box 10: Improving the health of poor groups – monitoring policy impact

An effective policy is one which achieves positive changes in targeted outcomes in disadvantaged groups: in their predisposing social conditions, in their intermediate risk factors and/or in their health. Policy monitoring and evaluation can therefore be limited to the disadvantaged populations to which the recipients belong, for example by using a case/control design to compare outcomes in a similar group without the policy intervention and/or by measuring changes in the recipient group against broader population trends.

While offering policy advantages, defining health inequalities as the health penalties of poverty has limitations. It conflates inequality and disadvantage: it turns socioeconomic inequality from a structure which impacts on everyone into a condition to which only those at the bottom are exposed. This has two important implications:

Box 11: Life expectancy at birth, women, 1972-1999, England and Wales[51]



- While the goal of improving health includes everyone, the goal of reducing health inequalities reaches only a minority; 1:5 households are poor (with incomes below 60% of median income)[49] and 1:4 people are in social class IV/V (semi- and unskilled manual households)[50]
- Better health for the poorest can be associated with a widening health gap between them and the rest of the population. In a society where rates of health are improving more quickly in better-off groups, improving the health of the worst off can leave them slipping further behind both those at the top of the social ladder and the population average (Box 11). It is for this reason that the government's 'vision of narrowing health inequalities' turns not only on absolute improvements in the health of poor groups, but on a 'determination to narrow the health gap between the worst off in society and the better off'.[52]

Narrowing health gaps

At the mid-point on the continuum in Box 9, health inequality is the gap between the health of the best-off and worst-off groups (Box 8, quotes 3 and 4). Narrowing health gaps means 'raising the health of the poorest, fastest'.[53] It requires both improving the health of the poorest and doing so at a rate which outstrips that of the wider population. Again, it is an important policy goal:

- It focuses attention on the fact that overall gains in health have been at the cost of persisting and widening inequalities between socioeconomic groups and areas. For example, mortality rates among children in social class V (unskilled manual households) fell between the late 1970s and the early 1990s, but they were still twice as likely to die between their 1st and 16th birthday as children in social class I (professional households)[54]
- It facilitates target setting, with England's health inequality targets seeking to close the health gap between disadvantaged groups and the population as a whole
- It provides clear criteria for monitoring and evaluation (Box 12).

Box 12: Narrowing health gaps – monitoring policy impact

An effective policy is one which achieves both an absolute and a relative improvement in the health of the poorest groups (or in their social conditions and in the prevalence of risk factors). Analyses of policy impact therefore still require data on absolute changes in the targeted outcomes among those groups defined as the worst off. In addition, information is required on absolute changes in the same outcomes among those with whom they are being compared: for example, among the highest socioeconomic group or among the population as a whole. Such information is needed to estimate whether the rate of improvement in disadvantaged groups is greater than that in the comparison group: a faster rate of improvement is the essential criterion of effectiveness when narrowing gaps is the policy goal.

However, focusing on health gaps can limit the policy vision:

- The problem and the policy response are again confined to a small proportion of the population. The life

expectancy target is aimed at the 20% of areas with the lowest life expectancy; the infant mortality target includes around 40% of births, but it has been criticised for not focusing sufficiently on the disadvantaged groups with the worst health outcomes[55]

- It can encourage perspectives which identify the lifestyles of disadvantaged groups as the cause of health inequalities. Much less attention is given to how the privileges enjoyed at the top of the socioeconomic hierarchy facilitate rates of health improvement which have consistently outstripped those of other socioeconomic groups
- It can obscure the pervasive effects which socioeconomic inequality has on health not only at the bottom, but across the socioeconomic hierarchy.

Reducing health gradients

Box 13: The health gradient

'The penalties of inequalities in health affect the whole social hierarchy and usually increase from the bottom to the top. Thus, if policies only address those at the bottom of the social hierarchy, inequalities in health will still exist.' (Acheson, 1998)[56]

At right of the continuum in Box 9, health inequality describes the fact that health improves at each step up the socioeconomic ladder (Box 8, quotes 5 and 6). There are gradients in disability and chronic illness (Box 14), self-rated health and psychological wellbeing, and life expectancy and premature mortality – as well as in most major causes of death, such as coronary heart disease and lung cancer.[58 59 60] There are also marked gradients with increasing levels of area deprivation in mortality from these major causes.[61]

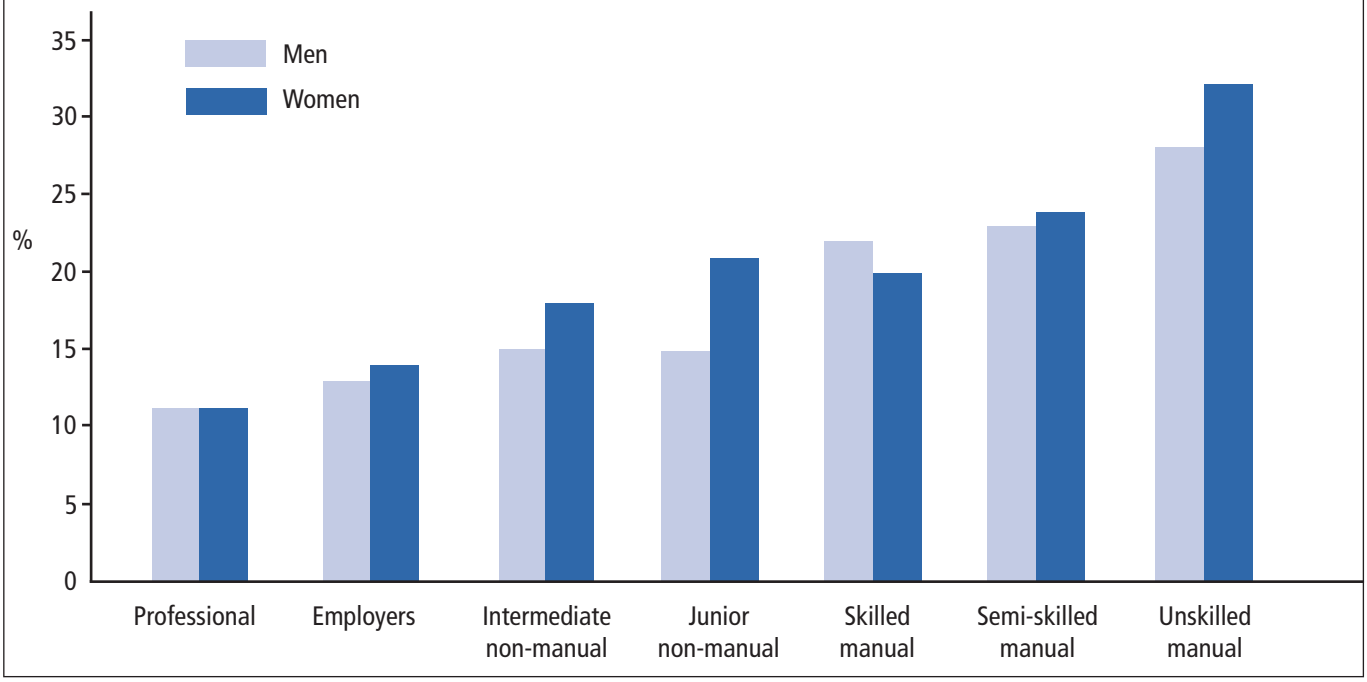
Tackling health gradients is in line with international health policy. The founding principle of the World Health Organization is that the enjoyment of the highest attainable standard of health is a fundamental human right,[62] and should be within reach of all 'without distinction for race, religion, political belief, economic or social condition'.[63] As this implies, the standards of health enjoyed by the best-off should be attainable by all.

Applying this principle, the Acheson report estimated the number of deaths that would be saved if mortality rates in social class III, IV and V were brought down to those in social class I and II.[64] The estimate for working age men – of 17,000 avoidable deaths a year – was included in the white paper guiding the new health strategy.[65] It is a way of representing health inequalities that makes clear that the costs are not only borne by those at the bottom.

A focus on socioeconomic differentials rather than on social disadvantages widens the frame of health inequality policy:

- It is an inclusive goal: improving the poor health of poor groups and narrowing health gaps are necessary but not sufficient to level up health across socioeconomic groups. It means that the three policy objectives can and should be pursued in tandem

Box 14: Prevalence of limiting longstanding illness by socioeconomic group (based on occupation of household reference person)[57]



- It directs attention to the majority of the population: to those socioeconomic groups lying between the top (professional and managerial) and the bottom (semi-skilled and unskilled manual). While health in these intermediate groups is better than among the poorest groups, their compromised health makes a larger contribution to the toll that socioeconomic inequality takes on the health of the population[66]
- The effects of policies to tackle health inequalities must therefore extend beyond those in the poorest circumstances and the poorest health (Box 15)
- It locates the causes of health inequality, not in the disadvantaged circumstances and health-damaging behaviours of the poorest groups, but in the systematic differences in life chances, living standards and lifestyles associated with people's unequal positions in the socioeconomic hierarchy.

Box 15: Reducing health gradients – monitoring policy impact

Assuming that health and living standards for those at the top of the socioeconomic hierarchy continue to improve, an effective policy is one that meets two criteria. It is associated with (i) improvements in health (or a positive change in its underlying determinants) for all socioeconomic groups up to the highest socioeconomic group and (ii) a rate of improvement which increases at each step down the socioeconomic ladder. In other words, a differential rate of improvement is required: greatest for the poorest groups, with the rate of gain progressively decreasing for higher socioeconomic groups.

Summary

The policy goal of tackling health inequalities has (at least) three meanings. Each adds a further layer to the policy challenge. Improving the health of the poorest is a goal in line with national trends. Narrowing health gaps and reducing the health gradient both require a reversal of the trends evident for major dimensions of health such as life expectancy.

This range of meanings suggests that the goal of tackling health inequalities can be adapted to local needs and community priorities, enabling broad coalitions of support to be mobilised. But clarity about these meanings is also important: 'what works' to improve the life chances and health prospects of poorer groups may not have the magnitude of effect necessary to bring them closer to the population average – or to reduce wider social and health inequalities. Being clear about what is being tackled should be integral to the development and delivery of policies to promote equity in health.

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