

Tackling Health Inequalities:
2003-05 data update for the National
2010 PSA Target

December 2006

The National Health Inequalities PSA Target

The national Health Inequalities Public Service Agreement Target is to:

Reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth.

This target is underpinned by two more detailed objectives:

- **starting with children under one year, by 2010 to reduce by at least 10 per cent the gap in mortality between routine and manual group and the population as a whole;**
- **starting with local authorities, by 2010 to reduce by at least 10 per cent the gap in life expectancy between the fifth of areas with the worst health and deprivation indicators (the Spearhead Group) and the population as a whole.**

Spearhead Group

The Spearhead Group consists of the Local Authority areas that are in the bottom fifth nationally for 3 or more of the following 5 factors:

- Male life expectancy at birth
- Female life expectancy at birth
- Cancer mortality rate in under 75s
- Cardiovascular disease mortality rate in under 75s
- Index of Multiple Deprivation 2004 (Local Authority Summary), average score

The Spearhead Group is made up of 70 Local Authority areas which following the NHS reconfiguration, map to 62 Primary Care Trusts.

A top NHS priority

Health inequalities has been made a top priority for the NHS for 2006-07 and for 2007-08 as set out in the NHS Operating Framework, putting the issue, and the target, at the heart of NHS service planning and performance. Making health inequalities a top priority recognises the enormous commitment that exists at local level to **improving life expectancy in the Spearhead areas with the worst health and deprivation**. It also recognises that **the target is achievable if local action is focused and evidence-based**, with effective accountability and performance management.

Reducing the gap in infant mortality in the routine & manual socio economic group is the second part of the national health inequalities target, and will also contribute to the life expectancy target. A review of the target has just been completed and will be published in the New Year.

Infant Mortality – the problem

Infant mortality is a good indicator of the overall health of a society, and while rates are at an all time low, and falling, each avoidable death is one too many and significant inequalities still remain. There were around 9,760 infant deaths in England and Wales in the period 2003-05 - a rate of 5.1 deaths per 1,000 live births. Of those with a valid socio-economic group (8,583), 44% of these deaths (3,775) were in the routine and manual groups alone.

Tackling health inequalities in infant mortality at local level is complicated by the small number of infant deaths in individual localities. The continuing decline in the overall number of infant deaths seen in most areas obscures the widening infant mortality gap between social groups. However, each avoidable death is one too many and the number of preterm babies is still too high. Many babies are left with long-term health conditions causing untold misery to families. This also has huge financial implications for families, government and society.

To help the target make sense locally, action on tackling the target will need to be delivered on an area basis by NHS organisations working with local government and other bodies, taking account of the spearhead group of local authority areas delivering the life expectancy element of the PSA target, many of which have high infant mortality rates.

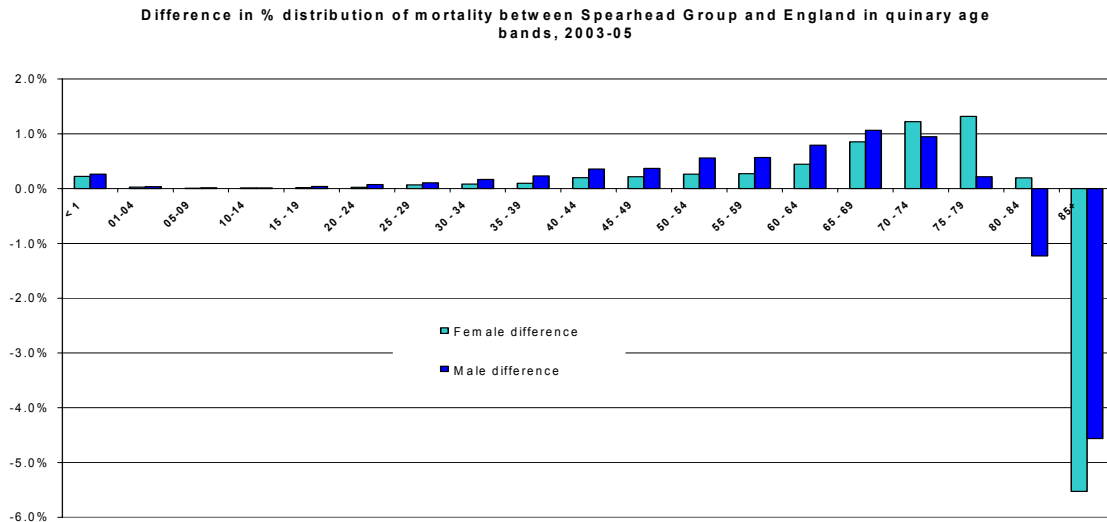
Life Expectancy - the problem

The focus of tackling inequalities is not just on small, specific 'hard to reach' groups. Tackling health inequalities is about major social change. For example, the Spearhead Group contains over a quarter of the population of England (28%) and contains 44% of the Black and Minority Ethnic population of England.

The life expectancy gap means some families losing loved ones earlier than others. Around **13,700 fewer people aged between 30-59 years old would have died in Spearhead Areas** across 2003-05 if death rates had been the same as in the rest of England. To meet the target, action needs to be focussed on preventing the early deaths of people who already have disease or are at high risk. So the NHS has a crucial role, reducing mortality in the short as well as longer term.

Figure 1 below demonstrates the thousands of people that are dying prematurely; from infancy and across all age groups (the negative bars indicate that in Spearhead Areas at older ages people who have already died). Effective action is essential to prevent this cycle continuing for generations.

Fig 1



Current performance

For infant mortality, the latest figures show a **slight narrowing in the gap between the “routine and manual” group and the population as a whole, compared with last year.** Over the period since the target baseline (1997-99), the gap had widened, although there have been year-on-year fluctuations in intervening years, and it remained static last year. The slight narrowing during the latest period is encouraging; however the target to narrow this gap by at least 10% by 2010 is still a challenging one.

The infant mortality rate among the “routine and manual” group was 18% higher than in the total population in 2003-05, compared with 19% higher than in the total population in 2002-04, the same as for 2001-03. This compares with 13% higher in the baseline period of 1997-99.

Figure 2 below shows the average infant mortality rates by social class in England and Wales since 1994-96.

Figure 3 shows the change in the infant mortality gap from 1994-96 to 2003-05 and contains projections to 2009-11(the end of the PSA target).

Fig. 2

3-year average infant mortality rates* by NS SEC90 for 1994-2001, and by NS SEC for 2001 onwards, by NS SEC analytical classes
ENGLAND AND WALES

Analytical classes	NS SEC90					NS SEC 2001				
	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001**	2000-2002**	2001-2003**	2002-2004	2003-2005
1 Managerial and professional	4.4	4.4	4.2	4.1	3.9	3.8	3.6	3.5	3.4	3.4
2 Intermediate	5.2	5.4	5.5	5.3	5.1	4.9	5.0	4.7	4.7	4.4
3 Routine and manual	6.7	6.6	6.4	6.3	6.2	6.2	6.0	6.0	5.9	5.7
Ratio: routine & manual/all	1.15	1.14	1.12	1.13	1.14	1.17	1.16	1.19	1.19	1.18
All***	5.9	5.8	5.7	5.6	5.4	5.3	5.2	5.0	4.9	4.8
Sole registrations #	7.9	7.5	7.4	7.6	7.6	7.6	7.3	7.2	6.7	6.8
Other ##	8.7	8.4	8.9	8.9	9.2	8.8	9.6	9.4	9.3	8.7

Source: Office for National Statistics

*Infant deaths per 1000 live births

**using NS SEC for 2001 and later years' data

Information on the father's occupation is not collected for births outside marriage if the father does not attend the registration of the baby's birth

***Infants born inside marriage or outside marriage jointly registered by both parents.

Figures for live births are a 10 per cent sample coded for father's occupation.

Births registered by mother alone

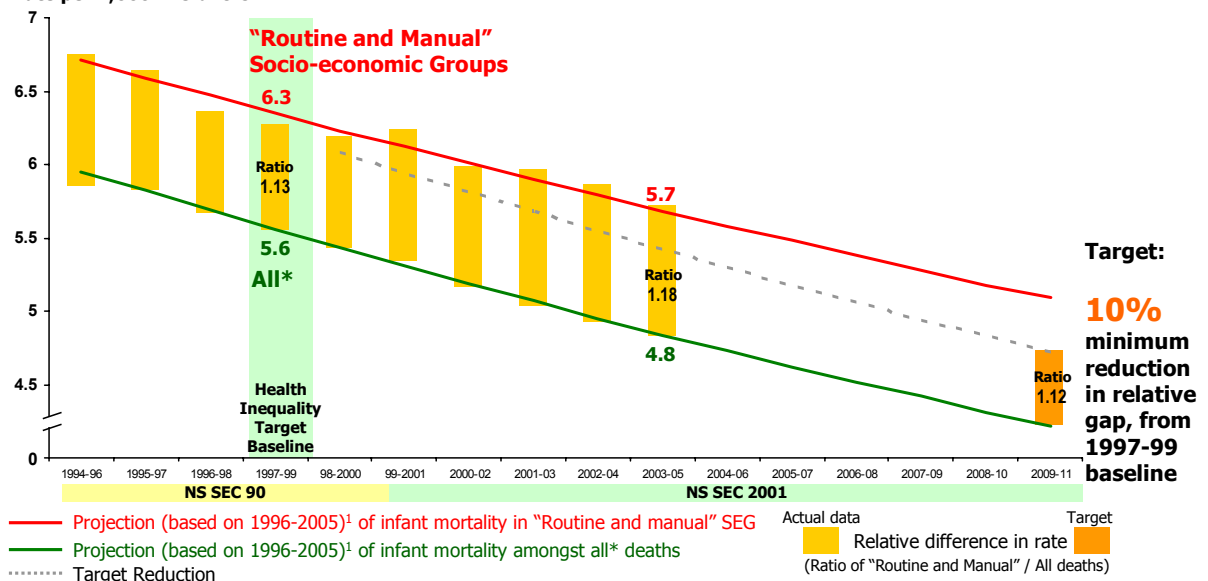
Students, never worked, long term unemployed, occupation inadequately described or not classifiable for other reasons

Fig.3

Infant mortality by Socio-economic Group England and Wales 1994 – 2005 and target and projection for the year '2010'



Rate per 1,000 live births



¹Projection of data for the five years 2001-2005, since NS SEC 2001 was introduced, result in a more encouraging assessment of progress.

* "All" relate to inside marriage and joint registrations outside marriage, not including "social class not specified" for 1995 and 1999. Sole registration and unlinked births are excluded. Information on the father's occupation is not collected for births outside marriage if the father does not attend the registration of the baby's birth. Figures for live births are a 10 per cent sample coded for father's occupation.

Source: Office for National Statistics



Nationally, **life expectancy is increasing for both men and women, including in the Spearhead areas.** But it is increasing more slowly there, so **the gap continues to widen, and it is widening more for women than men.** For males the relative gap is 2% wider than at the baseline (compared to 1% wider in 2002-2004), for females 8% wider (the same as in 2002-2004). The 2003-2005 relative gaps show little change over the 2002-2004 figures, and data are subject to year-on-year fluctuation.

Figure 4 below shows the average life expectancy at birth in years for males and females for England and in the Spearhead Group. It also shows the relative gap between England and the Spearhead average, which is the basis of the life expectancy PSA target.

Figure 5 shows the change in the relative life expectancy gap for males from 1993-95 to 2003-05 and contains projections to 2009-11 (the end of the PSA target).

Figure 6 shows the change in the relative life expectancy gap for females from 1993-95 to 2003-05 and contains projections to 2009-11 (the end of the PSA target).

Fig 4. Life Expectancy at Birth – Males and Females

Summary of data to 2005 for health inequalities headline indicator on male and female life expectancy

LIFE EXPECTANCY AT BIRTH - MALES												Target	
Life expectancy at birth (years)												2009-11	
	1993-95	1994-96	Baseline 1995-97	1996-98	1997-99	1998-00	1999-01	2000-02	2001-03	2002-04	2003-05		
England average	74.2	74.4	74.6	74.8	75.1	75.4	75.7	76.0	76.2	76.6	76.9		
Average for Spearhead group (70 LAs / 62 PCTs)	72.3	72.6	72.7	72.9	73.1	73.4	73.7	74.1	74.3	74.6	74.9		
Relative gap between England and Spearhead group (%)	2.51%	2.53%	2.57%	2.59%	2.66%	2.63%	2.62%	2.57%	2.61%	2.60%	2.61%	2.32%	
Change in relative gap - Baseline to current period (2003-05):											0.04	2%	-10%

LIFE EXPECTANCY AT BIRTH - FEMALES												Target	
Life expectancy at birth (years)												2009-11	
	1993-95	1994-96	Baseline 1995-97	1996-98	1997-99	1998-00	1999-01	2000-02	2001-03	2002-04	2003-05		
England average	79.4	79.6	79.7	79.8	80.0	80.2	80.4	80.7	80.7	80.9	81.1		
Average for Spearhead group (70 LAs / 62 PCTs)	78.0	78.2	78.3	78.4	78.5	78.7	78.9	79.2	79.2	79.4	79.6		
Relative gap between England and Spearhead group (%)	1.76%	1.77%	1.77%	1.83%	1.85%	1.87%	1.85%	1.86%	1.87%	1.90%	1.91%	1.59%	
Change in relative gap - Baseline to current period (2003-05):											0.14	8%	-10%

Note: The annual gap in life expectancy between England and the Spearhead Group is given to 2 decimal places in order to show year on year change. The assessment of the change in the gap is extremely sensitive to very small changes in life expectancy so this is rounded to a whole figure.

Fig. 5

Male life expectancy at birth

England 1993-2005 and target and projection for the year '2010'

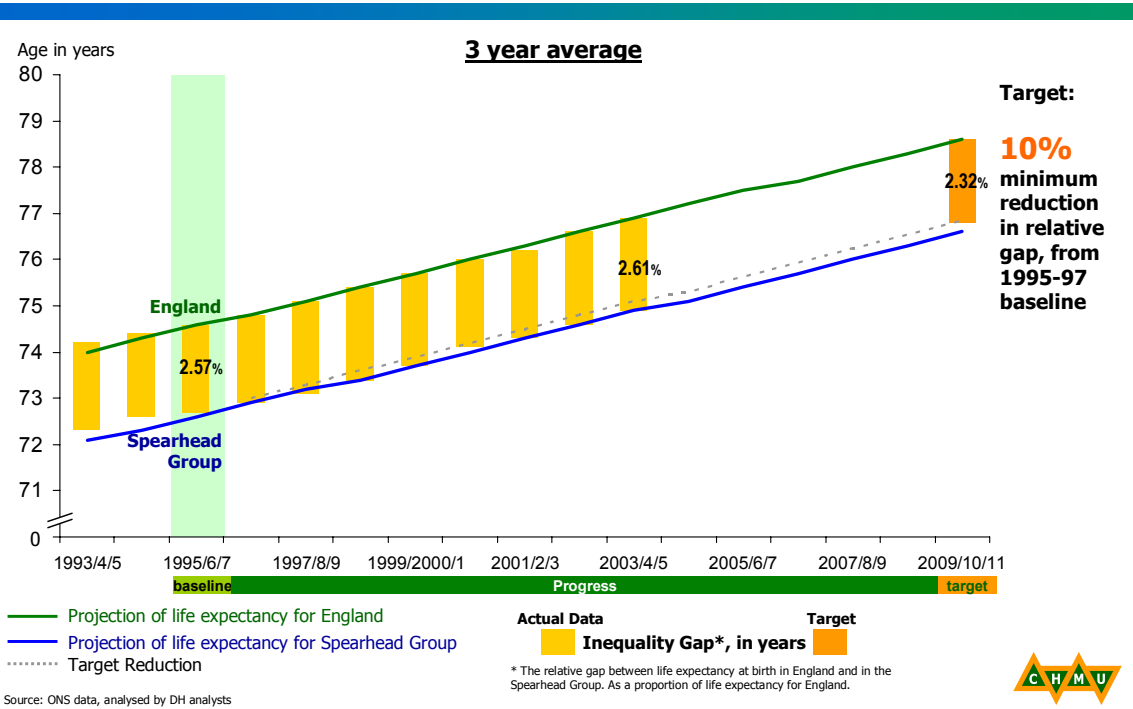
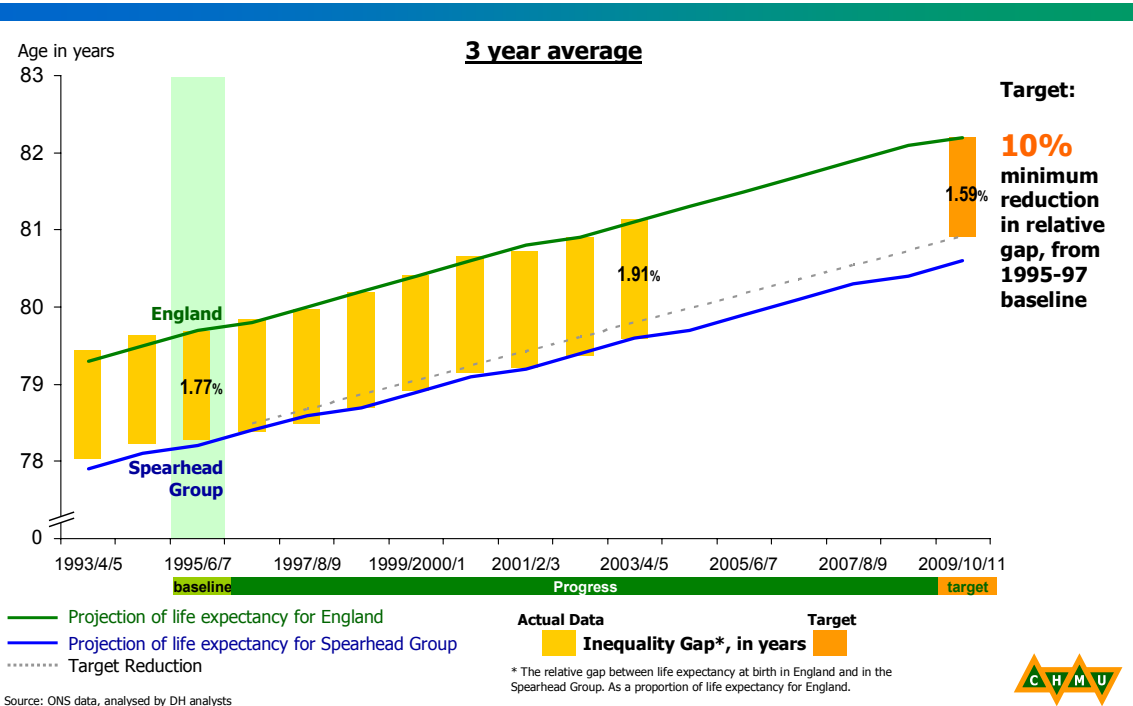


Fig. 6

Female life expectancy at birth

England 1993-2005 and target and projection for the year '2010'



There is a great deal of local variation within the Spearheads. **Life expectancy in some Spearheads is increasing faster than the average**, and if their trends were replicated in all Spearhead areas, the target would be more than met. To meet the Health Inequalities life expectancy 2010 PSA target, we will need to reverse a long-term trend and the target remains a challenging one, with widening trends for men and women at a national level.

Figure 7 compares the local authority areas with the highest life expectancy at birth in England, with the local authority areas with the lowest life expectancy at birth in England.

Fig. 7

	Life Expectancy at Birth Comparison	
	Male	Female
Highest at LA level	82.2 (Kensington & Chelsea)	86.2 (Kensington & Chelsea)
England Average	76.9	81.1
Spearhead Group Average	74.9	79.6
Lowest at LA level	72.5 (Manchester)	78.1 (Liverpool)

However, we are seeing some early signs of progress. For life expectancy, the 2003-2005 data show that **three fifths of Spearheads** are on track to narrow their own life expectancy with England by 10 percent by 2010 compared to baseline for either males or females or both. 24% are on track for males only, with a further 24% on track for females and 11% on track for both.

Figure 8 shows whether the 70 Spearhead Local Authorities are on or off track to narrow their share of the life expectancy gap by 10% for males or females or both by 2010 according to 2003-05 data. The table also shows a comparison to 2002-04.

Fig. 8 – Spearhead Group performance on life expectancy for males and females 2003 – 05 v 2002 -04

Local Authority	2003-05				2002-04			
	On track both	On track male	On track female	Off track both	On track both	On track male	On track female	Off track both
Hackney	•				•			
Hammersmith and Fulham	•				•			
Southwark	•				•			
Tower Hamlets	•				•			
Tameside	•						•	
Warrington	•				•			
Derwentside	•				•			
Hyndburn	•				•			
Islington		•						•
Lambeth		•			•			
Lewisham		•				•		
Newham		•				•		
Knowsley		•				•		
St. Helens		•			•			
Wirral		•				•		
Sunderland		•						•
Halton		•						•
Blackburn with Darwen		•				•		
Chester-le-Street		•				•		
Sedgefield		•				•		
Wear Valley		•				•		
Burnley		•						•
Lincoln		•				•		
Wansbeck		•				•		
Tamworth		•				•		
Greenwich			•				•	
Haringey			•				•	
Bury			•				•	
Doncaster			•				•	
Gateshead			•				•	
Newcastle upon Tyne			•				•	
North Tyneside			•					•
Birmingham			•				•	
Coventry			•		•			
Walsall			•			•		
Redcar and Cleveland			•				•	
Stockton-on-Tees			•		•			
Barrow-in-Furness			•					•
Carlisle			•		•			
Corby			•			•		
Blyth Valley			•				•	
Nuneaton and Bedworth			•		•			
Barking and Dagenham				•				•
Bolton				•				•
Manchester				•		•		
Oldham				•				•
Rochdale				•			•	
Salford				•				•
Wigan				•				•
Liverpool				•				•
Barnsley				•			•	
Rotherham				•				•
South Tyneside				•				•
Sandwell				•				•
Wolverhampton				•			•	
Bradford				•				•
Wakefield				•				•
Hartlepool				•				•
Middlesbrough				•				•
Blackpool				•				•
Kingston upon Hull, City of				•				•
North East Lincolnshire				•				•
Leicester				•				•
Nottingham				•				•
Stoke-on-Trent				•				•
Bolsover				•				•
Easington				•				•
Pendle				•				•
Preston				•		•		
Rossendale				•			•	

Early wins for NHS action

For the infant mortality target, the three main causes of death in infancy and which also account for most of the gap are:

- Immaturity related conditions
- Congenital anomalies and
- Sudden Unexpected Death in Infancy

Action to prevent these will reduce the gap and help meet the target. Further information on tackling the infant mortality gap will be contained in the report on the infant mortality review, to be published shortly.

To meet the life expectancy target, the focus needs to be on preventing deaths from early middle age in Spearheads, including those at older ages. Cardiovascular disease (mainly coronary heart disease), cancer and respiratory disease account for about two-thirds of the gap between Spearheads and the average. Addressing smoking prevalence will impact on all three.

Figures 9 and 10 below show which diseases account for the gap in life expectancy between Spearheads and England alongside national modelling of interventions to narrow the life expectancy gap based on 2002-04 data. These would need to be interpreted locally in the light of demographics such as specific Black and minority ethnic populations, existing performance and other local factors.

Fig. 9

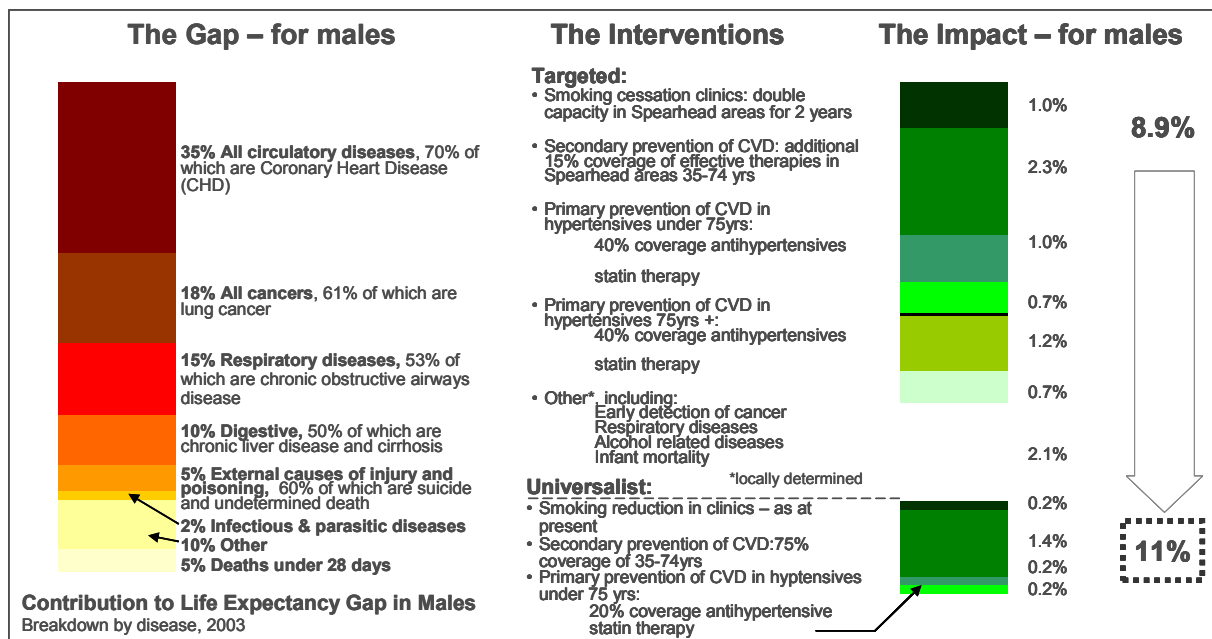
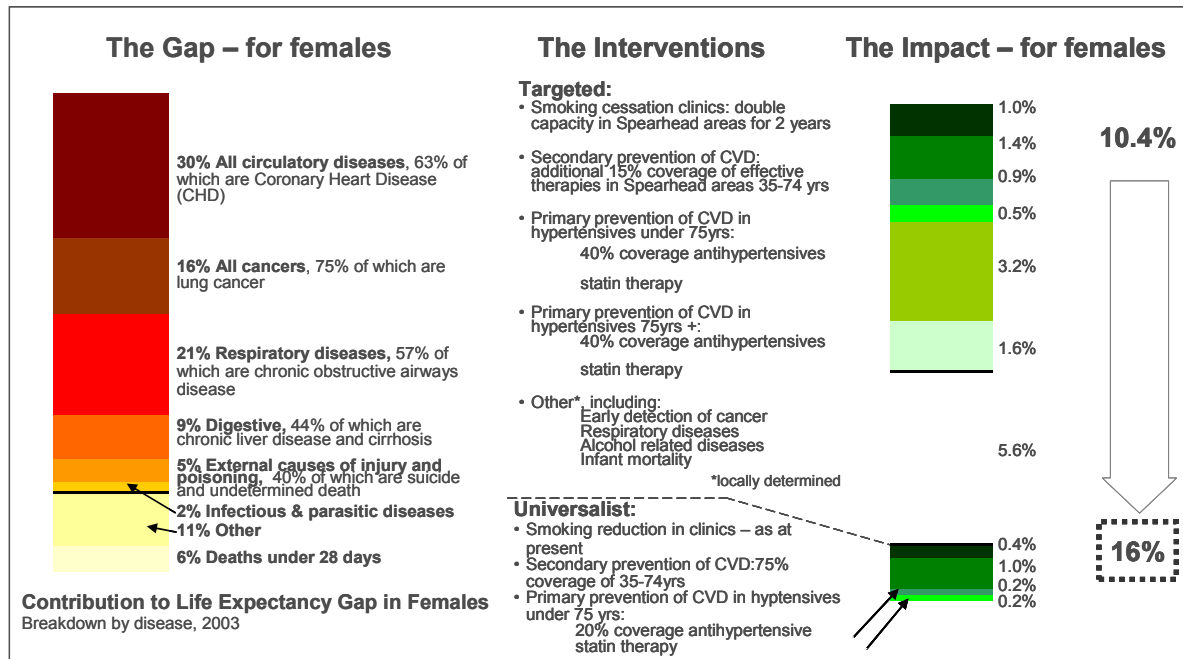


Fig. 10



The interventions shown are not exhaustive, but they do demonstrate that the target is achievable. **Figures 11 and 12** below show six high impact changes for the NHS and for local government to reduce health inequalities – grey boxes show areas of overlap where health and social care commissioners should work together:

Fig. 11

High impact changes for the NHS to narrow health inequalities

1. Know your gaps in life expectancy and infant mortality	4. Improving detection of cancer in local communities
2. Make smoking history – reduce smoking prevalence and target deprived areas	5. Focus Health Trainers and Life Check programmes on tackling health inequalities
3. Targeted prevention of cardiovascular diseases	6. Empower disadvantaged communities to aspire to good health

Fig. 12

High impact changes for local government to narrow health inequalities

1. Know your gaps in life expectancy and infant mortality	4. Focus Health Trainers and Life Check programmes on tackling health inequalities
2. Maximise use of Local Area Agreements or other local plans	5. The duty of wellbeing enables local authorities to improve the quality of life, opportunity and health of their local communities
3. Local Authority Scrutiny Committees – use their powers to reduce health inequalities	6. Empower disadvantaged communities to aspire to good health