The Department of Health has launched a new report outlining how it plans to tackle health inequalities by focusing on five key areas. Nerys Hairon finds out more

The Department of Health has published a report outlining progress to date on reducing health inequalities and future plans to combat this problem. It has also announced details of how £34m of funding will be allocated to support programmes tackling the issue (DH, 2008a; 2008b).

While key successes have occurred in overall health, such as life expectancy having improved year-on-year over the past decade, the DH (2008b) concedes the health of the most disadvantaged groups has not improved as quickly as that of more affluent groups. The report acknowledges that inequalities in health persist and, in some cases, have widened. Consequently, strategies will focus on five key areas to reduce health inequalities, as well as actions to tackle smoking, alcohol misuse and obesity.

KEY FINDINGS

In 2001 the government set national targets for health inequalities for the first time – in order to reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth by 2010 (see box, p22). In addition, an inequalities element has been introduced into national targets for cancer, cardiovascular disease and smoking.

The DH (2008b) reports there have been significant absolute improvements in the health of people in disadvantaged groups and areas. However, despite absolute improvements, the national target, based on relative change, remains challenging.

Nationally, life expectancy is increasing for both men and women, including in the Spearhead areas (targeting the most disadvantaged communities). However, it is increasing more slowly in these areas, so the gap continues to widen.

Regarding infant mortality, the health inequalities gap between routine and manual groups and the whole of the population has recently started to narrow but it is still wider than the gap at the 1997–1999 baseline. A DH review last year found that while the infant mortality rate in England was at an all-time low, the gap between different social groups had widened at this time (Hairon, 2007).

The DH will therefore intensify its efforts to cut health inequalities through various strategies, including scaling up the National Support Team for Health Inequalities, and developing new support teams for infant mortality and alcohol.

KEY AREAS FOR ACTION

The DH (2008b) identifies five areas in which early action will have the most impact:

- Investing in early years and parenting;
- Promoting equality;
- Using work to improve health and well-being;
- Developing mental health services further;
- Coordinating action on the influences on health – both nationally and locally.

Child health

The DH and the Department for Children, Schools and Families will jointly develop a new child health strategy, due to be published in the autumn. In addition, the government will support and promote breastfeeding to give all children the best start in life. The main challenge is to focus on interventions that will encourage more mothers, particularly teenage mothers and others from low-income groups, to start and continue breastfeeding. The DH says it wants to see all relevant hospitals and
community settings adopt the UNICEF Baby Friendly Initiative.

Another example of a programme to improve child health is the Family Nurse Partnership, which uses an intensive, structured model of nurse-led home visiting support for vulnerable first-time mothers from early pregnancy until children are two years old. Research from the US shows it has the potential to change inter-generational behaviour. The DH and the DCSF are currently testing this programme in 10 areas in England.

Other areas
To improve health and well-being through work, the government says it will develop Dame Carol Black’s (2008) recommendation to create a new Fit for Work service and pilot this in deprived areas with the most potential to prevent worklessness caused by ill health.

In the area of mental health, the DH plans to provide additional support for those with mental health problems, through expansion of the Improving Access to Psychological Therapy programme. This will cover a further 900,000 people by 2010–2011. The programme aims to ensure that access is equal for groups that traditionally miss out, such as older people and those from black and minority ethnic communities.

The department will also build on the lessons learnt from the Well-being Nurses programme, exploring how it can provide further support to those with mental illness.

CHANGING BEHAVIOURS
Many health inequalities arise as a consequence of lifestyle choices and behaviours. Many of these demonstrate a stark relationship with socio-economic factors. People in disadvantaged groups are more likely to smoke, be obese (particularly women) and are more likely to drink alcohol at levels that increase risks to health. As nurses are often involved in health screening and general health promotion, they are vital in tackling health inequalities related to lifestyle choices.

Smoking is responsible for one-sixth of all deaths in the UK, and is the area where behaviour change would make the greatest impact on health inequalities. According to the DH, research shows that smoking is the main cause of differences in death rates in middle age across socio-economic groups.

The government is to develop a new tobacco control strategy. It will also make NHS Stop Smoking Services more accessible and effective, increasing their use in areas and among groups with high smoking rates. Nationally accredited training will also be developed for NHS Stop Smoking advisers and other healthcare professionals who support smokers to quit.

In addition, the government will support communities with the highest smoking rates to implement multi-agency, community-based tobacco control programmes, including more accessible smoking cessation support.

In the area of alcohol, the DH acknowledges that while the social pattern of problem drinking is complex, disadvantaged communities have higher levels of alcohol-related mortality, hospital admission, crime, absence from work, school exclusions, teenage pregnancy and road traffic accidents associated with higher levels of alcohol consumption.

In order to speed up progress in this area, the government will implement a programme to cut, and in time halt, the rise in alcohol-related admissions to hospitals. This will include training and support for key medical staff on improving identification of those who need more support and providing more effective advice and treatment.

The National Support Team for Alcohol will provide in-depth analysis and support to those areas with the highest rates of alcohol-related hospital admissions.

The DH argues that obesity is one of the most important long-term challenges facing the nation’s health. Family lifestyle is the biggest immediate risk factor – in families where both parents are overweight or obese, children are six times more likely to be overweight or obese compared with those living with parents of a healthy weight.

In addition to existing commitments, the government will test a ‘full service’ model of local programmes and services to prevent and tackle child and adult obesity. This will seek to ensure all people and families have the information, support and services they need to make healthy decisions.

CONCLUSION
Primary care is highlighted as an important area for progress in terms of reducing health inequalities. As part of the NHS Next Stage Review, the DH is developing a primary and community care strategy that will set out how the government can support the NHS and health professionals in delivering more personalised, integrated and higher quality services.

Nurses have an important role in reducing health inequalities by identifying those at risk of poorer health and delivering targeted interventions to improve outcomes.