Closing the Health Inequalities Gap:

An International Perspective

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- to monitor, review and systematize the policy implications of the social and economic determinants of population health; and
- to provide services to help Member States in the WHO European Region increase their capacity to invest in health by addressing these policy implications and integrating them into the agenda for development.

ABSTRACT

This report presents an analysis of official documents on government policies to tackle inequalities in health from 13 developed countries. All countries recognize that health inequalities are caused by adverse socioeconomic and environmental circumstances. However they differ in their definitions of inequalities and in their approaches to tackling the problem. Sweden and Northern Ireland have structured their overall public health policy to tackle the underlying determinants of inequalities in health. England is the only country with a separate comprehensive policy. Most countries also have policies on poverty, social inclusion, and social justice. These are motivated by a concern for human rights and dignity and deal primarily with the underlying causes of health inequalities. While broadly setting the same overarching goal, policies on health inequalities show many different features. Policymakers face two challenges: to ensure that strategies to tackle the macroenvironmental factors feature in policy on inequalities in health, and to ensure that health becomes a prominent issue in social justice policy. Few countries have a coordinated approach to tackling inequalities in health.

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Acknowledgements

Caveat

This report is based on the extensive set of documents the authors were able to obtain from web sites, individuals and government departments. To maximize coverage, the Web was searched in a variety of ways and individual web sites were visited several times. However, due to the large volume of documents pertaining to inequalities in health, the authors cannot be certain that all relevant documents were obtained. Further, it is likely that some countries have documents on inequalities in health that have not been translated into English. Thus, some of the findings might well have been modified had the authors had access to a fuller set of documents.

Executive summary

Inequalities in health are a problem in all developed countries. This report reviews public health policies on health inequalities in 13 developed countries to establish how countries define the problem, how they measure it and the strategic approaches adopted to tackle it.

Methods

Current public health policies and other relevant documents were reviewed from the following countries: Australia, Canada, Denmark, England, Finland, Ireland, New Zealand, Northern Ireland, Norway, Scotland, Sweden, the United States and Wales. The findings were based on documents obtained by searching government web sites and through correspondence with ministers of health and experts in the field of public health. This report is based on policy documents that were available up to and including October 2004. The content of this publication was presented at the Knowledge Forum "Health, sustainable development and poverty reduction", held 25-27 November 2004 at the WHO European Office for Investment for Health and Development, Venice.

Results

Inequalities in health are recognized to be a major problem in all countries studied, with many reporting increases during the 1980s and 1990s. However, countries differ in their definitions of inequalities in health and their assessment of the scale of the problem. Inequalities in health are most commonly presented as the difference in health status between socioeconomic groups, but inequalities in health are also described by geographic location, employment status, gender and ethnic group. Many other specific groups are recognized to be at risk of inequalities in health including travelling people, prisoners, asylum seekers, the homeless and people with physical and mental disabilities.

The extensive data on the nature of inequalities in health in the United States shows a highly complex pattern across the high risk groups: not only are there many different

groups at risk of inequalities in health but the nature of the risks they face differ in complex ways. Depending on the measure of health status chosen, each subgroup may be at an increased or decreased risk. The important message from these data is that the term 'inequalities in health' embraces a varied set of differences in health status. If the nature of inequalities in health varies markedly across groups then so must the underlying causes. Tackling inequalities in health will thus require a set of strategies tailored to the individual needs of each group.

Tackling inequalities in health is an overarching aim of all public health policies. Most countries have ambitious goals for reducing inequalities in health: the United States goes so far as to set the goal of eradicating all inequalities in health by 2010. Other countries have goals to reduce the gap in health status between specified groups by amounts ranging from 10% to 50%. There are major differences in policy approaches to health inequalities. Two countries, Sweden and Northern Ireland, have structured their overall public health policy to tackle the underlying determinants of inequalities in health. England is the only country with a separate comprehensive policy on inequalities in health. New Zealand prescribes a framework to ensure that inequalities in health are tackled systematically across all health policies. Other countries address inequalities in health in their overall public health policy and in policies on specific topics.

Policies recognize that macroenvironmental factors, (the national socioeconomic factors and the physical and social environment), are the principal determinants of inequalities in health. These factors influence the living and working conditions of the individual, although their effect is moderated by local social and community - conditions. Ultimately, all these factors influence the health behaviours which individuals adopt, particularly those behaviours which adversely affect health (smoking, poor diet, lack of physical activity, excessive alcohol consumption and irresponsible sexual behaviour). The complexity of the causes of inequalities in health means that multifaceted and therefore multisectoral action is required to tackle the problem. Interventions must tackle the macroenvironmental factors (income and education) and the physical and social environment, as well as adverse health behaviours and access to health care. A challenge all countries face is the shortage of

evidence on effective interventions to reduce inequalities in health. In recognition of this several governments have established national research programmes.

Most countries have separate policies on poverty, social inclusion and social justice. Unlike policy on inequalities in health, these policies seldom emanate from departments of health. The social inclusion/social justice policies are motivated by a general concern for human rights and dignity, of which health is only a small part. However, as they deal with the underlying causes of inequalities in health (low income and unemployment, housing and homelessness, and social exclusion), they are directly relevant to health.

The social inclusion/social justice documents provide estimates of the scale of the problem of poverty across the countries. These are based on the proportion of the population who earn less than a specified fraction of the median income. The social inclusion/social justice approach provides coordinated strategies that tackle the major underlying determinants of inequalities in health. A key feature of the social inclusion/social justice programmes is the regular evaluation of progress towards targets.

Conclusions

This review of public health policy has established that inequalities in health exist in all countries and are considered unacceptable. All countries set an overarching goal to reduce inequalities in health, and recognize that interventions to achieve this must tackle the macroenvironmental factors (income and education) and the physical and social environment, as well as adverse health behaviours and access to health care. Interventions which only tackle adverse health behaviours will have little success: they offer microenvironmental solutions to a macroenvironmental problem. Policies on social inclusion/social justice are better placed to tackle the macroenvironmental factors. Unfortunately there is not always a strong link between inequalities policy and social justice policy. Thus, the challenge facing policymakers is to ensure that strategies to tackle the macroenvironmental factors feature in policy on inequalities in health and that health becomes a prominent issue in social inclusion/social justice policy. This may be best achieved by integrating the policies in these two areas.

Introduction

Life expectancy in developed countries has shown a steady improvement in recent years *(1)*. However, this improvement has not occurred consistently across all segments of the population. Inequalities in health exist between groups of the population and, in some countries, these inequalities are increasing. Inequalities in health are considered by all countries to be unacceptable. This was first expressed at the international level in the Declaration of Alma-Ata in 1978 which stated that "the existing gross inequality in the health status of the people … is politically, socially and economically unacceptable" *(2)*.

One of the most influential documents in putting inequalities in health on the agenda was the 1980 *Black Report (3)* from the United Kingdom. The concept that deprivation and ill-health were linked was not new, but Black produced convincing evidence that poverty and ill-health were inextricably linked and that material deprivation was a major determinant of ill-health and death. Further, the *Black Report* showed that inequalities in health had worsened in the United Kingdom despite the establishment of the National Health Service in 1948. It suggested that these inequalities in health did not result from failures in the health care system, but were due to other social inequalities that influence health: income and employment, education, quality of housing, diet and the working environment. In addition, Black concluded that people's behaviour is constrained by structural and environmental factors over which they have no control. The Report therefore recommended a raft of social policy measures to tackle inequalities in health. These were not welcomed by the government of the day. The then Secretary of State for Social Services, in a foreword to the report, recognized that the report recommended "a major and wide-ranging programme of public expenditure". However, he concluded that this was "quite unrealistic in present or any foreseeable economic circumstances".

Other countries were also assessing their situation. Following the publication of the *Black Report*, Sweden undertook a cross-national comparison. Although inequalities in health were less obvious, the study found some social class inequality within Sweden *(4)*. Equity in health was the first target in WHO's *Health for All by the Year*

2000 (5). The target stated that the actual differences in health status between countries and between groups within countries should be reduced by at least 25%, by improving the health of disadvantaged nations and groups. The importance of reducing inequalities was reaffirmed at the Fifty-first World Health Assembly in 1998, in recognizing Health-for-All in the 21st century, as a framework for the development of future policy *(6).* The target on equity in health was subsequently restated in the *Health 21 Strategy (7)* for the European region. The second of the 21 targets is: "by the year 2020, the health gap between socioeconomic groups within countries should be reduced by at least one quarter in all Member States, by substantially improving the health of disadvantaged groups".

There is now universal agreement that inequalities in health are unacceptable and require urgent action. Despite this, the gap in health status between the most affluent and the most disadvantaged has widened in recent years. The 1998 *Independent Inquiry into Inequalities in Health Report (8)* by Acheson, found that although prosperity has increased in England, the health gap between social classes had widened since the 1980s. This was primarily because of the faster rates of improvement in health of the more affluent groups *(9).* Australia, in its review *Health Policy and Inequality (10),* reported that a general population approach did not always reach those most in need. Norway has expressed it clearly: 'it is not the individual's conscious choice that is the crux of the matter. The problem is that people with a low social status, few assets and few resources also suffer from most pain, illness, disability and reduced life expectancy' *(11).*

The root causes of inequalities in health are the complex interaction between personal, social, economic and environmental factors *(12, 13).* This means that a broad-based policy is required to tackle inequalities in health. Mackenbach points out that the most fundamental approach to reducing such inequalities in health is to address directly inequalities in education, occupation and income *(14).* The lifecourse approach to inequalities in health indicates that there are opportunities for intervention at many points throughout life. This approach also shows that the greatest potential is for interventions targeted at children, as poverty and deprivation at an early age can have long-lasting effects.

The problem of inequalities in health is deep-seated and tackling it will require a sustained and systematic effort *(14)*. Action is required at many levels: international, national and regional; city and local community level; and with individuals, families and other social groupings *(15)*. Many countries have recently developed and implemented strategies to reduce inequalities in health. This report reviews public health policies on health inequalities in 13 developed countries, to establish how countries define the problem, how they measure it and the strategic approaches adopted to tackle it.

Aims

This study provides a review of official documents on government policies to tackle inequalities in health from 13 developed countries. The aims of the study were to:

- obtain policy documents with particular relevance to inequalities in health
- identify current perspectives on the nature and causes of the problem
- describe the ways in which inequalities in health are defined in different countries
- outline strategic approaches which have been developed to tackle inequalities in health
- describe the goals, targets and indicators used to monitor progress on reducing inequalities in health
- describe the proposals for the evaluation of the effectiveness of policy

Methods

This report is based on policy documents that were available up to October 2004. Policy documents and other background documents that tackle inequalities in health were obtained from 13 developed countries: Australia, Canada, Denmark, England, Finland, Ireland, New Zealand, Northern Ireland, Norway, Scotland, Sweden, the United States and Wales. The majority of documents were obtained from government web sites. As reducing inequalities in health is an overarching goal for public health strategies, the initial review focused on the overall public health policies from all countries. A further search identified those countries with stand-alone policies on inequalities in health and social inclusion /social justice. Finally, stand-alone policies on specific topics that address inequalities in health were sought. Although many documents were found on ministry of health web sites, strategies to address inequalities in health emanate from a range of government departments. The search therefore included many government department web sites. The public health policies from the United States, Denmark and the Health Strategy and Health Promotion Strategy from Ireland were obtained directly from their Health Departments.

Some countries have a limited number of documents in the English language available on the Ministry of Health web sites. For example, Norway and Sweden's public health strategies are only available as summary documents in English. Thus, the amount of information available varied substantially between countries. It is possible that the non-English-speaking countries have policies in their own language which we were unable to access.

Policy review

The policy documents were reviewed independently by two of the authors (LI and IKC). Data on the format and content of the policies, potential interventions to be implemented, and targets used were extracted from the documents. Particular attention was paid to the structure of approaches used to tackle inequalities in health. Summaries were prepared of the key policy features of policy: the assessment of the problem, the targets set; the interventions proposed; and the evaluations that have been put in place.

Structure of policy on inequalities in health

Section 1   Documents on inequalities in health

The volume of documents available on government web sites to address the problem of inequalities in health is vast. A list of over 180 documents identified from the countries studied can be found in Annex 1. The list covers all of the major documents and illustrates the range of material available.   However, it does not include all documents.   We have not included reports on local initiatives, nor have we systematically covered policies from departments other than the departments of health which could make reference to inequalities in health.   The Annex list also does not include the many papers that have appeared in the scientific literature.

The documents reviewed in this report fall into several categories. Those that chart the recognition of the problem of inequalities in health are not strictly policy documents, but provide important insights into the nature and causes of inequalities in health. These include the *Lalonde Report (16)*, the US Surgeon General's 1979 *Healthy People* Report *(17)*, the *Black Report (3)*, and the *Acheson Report (8)*.   These documents were commissioned by governments, although not always because of concerns with inequalities in health.

Reports assessing the nature and current scale of the problem can emanate from expert groups or government departments.   For example New Zealand's *Social Inequalities in Health (18)* was written by a group from Otago University for the Ministry of Health, whereas the report *Reducing inequalities in health* was produced by the Ministry of Health *(19)*. The Scottish review of inequalities in health *(20)* was written by the Health Promotion Policy Unit and the Public Health Institute of Scotland (a government funded department). *Inequalities in health in Ireland – hard facts (21)* was written by an expert group at Trinity College, Dublin using data supplied by the government, and with a foreword written by the Chief Medical

Officer. Public health reports and chief medical officers' reports also often describe inequalities in health within individual countries *(22, 23, 24)*.

The subject of inequalities in health is addressed within a range of policy documents. Most documents are issued by departments of health. General health strategies such as those from Ireland *(25)* and New Zealand *(26)* or *Improving Health in Scotland: The Challenge (27)*, often set the scene and give direction on how inequalities in health will be tackled. The overall public health policies from all of the countries studied give a more extensive coverage of inequalities in health. In addition topic specific policies, such as Wales' nutrition policy *(28)*, Ireland's National Children's strategy *(29)* and New Zealand's smoking policy *(30)*, often address inequalities in health. Some departments of health also give guidance to municipalities and district health boards on taking the health inequalities agenda forward. This is the approach adopted in Norway's *Use for Everyone (31)* and New Zealand's framework for developing policies to address inequalities in health *(19)*. Documents which are not directly about health can also be produced by departments of health, for example the *Youth Homelessness Strategy* from Ireland *(32)*. England is the only country with a stand-alone policy on inequalities in health which deals systematically with the underlying causes of inequalities in health *(33)*.

Many relevant policy documents have been produced by other government departments, such as Norway's *Plan of Action for Combating Poverty (34)* from the Ministry of Social Affairs and England's *National Action Plan on Social Inclusion* from the Department of Work and Pensions. Other examples include the *UK Fuel Poverty Strategy (35)* from the Department of Trade and Industry, and Northern Ireland's literacy and numeracy strategy *(36)* from the Department of Education.

Important information on policy approaches to inequalities in health is often presented in documents which are not formal policy documents. For example Finnish policies relevant to public health, including inequalities in health, are reviewed in a joint publication from the National Public Health Institute and the Ministry of Social Affairs and Health *(37)*. In the United States, the *Strategic Research Plan to Reduce and Ultimately Eliminate Health Disparities (38, 39)* was prepared by the National Institutes of Health on behalf of the Department of Health and Human Services.

Finally, Sweden's policies on inequalities in health are reviewed by senior members of the Swedish National Public Health Commission in a report published under the auspices of the World Health Organization *(4)*. Current Swedish policy is reviewed in two reports from the Swedish National Institute of Public Health *(40, 41)*.

Strategies to tackle inequalities in health are often developed in reports which follow policy documents. These come from government *(42, 43)*, from units within government departments *(44)* or from specially convened expert groups *(45)*. In some instances the details are presented in extensive web sites *(46, 47, 48, 49, 50)*.

This report is thus based on a wide range of documents, only some of which are formal policy documents. Together these provide a much fuller picture of the nature of inequalities in health and the strategies available to tackle them than would be obtained from policy documents alone. A further benefit of this inclusive approach is that it helps to ensure similar coverage of all countries. The way documents are produced varies between countries as does their status and influence. Including only policy documents would lead to the omission of valuable information from many of the countries. Annex 1 provides a list of documents which readers can access if they wish to explore the provenance of the documents cited.

Section 2   Description of inequalities in health

The complexity of causation

All countries review the nature of inequalities in health and most explore where they occur. Reasons why inequalities in health occur are often alluded to in policy documents but they tend to be discussed in more depth in background papers *(8, 19, 51)*. Inequalities in health are thought to result from a complex interaction of a range of factors which can be conveniently divided into five groups. The first group includes the general socioeconomic, cultural and environmental conditions that are present in society as a whole. These determine major factors such as levels of employment, salary scales and social welfare programmes.

The next group concerns the living and working environment. This includes the individual's position in society, with occupation, income and education playing a pivotal role. Poverty is the most important determinant of inequalities in health. Income depends on access to employment, which in turn is often influenced by educational level. Also included in this category are housing quality, access to health care and working conditions.

These factors are moderated by the third group, the social and community networks available to the individual. Feelings of insecurity and social exclusion have a detrimental effect on health.

All the above factors influence the health behaviours at the individual level, which make up the fourth group. Lifestyle choices such as smoking, lack of physical activity and poor diet all contribute to poor health. These health behaviours, although modifiable by the individual, are heavily influenced by socioeconomic position and the social environment.

Finally, also at the individual level, are the non-modifiable factors of age, gender and heredity.

Many of the factors that influence inequalities in health are beyond the control of the individual. The most disadvantaged are most susceptible to inequalities in health, as they have fewer opportunities to improve their physical and social environment. The complexity of causation of these problems means that tackling inequalities in health requires actions at a number of different levels. Interventions are required at all levels from national and local government through local communities and social groups to families and individuals. Thus actions will differ across these levels, and often require a multifaceted approach.

The relationship between disease and inequalities in health

Many countries recognize that inequalities in health occur in many disease groups including coronary heart disease, stroke, cancer, mental health problems and accidental death. Infant mortality also differs markedly across social groups. For

example, the infant death rate for American Indians and Alaska Natives is almost double that of white Americans *(52)*. Several countries give details of disparity related to chronic disease. The rate of death from coronary heart disease in England is three times higher among unskilled men of working age than among professional men *(53)*; death rates from cancer are 30% higher for African Americans than for white Americans *(52)*; and in Northern Ireland, women in the lowest social class are 60% more likely to experience some form of neurotic disorder than those in the highest social class *(54)*. These relationships are primarily due to the effect of deprivation on health. However, poor health can also lead to deprivation, largely because of its effect on education and employment which can result in downward social mobility at the individual level. New Zealand's Disability Strategy *(55)* specifically aims to reduce the impact of disability and chronic illness on socioeconomic status. In addition, New Zealand's framework for reducing inequalities in health *(19)*, states that all health policies should address the potential impact of disability on individuals and their families.

Measuring inequalities in health

Inequalities in health occur between many different groups in all societies. All countries agree that inequalities in health exist between socioeconomic groups. Denmark and Norway focus on these social inequalities in health, stating that the prevalence of illness and health are characterized by differences in education, income and occupation *(31, 56)*. For example, mortality in Denmark is 50% higher among unskilled men than among salaried workers *(56)*. Finland reports that the average life expectancy of an upper-level white collar worker is about 5.5 years longer than that of a blue collar worker *(57)*. Both Ireland and Northern Ireland highlight the association between poverty and poor health *(24, 54)* with Northern Ireland's public health policy stating that "poverty is the greatest risk factor for health".

New Zealand, in the report, *Social Inequalities in Health, New Zealand 1999 (58)*, expresses inequalities in health by deciles of the whole population using an index known as the NZDep96. The NZDep96 is a deprivation index that combines nine variables from the 1996 census for small areas (median of 90 people). The scores are grouped into deciles. Life expectancy for men in decile 1 (the least deprived) was 78

years in 1995–1997 compared with 69 years for those in decile 10. The use of deciles in New Zealand gives the appearance of a large gap between those in decile 1 and decile 10. By using deciles, differences between the lowest and the highest groups are more obvious. Countries that use broader groupings, for example quintiles, would detect much smaller differences between the most affluent and the most deprived.

Several countries also measure inequalities in health by geographic location, both within their own country and through comparison with other countries. Denmark reports that life expectancy in Copenhagen is four years less than in the rest of Denmark *(56)*. Wales is concerned about regional differences, particularly in the valley areas in the south of Wales *(23)*. In Finland cardiovascular disease is more common in the north and east of the country *(59)*. These cannot be explained by differences in risk factors and are considered to be at least partially explained by differences in people's environment, behaviour and sociocultural patterns. Scotland also compares geographical location, including comparisons within mainland Scotland, and with England *(45)*. For example, for the period 1998–2000, the difference in life expectancy for men in East Dunbartonshire and Glasgow city was 7.4 years. The recent report by the Measuring Inequalities in Health Working Group *(45)* also highlights the higher rates of premature death in all social groups compared with England. In addition, inequalities in health between the most affluent and the most deprived is greater in Scotland than it is in England.

The marked differences in health between men and women is widely recognized. In the United States in 1998, there were 165 deaths from coronary heart disease per 100,000 of the population among women, while the rate was 265 per 100,000 among men *(52)*. Finland reports a seven year difference in life expectancy between men and women *(59)*, while in England the difference is approximately five years *(53)*.

Inequalities in health between ethnic groups are also commonly reported. In New Zealand it is the area that receives most attention *(19)*. Maori and Pacific people have poorer health status at all levels of education and income than other New Zealanders, with Maori experiencing even worse health than Pacific people. In other countries, such as the United States and the United Kingdom, it is the immigrant populations that have the poorest health. Norway is particularly concerned about the social

inequalities and resulting health inequalities among the non-western immigrant population *(11)*.

Some countries systematically review inequalities in health across many different groups. Sweden *(40)*, England *(53)* and the United States *(52)* all agree that inequalities exist by socioeconomic status, educational level, geographic location, gender, ethnic group and age group. In addition, the United States also includes disability and sexual orientation as areas where inequalities in health exist. For example, among adults aged 65 to 74 years, 34% of those with a disability have lost all of their natural teeth compared with 22% of those with no disability *(52)*.

England, in the *Cross-Cutting Review on Inequalities in Health (53),* quantifies how inequalities in health are manifested in different ways. The gaps in health status between socioeconomic groups are illustrated in several ways: life expectancy, where the gap between social class I (most affluent) and social class V (most disadvantaged) is 7.4 years in men and 5.7 years in women; infant mortality, where there are 4 deaths per 1000 live births in social class I and 8.1 per 1,000 in social class V; and the risk of accidental death in children where the risk is 16 per 100,000 in social class I compared with 83 per 100,000 in social class V. The influence of geographic location is illustrated by the death rate from coronary heart disease. The death rate for people under 65 years in Manchester is 69.3 per 100,000 while in Kensington and Richmond it is 20.6 per 100,000. Similarly, women with a diagnosis of breast cancer living in affluent areas have a 71% survival rate after five years compared with 63% for those living in deprived areas. Finally, among minority ethnic groups, infant mortality in babies born to women who were born in Pakistan is double the rate of infant mortality among all babies born in England.

High risk groups

Policies also make reference to specific groups within populations that suffer from inequalities in health. All countries identify people from ethnic minority groups as vulnerable. This includes immigrants and asylum seekers where access to mainstream services is often limited. However, in several countries the indigenous people are also often at risk. Such populations include Maori and Pacific people in New Zealand *(60, 61)*, Canada's Inuit people *(62)*, and the Saami people from the Nordic countries *(31)*.

People with chronic disease and disability and people with mental illness are highlighted as groups that may suffer greater inequality in health *(54, 55)*.

Several countries identify socially excluded groups. Ireland and Scotland are concerned about the poor health of the travelling people *(63, 64)*. In Ireland, travelling people's life expectancy has been shown to be 9.9 years less for travelling men than for settled men and 11.9 years less for travelling women than settled women *(25)*. Both Northern Ireland and Ireland highlight the needs of homeless people. In fact, Ireland has two homeless strategies, one integrated strategy *(65)* and *The Youth Homelessness Strategy (32)*. Other countries, including New Zealand, Australia and England, are concerned about inequalities in health among prisoners. The majority of countries target high-risk children as inequalities in health in adulthood can often be traced back to conditions in early life. Sweden's new public health policy notes that most of the foundation for social inequalities in health is laid during childhood and adolescence *(40)*. At the other end of the spectrum, older people may also suffer from inequalities in health. The United States reports that while 45% of people of all ages with diabetes received formal diabetes education, only 27% of those over the age of 75 years received the education *(52)*.

The United States has by far the most extensive system for assessing inequalities in health across several high-risk groups. The 1990 report, *Healthy People 2000 (66)* described inequalities in health for American Indians/Alaskan natives, Asian/Pacific Islanders, black/African Americans, Hispanics/Latinos, people with low income, and people with disabilities. The *Healthy People 2000 Final Review*, published in 2001, identified mixed progress in achieving the intended improvements *(67)*. Uniquely, as well as collecting data on mortality and morbidity for each of these groups, the United States routinely collects data for risk behaviours (for example smoking, diet and alcohol consumption), risk factors (for example overweight and obesity) and health care utilization (for example dental visits, breast cancer screening, immunization, and screening of the new born). The data highlight the complexity of inequalities in health as the different subgroups differ in mortality and morbidity, risk behaviours and health care utilization. For example, American Indians/Alaska Natives have a lower rate of coronary heart disease than white Americans whereas black/African Americans have a much higher coronary heart disease death rate. In contrast the

perinatal death rate is higher among American Indians/Alaska Natives than among white Americans. Similarly, Hispanics/Latinos have a lower overall death rate from cancer than white Americans but have a higher death rate from cirrhosis of the liver. Diversity is also seen in risk factors where American Indians/Alaska Natives have a higher prevalence of smoking than white Americans whereas Asians/Pacific Islanders have a much lower prevalence. Health care utilization shows a very complex pattern. For example black/African American women have similar rates of mammography to white women whereas American Indian/Alaska Natives have much lower rates. However, Asians/Pacific Islanders have similar rates of childhood vaccination to white Americans whereas black/African Americans have much lower rates.

Scale of the problem

Few policy documents give details of the proportion of the population suffering from inequalities in health. England estimates that the greatest burden of disease exists among the most deprived 30 – 40% of the population *(33)*. It therefore maintains that in order to reduce inequalities in health and to achieve the targets set, improvements much be achieved within this group *(33)*. The proportion of people living in poverty is more commonly given in policies on social inclusion/social justice (see Section 5).

Trends in inequalities in health

There is much concern that inequalities in health have recently increased. Some countries, such as England *(8)*, Sweden *(4, 68)*, Northern Ireland *(54)*, Scotland *(20)* and New Zealand *(18)* describe the increase in inequalities in health which occurred during the 1980s and 1990s. The impact of the major recession of the early 1990s is also discussed in documents from Finland *(59, 69)* and Sweden *(68)*. In a major review in 1998, New Zealand not only confirmed that inequalities were worsening, but concluded that they were likely to widen even further because of current trends in the underlying socioeconomic determinants *(70)*.

The extensive American data on inequalities in health in several high-risk groups provides intriguing evidence on trends in inequalities in health. An encouraging

finding is that between 1988 and 1998 the difference in life expectancy between whites and blacks decreased for both men and women *(67)*. Further, over the 200 special population sub-objectives, covering mortality, morbidity, risk behaviour and health care utilization many disparities were reduced or eliminated. For example disparities experienced by black/African Americans were reduced for cancer and firearms related deaths and for rates of mammography. However, the disparity increased for diabetes, maternal mortality and fetal alcohol syndrome. Asians/Pacific Islanders experienced a decrease in disparity for flu vaccination, but the disparity in the number of tuberculosis cases increased. Among people with low socioeconomic status there were encouraging improvements in breastfeeding and the use of contraception. However, there were adverse trends in certain oral health issues and in the proportion of people who were overweight.

Section 3   Strategic approaches to tackling inequalities in health

Strategies to address inequalities in health can be found in policies from all areas of public health. Three approaches were identified in policy documents. The first is to incorporate strategies within the overall public health policy. Another approach is to tackle the problem through individual health topics such as smoking or nutrition. The final approach is to have a stand-alone policy addressing inequalities in health. England is the only country to have such a comprehensive policy.

Incorporating inequalities in health in overall public health policy

Although all countries with overall public health policies have an overarching goal to reduce inequalities in health, the extent to which it is addressed within these policies varies. The United States' *Healthy People 2010 (52)* includes a section on disparities in health in all 28 of its focus areas. These sections give details on where the disparities lie within each topic area. The policy, however, does not provide a strategy on how inequalities in health should be tackled within the focus areas.

Denmark, Finland and Norway also tackle the problem of inequalities in health within a section of the overall public health policy. Denmark's *Programme on Public Health and Health Promotion (56)* aims "to reduce social inequality in health to the extent possible above all by strengthening efforts to improve health for the most disadvantaged groups". Thus, actions in the 15 areas identified will be targeted towards the most disadvantaged. The *Programme* therefore calls for the monitoring of morbidity and mortality in various social groups for the duration of the *Programme* period. Denmark's more recent strategy, *Healthy throughout Life (71)*, endorses the Government's commitment to tackling inequalities in health. It states that the Government believes that social equity in health is one of the fundamental values of a welfare society. The *Finnish Programme (57)* reports that in implementing its public

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health targets one aim will be to reduce inequality and increase the welfare and relative status of those in the weakest position. Few details of initiatives to be implemented are given in these documents. Norway acknowledges that public health policy has been more concerned with the average health of the population than with the diversity in health between groups, a point emphasized by Dahl *(72)*. The current policy, however, promises to be geared more specifically to parts of the population where both the challenges and potential for improvement are greatest *(11)*.

Northern Ireland and Sweden have a more comprehensive approach. Both countries have structured their public health policies around inequalities in health. Thus, the areas for action differ from those of most other countries. *Investing for health (54)*, Northern Ireland's strategy, aims to address the wider determinants of health. Areas for action therefore include tackling poverty and social exclusion; education; mental health and emotional well being; the living and working environment; the wider environment; accidental deaths and injuries; and making healthier lifestyle choices. *Investing for Health* is consistent with and complements other interdepartmental initiatives, particularly the action plan *NewTSN* (Targeting Social Need) *(73)*.

The approach taken in *Sweden's new public health policy (40)* is similar to that of Northern Ireland. The strategy is founded on one overall aim: "the creation of societal conditions which ensure good health, on equal terms, for the entire population". Improving the health of those groups that are most vulnerable to ill-health is particularly important and work focuses on those factors that influence public health: living conditions, environments, products and lifestyles. The policy is based on 11 objectives containing the most important determinants of public health:

1   participation and influence in society

2   economic and social security

3   secure and favourable conditions during childhood and adolescence

4   healthier working life

5   healthy and safe environments and products

6   health and medical care that more actively promotes good health

7   effective protection against communicable diseases

8   safe sexuality and good reproductive health

9   increased physical activity

10   good eating habits and safe food

11   reduced use of tobacco and alcohol, a society free from illicit drugs and doping
       and a reduction in the harmful effects of excessive gambling

The first six objectives relate to structural factors while the remaining five are about lifestyle choices which an individual can influence, but where the social environment plays an important part. Responsibility for meeting these objectives is divided among various sectors and different levels in society. Municipalities, county councils, voluntary organizations and other actors are encouraged to use the 11 general objectives in their own activities to achieve the overall aim.

Topic-specific policies that mention inequalities in health

Some countries such as New Zealand, Scotland, Ireland and Wales address inequalities in their overall policy and also within topic-specific policies. Examples include Scotland's sexual health strategy *(74)* and physical activity strategy *(75)*, Ireland's *National Children's Strategy (29)* and New Zealand's smoking policy *(30)*. These strategies highlight where the inequalities in health lie and identify areas for action. The recent nutrition strategy from Wales, *Food and Well Being (28)*, has the subtitle *Reducing inequalities through a nutrition strategy for Wales*. Although this strategy aims to improve nutrition throughout Wales, it is also intended to reduce inequalities in health by improving nutrition in the most vulnerable groups. Two levels of priority have therefore been set for the strategy. The level one priority groups include those on low income; other vulnerable people such as ethnic minority groups and older people; and children and young people. Level two priority groups include women of childbearing age, particularly pregnant women; and men, particularly middle-aged men.

Initiatives in the United States

The US Department of Health and Human Services has an array of programmes for disadvantaged groups *(76)*. These cover all age groups and many different groups in society. Services for specific populations include those for agricultural workers/migrant workers; people with disabilities; ethnic and racial minorities; gay men and lesbians; homeless people; immigrants and refugees; people living in rural

areas; and travelling people. The programmes involve a range of activities including the provision of information on health, health risks, health care and welfare benefits through a variety of web sites, publications and outreach programmes. A notable development was the New Freedom Initiative announced in February 2001, aimed at promoting full access to community life for Americans with disabilities *(77)*.

The most well known and extensive of the initiatives is the Head Start programme *(78, 79)*. The United States has for many years run comprehensive child development programmes for disadvantaged children.   Head Start and Early Head Start are programmes for children from birth to age 5, and for pregnant women and their families. The programmes are child focused and have the overall goal of assisting children from low-income families to prepare for school. Project Head Start was launched in 1965 in response to a request from the United States Government to draw up a programme to help communities meet the needs of disadvantaged children aged three to five years. Early Head Start, which was launched in 1994, is aimed at families with infants and toddlers, and pregnant women.

The programmes are based on research evidence and practice which show that children's physical, social, emotional, and cognitive development may be enhanced through early intervention. In addition, parents are assisted in becoming better caregivers and are enabled to meet their own goals, including economic independence. Action plans are developed jointly by the parents and staff.   The programmes provide a range of services including home visits, access to the Early Head Start centres, and other support such as family or centre-based childcare.

The programmes are extensive, reaching children and families across the country. The Department of Health and Human Services directly funds Head Start's 19,000 centres, which are operated by community and faith-based organizations and local public schools.   Since its inception, Head Start has enrolled over 21 million individuals. Other countries, for example Canada *(49)* and the United Kingdom countries *(46)*, have replicated this approach.

New Zealand's framework for reducing inequalities in health

Reducing inequalities in health underpins all of New Zealand's health policies. *The New Zealand Health Strategy (26)*, sets the scene by identifying the priority areas for action, and stipulates that all policies and programmes to be introduced should aim to reduce inequalities in health. To this end a framework to be used in development of policies and programmes has been developed. The document containing this framework, *Reducing Inequalities in Health (19)*, was produced as a guide for all of those working to reduce inequalities in health. It describes inequalities in health in New Zealand and identifies the scale of the problem. It then sets out a framework that can be used at all levels (national, regional and local) by policy makers, service providers and community groups to develop strategies to reduce inequalities in health. The framework proposes that interventions should be developed and implemented at four levels:

Level 1   Structural

Social, economic, cultural and historical factors fundamentally determine health. The most basic way to reduce inequalities in health is to tackle these factors. This requires investment in education, and the social security system, and also the development of labour market policies that will favour those most at risk of unemployment. The disadvantage of this approach is that it is not directly within the control of the health system. Health care professionals are encouraged to advocate that other sectors introduce policies that will improve health and reduce inequalities in health.

Level 2   Intermediary pathways

The impact of social, economic, cultural and historical factors on health is mediated by a range of other factors such as material, psychological and behavioural factors, all of which may be amenable to intervention. Potential interventions include: improving living conditions through housing policy and community development programmes; improving the physical and social environment at work; and community and school based programmes to help people from disadvantaged groups gain control over their lives and improve their coping skills.

Level 3   Health and disability services

Health care services have an important role to play in reducing inequalities in health. Health and disability services contribute by ensuring equity of access to care by distributing resources in relation to need by and removing barriers, however defined, that prevent the effective use of services for all ethnic groups.

Level 4   Impact

Actions at this level aim to minimize the impact of disability and illness on socioeconomic position. People who are chronically ill, or who have a disability or mental health problem, find it more difficult to gain employment or promotion. Specific actions include: income support; disability allowance; accident compensation; and antidiscrimination legislation and education.

A Health Equity Assessment Tool for tackling inequalities in health

More recently the Health Equity Assessment Tool (HEAT) has also been introduced in New Zealand *(80)*. It is used to review how particular inequalities in health come about and identify how they may best be tackled. It consists of a set of questions that can be applied to specific areas to be addressed:

1   What health issue is the policy/programme trying to address?

2   What inequalities exist in this health area?

3   Who is most advantaged and how?

4   How did the inequality occur? (What are the mechanisms by which this inequality was created, is maintained or increased?)

5   What are the determinants of this inequality?

6   How will you address the Treaty of Waitangi (the founding document of New Zealand) in the context of the New Zealand Public Health and Disability Act 2000?

7   Where/how will you intervene to tackle this issue? Use the Ministry of Health Intervention Framework to guide your thinking.

8   How could this intervention affect health inequalities?

9   Who will benefit most?

10   What might the unintended consequences be?

11   What will you do to make sure it does reduce/eliminate inequalities?

12   How will you know if inequalities have been reduced/eliminated?

Overall policy on reducing inequalities in health

England is the only country with a comprehensive stand-alone policy on reducing inequalities in health. The strategy has been developing since 1997 when the new Labour Government came into power. Work began with the commissioning of the *Acheson Report* in 1997. This Report confirmed that inequalities in health were increasing and made many recommendations for action *(8)*. A *Programme for Action (33)* was subsequently published in 2003 following a public consultation *(81)* and a Treasury led *Cross-Cutting Review* on inequalities in health *(51)*.

The *Cross-Cutting Review* recommended that tackling health inequalities should be incorporated into priority programmes. It identified five areas and named the government departments required to take the lead:

Breaking the cycle of health inequalities
Examples of suggested actions are: to reduce poverty through measures in the tax and benefit system; to improve educational attainment among disadvantaged children; to reduce teenage pregnancy and improve antenatal, maternal and child health services for disadvantaged and minority ethnic groups; and to promote healthy schools, particularly in disadvantaged areas.

Tackling the major killers
Promoting smoking cessation; improving screening; improving nutrition; increasing physical activity; and reducing accidents, particularly among disadvantaged groups, are identified as key areas for action.

Improving access to public services and facilities
Examples include: ensuring services are accessible to all, taking into account cultural and language barriers; improving primary care services in underserved inner city or rural areas; improving access to affordable food; and improving accessibility of disadvantaged groups to core facilities.

Strengthening disadvantaged communities
Neighbourhood renewal of deprived areas, including action on work and enterprise, crime, education, health and housing; promoting environments where people feel safe to go out; and improving housing conditions are included as areas for action.

Supporting targeted interventions for specific groups

Targeted interventions include ensuring that services can meet the complex needs of vulnerable people such as minority ethnic groups, older people, homeless people, prisoners, refugees and asylum seekers and people with long-term medical or mental health problems.

The *Cross-Cutting Review (51)*, like the *Acheson Report (8)* before it, concluded that in order to achieve the targets set, action would be required across government. *Tackling Health Inequalities. The Programme for Action (33)*, is therefore backed by 12 government departments.

The *Programme* presents a strategy on targeting resources and actions along four themes:

- supporting families, mothers and children
- engaging communities and individuals
- preventing illness and providing effective treatment and care
- assessing the underlying determinants of health

The themes are underpinned by five principles:

- preventing health inequalities becoming worse by reducing exposure to risks and addressing the underlying causes of ill-health
- working through the mainstream by making services more responsive to the needs of disadvantaged populations
- targeting specific interventions through new ways of meeting need, particularly in areas resistant to change
- supporting action from the centre by clear policies that are effectively managed
- delivering at local level and meeting national standards through diversity of provision

The *Programme for Action* provides a detailed strategy with a timescale for action for all the government departments involved. To illustrate how the strategy cuts across government departments, the key actions and targets for one of the themes, *Supporting Families and Children,* are given in Annex 2. It lists the role of each

department for three areas for action: maternal and child health and child health development; improving life chances for children and young people; and reducing teenage pregnancy and supporting teenage mothers.

Working in partnership is seen to be the key to the success of the *Programme*. This will involve cooperation and collaboration between the National Health Service Trusts, Primary Care Trusts, local government, Strategic Health Authorities and Local Strategic Partnerships which bring together different stakeholders, including communities, businesses, and the voluntary sector.

Responsibility for the inequalities agenda

Policies on inequalities in health emanate, as would be expected, from departments of health. In Finland the department is titled Social Affairs and Health, and in Northern Ireland the department is Health, Social Services and Public Safety. Despite this pre-eminence of health most countries recognize that the causes of, and hence the solutions to, inequalities in health lie with other government departments. Thus the relevant departments are recognized within policy documents. In some countries it is clear that these departments are actively involved in the development and implementation of policy. The English *Programme for Action (33)*, although led by the Department of Health, was developed by 12 government departments including: the Office of the Deputy Prime Minister; the Cabinet Office; HM Treasury; the Home Office; the Departments for Trade and Industry, Work and Pensions, Transport, Environment, Food and Rural Affairs, Culture, Media and Sport, Education and Skills and Constitutional Affairs. Similarly, the public health policies from Northern Ireland and Denmark include many departments. *Investing for Health (54)*, Northern Ireland's strategy, includes an appendix which names the 11 government departments that will be involved and gives details of their role in delivering the health inequalities agenda.

The need for research

Several countries have identified the pressing need for research on inequalities in health, and have established research units to carry this out. The objective is to

improve understanding of the routes through which deprivation leads to ill-health as well as developing and testing interventions to reduce inequalities in health.

In the United States the National Institutes of Health lead research on health disparities and currently have a *Strategic Research Plan and Budget to Reduce and Ultimately Eliminate Health Disparities (38, 39)*. The *Plan* has three major goals: research, research infrastructure and public information and community outreach. The Canadian Institutes of Health Research (CIHR) is the major federal agency responsible for funding health research in Canada *(82)*. The Institute of Population and Public Health (IPPH) and the Canadian Population Health Initiative (CPHI) also undertake research on inequalities in health *(83, 84)*. In the United Kingdom, the Economic and Social Research Council (ESRC) *(85)* is the leading research funding body addressing economic and social concerns. The National Public Health Institute of Finland *(86)* currently runs a research programme on socioeconomic inequalities in health. The aim is to improve the conditions for reducing inequalities in health by carrying out research on time trends and determinants of health disparities. The National Institute of Public Health in Sweden *(87)* which was established in 1992, leads on all public health research in Sweden.

Australia sees the lack of evidence of effectiveness as a reason for caution when implementing unproven interventions to reduce inequalities in health. It does not propose inaction, but has a careful programme to evaluate experimental interventions. The Australian Government is committed to building a strong evidence base for the development and implementation of effective health policies, including those aimed at reducing inequalities in health. To this end the Health Inequalities Research Collaboration (HIRC) *(88)* was established. Its goal is to enhance Australia's knowledge on the causes of and effective responses to health inequalities, and to promote the evidence in order to reduce health inequalities in Australia. Three research networks: children, youth and families, sustainable communities and primary health care have been established. Rural health and the health of indigenous Australians will be considered by all three networks.

Section 4   Evaluation of current policy

Goals and targets for reducing inequalities in health

Tackling inequalities in health is currently an overarching goal of all public health policies. It is usually the second of two main goals, the first being to increase health in the whole population, measured by life expectancy or health expectancy. Some countries have had a goal on inequalities in health for many years, while for others it is a more recent development. As early as 1986 Finland's *Health for All Programme* aimed to reduce disparities between population groups. This was in line with the *Health for All by the Year 2000* targets. *Healthy People 2000 (66)*, launched by the United States Government in 1990, included "reducing health disparities among Americans" as one of its three goals.

Countries differ in the amount of reduction desired in the gap between groups and also in the choice of indicators used to measure progress towards the goal of reducing inequalities in health. Goals can be set for many different subgroups within the population using a variety of different indicators of ill-health. This is explored below through the policies of five countries.

The current goal in *Healthy People 2010 (52)* is to eliminate health disparities that occur by gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation by 2010. The United States is the only country to have such an ambitious goal.

England has set national health inequalities targets in two areas: infant mortality and life expectancy. The targets aim to reduce the gaps in:
- infant mortality by at least 10% by 2010 between manual groups and the population as a whole
- life expectancy by at least 10% by 2010 between the 20% of areas with the lowest life expectancy and the population as a whole.

The Irish health strategy, *Quality and Fairness (25)*, gives four targets for 2007. These were developed to reflect the overall goal of the *National Anti-Poverty Strategy*

(89), that is to eliminate the impact of deprivation and disadvantage on health status. Ireland seeks a 10% reduction in the gap between groups:

- the gap in premature mortality between the lowest and highest socioeconomic groups should be reduced by at least 10% for circulatory disease, cancers, injuries and poisoning by 2007
- the gap in life expectancy between the travelling community and the whole population should be reduced by at least 10% by 2007
- the gap in low birth weight rates between children from the lowest and highest socioeconomic groups should be reduced by 10% from the current level by 2007

Finland's public health strategy has a total of eight public health targets *(57)*. The final one is "to reduce inequality and increase the welfare and relative status of those population groups in the weakest position". The objective is to reduce mortality differentials by gender, education and occupation by 20% by 2015.

Northern Ireland's goal is to reduce inequalities in health between geographic areas, socioeconomic groups and minority groups *(54)*. This is supported by two ambitious targets:

- to reduce the gap in life expectancy by 50% for those living in the 20% most deprived electoral wards and the average life expectancy
- to reduce the gap in the proportion of people with long-standing illness between those in the lowest and highest socioeconomic groups by 20% between 2000 and 2010

Scotland's recently published spending review reveals the Scottish Executive's new target to reduce inequalities in health *(90)*. Within the area of *Health and Community Care* the first objective is "to reduce the health gap between people living in the most affluent and most deprived communities". The target set is "to reduce health inequalities by increasing the rate of improvement across a range of indicators for the most deprived communities by 15%, by 2008".

Indicators to monitor progress towards targets

Goals that have been set for reducing inequalities in health are long term. However many indicators have also been identified so that progress in the short and medium term can be monitored. The indicators may be broad ranging to identify the many areas where inequalities in health are apparent. Examples from four countries – England, New Zealand, Northern Ireland and Scotland – illustrate the variety of indicators which may be used. Indicators from England and Northern Ireland are identified from policy *(33, 54)*. Those from New Zealand can be found in the Ministry of Health publication *Indicators of Inequality (91)*, and the Scottish indicators have been proposed in the recent report *Inequalities in Health (45)*. This section does not illustrate the differences between countries, but serves to indicate the range of indicators suggested by these countries. Scotland and New Zealand propose indictors on health only, while England and Northern Ireland, broaden the scope to include poverty, education and housing.

Breaking the cycle of poverty and inequalities in health is fundamental to health inequalities strategies. Lifting children out of poverty and reducing health inequalities from an early age is important. Therefore many of the indicators that have been identified focus on the health of children. Antenatal health, smoking during pregnancy, low birth weight, breastfeeding and infant mortality are all used. The dental health of children and accidents among children are both areas where there are marked differences between social groups. Physical activity levels both at school and outside the curriculum are also used. The United Kingdom is committed to halving child poverty by 2010 and eradicating it by 2020. The proportion of children living in low income or workless households is therefore used as an indicator in England. Northern Ireland reports that as data on children living in low income families are not currently available, the proportion of children entitled to school meals will be used in the meantime. Teenage pregnancy, accident rates, and attempted suicides have been identified as indicators for young people. England and Northern Ireland also include educational attainment at various stages.

Among adults, diet, particularly the consumption of fruit and vegetables and levels of obesity are used as indicators, as is the proportion of adults who smoke. Self-reported

health status, disability prevalence, and measures of mental health may also be used. Mortality from the major diseases such as coronary heart disease and cancer are also important measures. New Zealand will also use diabetes and hypertension rates and will monitor registration for breast cancer and cervical cancer. Other indicators for adults include: unemployment rates among specific groups; literacy and educational opportunities; accident mortality and road traffic casualties; accessibility to buildings by people with disabilities; and participation in drug rehabilitation programmes. Among older people, while all countries use mortality rates from chronic disease, New Zealand and England also include uptake of influenza vaccination and the proportion of older people living independently. More general indicators include housing quality, fuel poverty, air quality in cities and burglary rates. Finally, there are several indicators of access to health care services for all people, particularly primary care and child health services.

Section 5   Social inclusion and social justice policy

All countries have social welfare systems which have been in place for many years. These provide support and services to people, when required, at various stages of their lives. It is beyond the scope of this study to review the history of social welfare systems. However, there have been some developments in the broad area of social welfare in recent years. Two types of policy are particularly relevant to inequalities in health: social inclusion and social justice. Although there is overlap between the two types of policy, they differ in their origins and in their major goals. Some of these policies have been stimulated by international agreements and, although motivated more by human rights considerations than inequalities in health, they are highly relevant to inequalities in health. The major determinants of inequalities in health can be addressed through the social inclusion/social justice system.

Early developments

Some countries have had social inclusion/social justice policies in place for many years. For example, Finland's Social Protection Strategy *(92)* has been built up over several decades. The concept of social protection in Finland is broad. Thus it covers cash benefits, social welfare and health care services, preventive action and occupational health and safety. The main aims of the strategy are: promoting health and functional capacity; making work more attractive; preventing and combating social exclusion; and providing efficient services and income security.

Another country with a long-standing policy is Northern Ireland. Its Targeting Social Need (TSN) initiative was first introduced in 1991. It was initially intended to tackle problems arising from the Troubles in Northern Ireland, and the differences in the socioeconomic status of the Catholic and Protestant communities. When the Labour government came to power in May 1997, the policy was revamped and re-launched as *NewTSN (93)*. The 1998 White Paper *Partnership for Equality (94)*, sets out the objectives for *NewTSN*. The Belfast Agreement, known as the Good Friday Agreement, also identified *NewTSN* as one of the Government's socioeconomic commitments. The programme was formally launched on 28 July 1998.

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The aim of *NewTSN* is to encourage all government departments to target efforts and resources towards the most disadvantaged people in the areas of greatest social need. The policy has three strands:

- tackling the problems of unemployment and increasing employability

- reducing inequalities in other policy areas such as health, housing and education

- promoting social inclusion (PSI), through which it seeks to develop a coordinated and multiagency approach to tackling the problems of those groups and areas most at risk of social exclusion

The first PSI priority issues announced in June 1999 were:

- a strategic approach to the needs of minority ethnic people

- action to alleviate the needs of travelling people

- tackling the problems of teenage parenthood

- strategies for making services more accessible to minority groups and others at risk of social exclusion

The *NewTSN* requires all government departments to formulate action plans that identify social need within their area of responsibility and to set out ways to address this. The action plans provide objectives and targets to be achieved within specified time periods.

International developments on social justice

Several international developments have influenced the introduction of social justice policies. One of the most influential was the United Nations World Summit for Social Development which was held in Copenhagen in 1995 *(95)*. At this meeting 117 countries signed the Copenhagen Declaration on Social Development. Of the 10 commitments in the declaration one focused on the eradication of poverty.

Ireland was the first country to respond to the 1995 Copenhagen Summit. It initiated a widespread consultation, and in 1997 the 10-year *National Anti-Poverty Strategy* was launched *(89)*. The global target was to reduce the numbers of those who are 'consistently poor' from 9%-15% of the population to less than 5%-10%. Consistent poverty is defined as being below 50%-60% of average household income and experiencing enforced basic deprivation. Due to progress towards this target, in June

1999, the Government set a new target of reducing consistent poverty to below 5% by 2004. While the *National Anti-Poverty Strategy* looks at poverty in a global context, it also examines specifics within five key themes, each with its own subsidiary targets and timeframes. These themes are unemployment, income adequacy, educational disadvantage, urban disadvantage and rural poverty. A revised strategy, *Building an Inclusive Society (96)*, was launched in 2002.

From 1997 Scotland began developing a range of programmes to tackle social exclusion and poverty. The first policy to be introduced, *Social Inclusion – Opening the door to a better Scotland (97)*, was published in 1999. Later that year, following the opening of the Scottish Parliament and the establishment of a Ministerial Taskforce on Poverty and Inclusion, the social justice agenda was introduced *(98)*. The social justice framework has 10 targets and 29 milestones to monitor progress in five areas: children, young people, families, older people and communities. The milestones are broad ranging covering areas such as poverty, educational attainment, employment opportunities, housing, and health issues such as breastfeeding and smoking. The social justice strategy is currently being superseded by *Closing the Opportunity Gap (99)* which has been developed in response to the Scottish Executive document *Partnership for a better Scotland (100)*. *Closing the Opportunity Gap* involves collaboration between all government departments. It is based on 6 objectives and 10 targets and aims to prevent families and individuals from falling into poverty; to provide routes out of poverty; and to sustain individuals or families in a lifestyle that is free from poverty. One of the targets focuses on the major causes of death: coronary heart disease and cancer.

International developments on social inclusion
Another important development was the European Council in Lisbon in March 2000. At this meeting, European Union Member States agreed on the need to tackle poverty. The Council set out a 10-year strategy to make the European Union the world's most dynamic and competitive economy. The strategy was intended to provide a stronger economy which would enhance job creation as well as the development of social and environmental policies that would ensure sustainable development and social inclusion.

This agreement was affirmed at the European Council in Nice in December 2000 and Member States signed the Charter of Fundamental Rights of the European Union *(101)*. Curiously, this charter makes no reference to inequalities in health. However Member States agreed to produce regular national action plans to reduce poverty. Following the conclusions of the European Council in Nice, all European Union states prepared national action plans according to the jointly agreed principles. The first round of action plans was published in 2001, and the second in 2003.

The original overall objectives for the national action plans agreed in Nice were:
- to facilitate participation in employment and access by all to resources, rights, goods and services
- to prevent the exclusion of people from work
- to help the most vulnerable
- to mobilize all relevant bodies

In 2003, it was agreed that for the second round there was no need for significant change to these original objectives. However, three areas were identified as in need of change: establishing targets in order to significantly reduce the number of people at risk of poverty and social exclusion by 2010; placing more emphasis on gender; and ensuring a greater awareness of the high risk of poverty and social exclusion faced by immigrants. Based on these objectives, each Member State presented its priorities and efforts for the coming two years in promoting social inclusion and combating poverty and social exclusion.

Major areas addressed by social inclusion/social justice

The major concerns for social inclusion/social justice policies are tackling poverty; improving access to employment, education, health care and other services; and preventing the social exclusion of vulnerable groups. Wales states clearly that tackling poverty is at the heart of social inclusion *(102)*. It notes that poverty is concentrated in particular areas and consequently targets the most deprived areas. As well as tackling poverty directly, it has much wider aims including improving self esteem, education, housing and the physical environment and making communities safe and crime free.

Securing employment is one of the best ways to avoid poverty and social exclusion. Thus, it is essential to improve employment opportunities by maintaining low unemployment levels and removing obstacles such as lack of part-time jobs, or poor prospects for people with disability *(69)*. Improving educational attainment is a key factor in increasing prospects for employment and reducing the risk of social exclusion. Policies usually highlight the need for good education from an early stage, ensuring that young people do not leave school without having attained a satisfactory standard of education. Adult literacy, tertiary education and lifelong learning are also important. Some of the people most at risk from poverty and social exclusion are those who cannot work. It is important that the social protection of these people is assured through a system of income support and benefits *(103)*. Access to a range of services is a feature of all policies. These services include: health care; housing including measures to combat fuel poverty; transport; legal assistance; and culture, leisure and sport. Vulnerable groups are given special consideration within social inclusion/social justice policies.

Prevention of social exclusion is also a major area of policy. It covers a range of topics including links to the health inequalities agenda; homelessness; debt problems; teenage pregnancy; alcohol and drug use; supporting families; domestic violence; care for children and older people; and support for older people living in the community *(102)*. Social connectedness, including access to the Internet and opportunities for social participation, are also important *(98)*. In addition to the areas described above, vulnerable groups whose needs are greater are identified. The groups identified vary between countries. Children and young people are of paramount importance. Older people and people with disability are also mentioned *(98)*. Travellers, prisoners, asylum seekers and refugees are all at high risk of social exclusion *(34)*. People living in deprived inner city areas and remote rural areas may also need special consideration *(104)*.

Together these factors are covered in the broad policies to reduce poverty and social exclusion. Interventions range from increased investment in social protection through improving benefits systems; improving employability through training and education; providing childcare; providing affordable housing; providing family services and targeted health initiatives; and community development programmes.

Scale of the problem

Policies on social inclusion/social justice provide estimates of the extent of the problem of poverty, often using income as the guide. Poverty can be measured in a number of different ways. The European Union recommends that incomes below 60% of the median should be used as a headline indicator for international comparison. However, countries use different definitions. Wales in its *Third Annual Report on Social Inclusion in Wales* in 2004, states that 25% of residents were in households with incomes below 60% of the median income of Great Britain *(102)*. Ireland gives the proportion as 22%, based on the number of households with income below 60% of the median income in Ireland in 2001 *(104)*. Finland's definition is based on income less than 60% of the median household income in the European Union. In 2001 only 11% of Finnish households fell into this category *(69)*. Sweden reports that 9% of its population is poor, as measured by households with incomes below 50% of the median income in Sweden. Finally, Norway estimates that in 2000, 2.7% of the population had an income that was less than 50% of the median income for Norway, while 5.4% were below 60% of the median national income *(34)*.

Relationship of social inclusion/social justice to inequalities in health

Social inclusion/ social justice policies are concerned with human rights and human dignity. Inequalities in health feature among these concerns, but form only a small part of them. Although many of the social inclusion/ social justice initiatives will impact on inequalities in health, this is not the motivation. For example, homelessness is addressed not because it can lead to poor health, but because it is viewed as unacceptable in its own right. Priorities for social justice will tend to be set by potential ability to improve basic rights rather than ability to improve health. However the aims of policies on inequalities in health and social inclusion/social justice are inextricably linked. Some countries have policies on inequalities in health and social inclusion/social justice which have common goals. For example, Northern Ireland's *Targeting Social Need* programme *(105)*, England's Programme for Action

(33) and Ireland's *Building an Inclusive Society (96)* are examples of well integrated programmes.

Evaluation of social inclusion/social justice policy

Social inclusion/social justice policies require annual reports on progress. This is unusual for policy. Naturally, poverty among various groups is one of the main indicators used. The range of indicators includes measures of poverty such as households with no working adults, unemployment, literacy and educational attainment, fuel poverty, and environmental measures such as housing quality and air quality. New Zealand adds some additional domains which could well be more widely adopted *(106)*. These include important topics such as civil rights, the cultural environment, social connectedness and leisure and recreation. Finland, in its *National Action Plan against Poverty and Social Exclusion for 2003-2005 (69)*, has several important measures of exclusion including:

- economic exclusion with relative risk of poverty of different groups, households with income support, those with debt problems
- health problems, including perceived health, functional capacity of older people and health differences according to socioeconomic status
- exclusion from the labour market, including current unemployment among different groups, long-term unemployment, unemployment among people with disability and measures to promote employment
- exclusion from the housing market, including poor accommodation and homelessness
- exclusion from education
- other exclusion, including young people who are out of school but not in work; children in care; people with criminality, self-destructiveness or intoxicant problems; and people with alcohol or drugs-related problems.

The benefit of the regular evaluation built into the social inclusion/ social justice programmes is that it enables effective strategies to be identified so that they can be extended and disseminated to other countries. For example, in Ireland's comprehensive review of progress, details are given of many achievements such as

the provision of new childcare places, the extension of the house building programme, the provision of accommodation for travelling people, the participation of vulnerable groups in higher level education and the provision of transport in rural areas *(104)*. Sweden provides an excellent example of this in its 2001 report on the action plan against poverty and social exclusion *(107)*. It describes the success of a scheme aimed at making it easier for both parents to combine parenting with their employment. The scheme was so successful that in 2001 the Swedish Government decided to extend it. The Swedish report also describes initiatives aimed at helping the disabled and persons with intellectual disabilities that are currently underway and will shortly be evaluated. Likewise the United Kingdom's *National Action Plan (103)* presents a chapter which describes the impact of four major initiatives. For example, it describes the impressive reduction of 71% of people sleeping rough in England and the increase by the year 2000 in the provision of out-of-school childcare.

Synthesis

Inequalities in health are recognized to be a major problem in most developed countries and tackling them is an overarching aim of most public health policies. The recognition and concern reflect the scale of the problem which has been increasing in recent years. This synthesis draws on the many policy documents which cover inequalities in health, and it also draws on the documents on social inclusion/ social justice because of their importance for inequalities in health.

The twin goals of public health policy: are they in conflict?

Public health policies have two overarching goals: to improve the average health of the population and to reduce inequalities in health between groups within the population. The first aims to increase life expectancy of the general population by reducing the overall frequency of mortality and morbidity. However the strategies to achieve the first goal could be in conflict with the goal on inequalities in health. At issue is the way resources are used. Policies to increase average life expectancy would direct resources towards the major causes of mortality in all social groups, and might tend to use resources to tackle the health problems most amenable to improvement. Their aim would be to achieve the greatest overall improvement in health for the available resources. In contrast, policies targeted at reducing inequalities in health would devote most resources to disadvantaged groups, recognizing that they are trying to tackle particularly intractable problems. Thus the overall health gain of the population from policies targeted at disadvantaged groups would be smaller than if resources were used equally within all groups of the population. This potential tension is not acknowledged within policy documents.

Policy documents

Policies on inequalities in health are organized in many different ways. Some countries such as Northern Ireland *(54)* and Sweden *(40)* structure their overall public health policy into sections which tackle the main causes of inequalities in health. Thus they address poverty and social exclusion, the physical and social environment, and

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adverse health behaviours. Other countries, including Denmark *(56)*, Ireland *(25)* and Norway *(11)* have sections on inequalities in health within their overall health care or public health policies. Some policy documents address inequalities in health for specific topics such as smoking *(30)* and diet *(28)* or for specific groups within society. Other documents review particular factors which contribute to inequalities in health, such as unemployment and fuel poverty. Only one country, England *(33)*, has a single comprehensive policy to tackle inequalities in health.

Social inclusion and social justice

As well as policies on inequalities in health most countries have separate policies on poverty, social inclusion and social justice. These policies are motivated by a general concern for human rights and dignity, of which health is only a small part, and were largely motivated by international agreements. The United Nations World Summit for Social Development in 1995 in Copenhagen committed countries to the eradication of poverty. For European countries, the European Union Council in Nice in December 2000 committed Member States to produce national action plans to reduce poverty combined with regular monitoring of progress. As social inclusion/social justice policies deal with the underlying causes of inequalities (low income and unemployment, housing and homelessness and social exclusion) they are directly relevant to health.

The social inclusion/social justice documents provide estimates of the scale of the problem of poverty across the countries. These are based on the proportion of the population who earn less than a specified fraction of the median income. All countries are concerned that poverty levels are increasing. Unfortunately many different definitions of poverty are used: the median income may refer to the national value or the European Union average and the threshold for poverty may be 50% or 60% of the median value.

One of the main advantages of the social inclusion/social justice approach is that in covering a wide range of areas, coordinated policies will be developed. The need for this coordinated approach is often emphasized in these policies. For example in its 2003 report, Wales devotes a whole chapter to "ensuring a cross-cutting approach"

(108). Ireland reports that its *National Action Plan against Poverty and Social Exclusion (104)* is coordinated with the Action Plan on Employment, and points out that plans should be read together "to get a fuller picture of the measures being taken to combat social exclusion".

Another key feature of social inclusion/social justice programmes is the regular evaluation of progress towards targets. This clarifies where initiatives have been successful and equally where additional efforts are required. Several countries such as Sweden *(107)* and the United Kingdom *(103)* publish exemplars of good practice so that other countries might benefit from them.

The challenge of coordinating policies

This review has established that policies relevant to inequalities in health can be found in an array of documents on overall public health policy, policies on specific health problems and on specific groups within society as well as the many social inclusion/social justice documents. One challenge this array of documents poses is coordination: ensuring that separate policy initiatives are implemented to act synergistically where possible. Unfortunately there is not always a strong link between the many documents and particularly between inequalities policy and social inclusion/social justice policy.

Measuring inequalities in health

Inequalities in health are most commonly described in public health policy documents in terms of mortality differences between groups, typically expressed as life expectancy. Other measures, such as standardized mortality ratios, are sometimes used, most often to describe overall mortality. Many countries, such as England *(51)* and Ireland *(25)*, provide comparisons of mortality from several diseases including coronary heart disease, stroke and cancer, as well as diabetes, injuries and poisoning. Sweden *(40)* comments on inequalities in physical health and mental health. In general, measures of morbidity are much less commonly presented than those for mortality. Some social measures are occasionally used: for example Northern Ireland

(54) and England *(33)* measure the proportion of children living in workless households.

As well as describing inequalities in health in policy documents several countries have reviewed them in supporting documents from government departments or research institutes. These provide much more detailed descriptions of the nature of inequalities in health. In the English *Cross-Cutting Review (51)* analyses of mortality from all the major causes of disease are presented together with rates of hospital admissions or consultations with GPs, uptake of cervical screening, prevalence of major risk factors (such as smoking and diet) and other factors such as teenage pregnancy. Similarly, in its review, New Zealand presents extensive detail on overall mortality, infant mortality, hospitalization, smoking prevalence and alcohol consumption *(70)*. However, New Zealand also distinguishes between avoidable and non-avoidable mortality and hospitalizations. Avoidable deaths are those in people aged less than 65 years which could have been avoided by the provision of standard modern health and social services. Ireland, in a report from Trinity College in Dublin, gives data on psychiatric admissions and hospital discharge ratios for ischaemic heart disease, cancers, injuries and poisonings *(21)*.

Who experiences inequalities in health?

Inequalities in health affect many different groups within society. Most countries identify differences in health status by social group and economic status. Several countries contrast the life expectancy in the richest and the poorest fifths of the population. For example among men in Canada this difference was 5 years *(109)* whereas in Northern Ireland *(54)* it was 6.5 years. Others compare occupationally based classifications: Ireland found a three-fold difference in age-standardized mortality between men in the lowest and highest occupational groups. Differences in geographical location are also highlighted: in England male residents of Manchester live almost 7 years less than those in Barnet *(81)*. In addition many countries also mention employment status, gender, and ethnic group. However, although many measures are being used, countries differ in the extent to which they provide estimates of inequalities in health in these groups.

Many specific groups within society are recognized as being likely to suffer from inequalities in health. Considerable attention is given to indigenous people in the policies of Canada *(109)*, New Zealand *(60, 61)* and Australia *(10, 110)*. However several countries have specific policy documents concerned with improving the health of other groups. For example, Ireland has strategy documents for travelling people *(63, 111)* and for homeless young people *(32, 65)*, and New Zealand has a separate document for disabled people *(55)*.

The United States provides extensive data on the nature of inequalities in health in several risk groups *(67)*. This shows a highly complex pattern: not only are there many different groups at risk of inequalities in health but the nature of the risks they face differ in complex ways. This complexity is seen for mortality and morbidity, risk behaviour and health care utilization. Depending on the measure of health status chosen, each subgroup may be at an increased or decreased risk. The important message from these data is that the term 'inequalities in health' embraces a varied set of differences in health status. If the nature of inequalities in health varies markedly across groups then so must the underlying causes. Tackling inequalities in health will thus require a set of strategies tailored to the individual needs of each group.

The complexity of causation

All countries recognize that health is largely determined by the social, economic, physical and cultural environment. The development of this view can be traced back to the Canadian *Lalonde Report* in 1974 *(16)* and the US Surgeon General's 1979 Report *(17)*. Macroenvironmental factors are thought to have the dominant role in the causation of inequalities in health. These include the national socioeconomic factors and the physical and social environment. These influence the living and working conditions of the individual, but their effect is in turn moderated by local social and community influences. Ultimately all these factors influence the health behaviours which individuals adopt, particularly the factors which adversely affect health (smoking, poor diet, lack of physical activity, excessive alcohol consumption and irresponsible sexual behaviour).

New Zealand *(70)* and England *(51)* have published models of the determinants of inequalities in health that clarify how complex the process is. Among these factors poverty is acknowledged to be the dominant risk factor for ill-health. However several countries, such as Northern Ireland *(54)* explicitly state that income is not the only factor contributing to inequalities in health; they result from the interaction of a range of factors.

Multifaceted/multisectoral interventions

The consequence of the complexity of causation is that interventions to tackle inequalities in health must tackle different issues simultaneously. Many of the interventions required to change the physical and social environment lie outside the remit of health care. Thus action is needed at a number of different levels, from national and local government through local communities and social groups to families and individuals. It is essential that all government departments involved have health and inequalities in health high on their agenda. The problem for governments is that tackling the structural factors, such as unemployment, education or housing policy, is likely to be very expensive. Concerted action over many years will be needed to eradicate inequalities in health.

A variety of approaches have been proposed for tackling low income, particularly in the social inclusion/ social justice policies. All countries recognize the contribution of social welfare programmes to the alleviation of the effects of poverty. Considerable attention is also paid to policies aimed at reducing unemployment. However, Canada also identifies the important role of government in using the taxation system to redistribute income *(109)*. England, with its comprehensive policy on inequalities in health, has had some success in redistributing income but has kept relatively quiet about it *(33)*.

Australia *(10)* has concluded from a review of the research evidence that other approaches to tackling the effects of poverty may be necessary. It found that, rather than remaining in poverty throughout life, many individuals move into poverty and subsequently escape from it. Poverty is thus seen as a consequence of adverse life events such as illness, unemployment, or divorce. This view would lead to

interventions targeted at the vulnerable groups when they experience the adverse events. The measures needed include employment programmes and safety nets, such as insurance schemes and short-term emergency support.

Families and children

Several countries, such as Sweden *(40)* and New Zealand *(18)* recognize the importance of the lifecourse perspective, which identifies a range of entry points for interventions from infancy to old age. This leads to a focus on families and children because physical and behavioural developments at a young age have major consequences throughout life. There is also concern to break the cycle of deprivation, preventing today's disadvantaged children from becoming the parents of the next generation of disadvantaged children. The United States pioneered the *Head Start* programme *(79)*, which provided a comprehensive programme to meet the emotional, social, health, nutritional and psychological needs of disadvantaged children. Several countries have been influenced by the success of this programme. Canada has its own *Aboriginal Headstart Program (49)*. Canada *(109)* also points out the potential economic benefits of this programme: data from the United States suggest that $8 could be saved for every $1 invested. The United Kingdom countries have named their programme Sure Start *(46)*. New Zealand's programme Strengthening Families, which is supported by the Ministries of Health and Education and the Ministry of Social Development, works with a number of agencies to improve outcomes for families at risk *(50)*. Finally, Ireland *(112)* has provided a useful review of what works in family support services for vulnerable families.

Goals for inequalities in health

The setting of goals for the reduction of inequalities in health was pioneered by the World Health Organization in Health for All by the year 2000 *(5)*. The first of the 38 targets was the commitment to a 25% reduction in inequalities in health. The importance of reducing inequalities was reaffirmed at the Fifty-first World Health Assembly in 1998, in recognizing *Health-for-all policy for the twenty-first century (6)*, as a framework for the development of future policy. Again a target of at least a

25% reduction in inequalities was set by the European Region of the World Health Organization *(7)*.

Most countries have set ambitious goals for reducing inequalities in health: the United States goes so far as to set the goal of eradicating all inequalities by 2010 *(52)*. Other countries have goals to reduce inequalities in health by 10%, 20% or 50%. These goals are typically set for some 10 to 20 years in the future. Comparison between countries is difficult because there are marked differences in the way these goals are framed. The disadvantaged groups can be defined by socioeconomic status, by geographical location, or for particular age groups or specific social groups. They also differ on the measure of health that is used. Often this is life expectancy but it can also be mortality from specific diseases, frequency of longstanding illness or birth weight of infants.

Evaluating interventions to reduce inequalities in health

The progress towards reducing inequalities in health will be measured against the overarching goals described in the previous section. However many countries also have a range of indicators which can measure short and medium term progress. These indicators cover several dimensions. Many monitor health behaviours such as smoking, diet and breastfeeding and health outcomes such as low birth weight and dental health. Particular attention is given to indicators which monitor the health of children and young people. These indicators are necessary because many of the interventions proposed in policy will take years to show a real difference in life expectancy. Although improvements to individuals' physical and social environment, increased access to education and employment and lifestyle changes will give immediate benefits, the effect on reducing inequalities in health will be in the long term.

The socioeconomic and environmental indicators are principally seen in social inclusion/social justice policies. These indicators cover a range of topics including unemployment, literacy, and fuel poverty, and environmental measures such as housing quality, air quality, and burglary rates. (However England, Sweden and

Northern Ireland also describe these indicators in their public health policy documents.)

As well as assessing the effects of policy in the short and medium term there is a need to assess the extent to which interventions cover all disadvantaged groups. For example, the workplace is often used as a site for the implementation of initiatives, whereas it is more difficult to reach people who are not in employment. Similarly, interventions mounted through health care systems may miss groups such as travelling people, migrant workers or homeless people who may make irregular contact with services. Even school-based interventions, which in theory should have universal coverage, may fail to reach those who play truant or who are disenchanted with school because they have such adverse life circumstances.

A limitation of the indicators proposed in policy is that, although they will enable overall progress to be monitored, they will often not be able to assess the effectiveness of specific interventions. Some factors such as breastfeeding, teenage pregnancy or crime rates are influenced by a wide range of factors. Achieving improvements in these will require a correspondingly wide set of actions. When policy interventions are implemented across several sectors, the evaluation will not identify which parts of policy are working. Furthermore, for those interventions which are ineffective, the evaluation will not show which parts were ineffective and will give no indication of the reasons for failure.

Most countries report a shortage of evidence of effective interventions to tackle inequalities in health. One danger is that interventions that have been shown to be successful in the whole population will be used for high-risk populations. This is particularly problematic for interventions intended to modify lifestyles. Achieving change in behaviours such as smoking, diet and alcohol consumption is known to be difficult. It is likely to be even more challenging among individuals living in a poor physical and social environment.

Conclusions

This review of public health policy has established that inequalities in health exist in all countries and are considered unacceptable. All countries set an overarching goal of reducing inequalities in health, and recognize that interventions to achieve this must tackle the macroenvironmental factors (income and education) and the physical and social environment, as well as adverse health behaviours and access to health care. Interventions which solely tackle adverse health behaviour will have little success; they offer microenvironmental solutions to a macroenvironmental problem. Policies on social inclusion/social justice are better placed to tackle the macroenvironmental factors. Unfortunately, there is not always a strong link between inequalities policy and social inclusion/social justice policy. Thus the challenge facing policymakers is to ensure that strategies to tackle the macroenvironmental factors feature in policy on inequalities in health and that health becomes a prominent issue in social inclusion/ social justice policy. This could be best achieved by integrating the policies in these two areas.

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Annex 2

Departmental commitments to the English Government's programme of work to tackle health inequalities for the area *Supporting Families and Children (33)*

Maternal and child health and child health development

Department for Work and Pensions

- Reduce by 25% the number of children in low-income homes (by 2004)

- Halve child poverty by 2010 and eradicate it (by 2020)

SureStart

- Increase attendance of pregnant women at antenatal classes

- 2% increase on previous year on breastfeeding initiation rates until 2010

- 522 Sure Start programmes to be set up in disadvantaged areas (by 2004)

- Within 2 months of birth all families within a Sure Start area to be visited (by 2006)

- 10% reduction within Sure Start areas of children admitted with severe injury (by 2010)

Department for Education and Skills

- Free nursery places for all 3 year olds (by 2004)

- 45,000 neighbourhood nursery places (by 2004)

- 250,000 new childcare places, 180,000 in the 20% most disadvantaged wards (by 2006)

- Children centres in 20% of the most disadvantaged wards within Sure Start areas for 650,000 children (by 2006)

Department of Health

- Launch of *Healthy Start*

Improving life chances for children and young people

Department for Work and Pensions

- £450 million for Children's Fund (by 2005)

Department of Health

- A comprehensive mental health service for children and adolescents (by 2006)

Department for Education and Skills

- 85% of 11 year olds achieving level 4 in English and Maths (by 2004)

- Reduce schools where 65% of pupils do not achieve level 4

- 20% of 16 year olds achieving 5 GCSEs A*-C (by 2004) and 25% (by 2006)

- 38% of pupils achieving 5 or more GCSEs A*-C in each Local Authority Area (by 2004)

- 90% of 12 year olds to achieve level 4 in English and Maths (by 2007)

- Reduce truancy by 10% (by 2004)

- Improve by 15%, GCSEs A*-C grades from 16 year olds in care (by 2004)

Department for Culture, Media and Sport

- Increase to 75% the number of 5 – 16 year olds spending 2 hours a week on PE and school sport

Department for Transport

- Increase the number of schools implementing school travel plans to 25% by 2005

Reducing teenage pregnancy and supporting teenage mothers

Department of Health

- Reduction on previous year in gap in under 18 conceptions between worst fifth and national average (until 2010)

- No lone parents (16 – 17) in unsupported tenancies (by 2004)

- Reduce under 18 conception rate by 15% (2005), 25% (by 2006) and 50% (by 2010)

- Increase to 60% the number of teenage mothers obtaining at least an NVQ level 1 (by 2010)

Sure Start

- New childcare programmes for teenage parents (by 2004)

- New childcare places for 1.6 million children (by 2004)

- Reduce by 12% the number of 0 -3 year olds in Sure Start areas living in households where no one is working (by 2006)

Department for Education and Skills

- Increase the number of SRE accredited teachers; 750 new teachers to be SRE accredited (by 2006)

- No PHE teaching to be rated poor (by 2006)

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