Royal College of Physicians

RCP view on health inequalities:

the case for a cross-government strategy

September 2021

Summary

Health inequality was a problem before COVID-19 – with a gap in healthy life expectancy between the richest and poorest areas of around 19 years – but the pandemic has tragically demonstrated how these inequalities can have an impact in just a matter of weeks.

The Royal College of Physicians (RCP) convenes the Inequalities in Health Alliance (IHA), which first called for a cross-government strategy to reduce health inequalities when it launched in October 2020. The RCP believes the best way to improve health is to focus on the factors which shape it.

Recommendation

To ensure that the recovery from COVID-19 is a turning point for the health of the nation, the RCP is calling for:

– **A cross-government strategy to reduce health inequalities, led by the prime minister, including targets and evaluation metrics that go beyond the government's aim of increasing healthy life expectancy by just 5 years over the next 14 years.**

Health inequalities in the UK

Before the pandemic, life expectancy had stalled for the most deprived in England. While women and men in the least deprived areas had seen their life expectancies grow significantly between 2014 and 2019, there had been no significant changes for men and women in the most deprived areas.[1,2] For women in the most deprived areas of England, life expectancy fell between 2010 and 2019.[3]

We came into the pandemic with unequal levels of general health across the country – and COVID-19 brought the impact of that inequality into sharp relief. The Health Foundation has estimated that working age adults in England's poorest areas were almost four times more likely to die from COVID-19 than those in the wealthiest areas.[4]

Many deaths could have been prevented if there had been better levels of general health before the pandemic.

COVID-19 exposed health inequalities by showing the impact they can have on a national scale, but this is not a new problem. The Marmot Build Back Fairer report[5] found that mortality rates from COVID-19 mirrored mortality rates from other causes, suggesting the underlying drivers of COVID-19 deaths are similar to the causes of health inequalities more widely. That has a toll on individuals, regions and the country as a whole: in the areas of England with the lowest healthy life expectancy, more than a third of 25 to 64 year olds are economically inactive due to long-term sickness or disability.[6] Indeed, before the pandemic, health inequalities were estimated to cost the UK £31bn to £33bn each year in lost productivity and £20bn to £32bn in lost tax revenue and higher benefit payments.[7] We can see the consequences of not tackling health inequalities sooner – excess mortality and a significantly widened gap between the most and least deprived in England.

> **'Poverty, deprivation and various factors are contributing to health inequalities. That is something we do know. Those issues will not be solved by a year-long review. They need to be looked at across Government … and the Government are absolutely committed to that.'**
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> **– Kemi Badenoch MP, minister for equalities; House of Commons 'COVID-19: Disparate Impact' statement, October 2020**

A comprehensive cross-government strategy will reduce the cost to the public purse. But it will also enable more people to live longer, healthier and more productive lives. If we can improve levels of general physical and mental health, we will reduce the need for costly clinical interventions and therefore in the long term reduce pressure on the NHS.

The recovery from COVID-19 must be a turning point for the health of the nation.

The case for a cross-government strategy to reduce health inequalities

The links between poor health and social factors such as discrimination, housing and employment – including how much money you have – are well known. As the Black Report[8] set out over 40 years ago, 'the influences at work in explaining the relative health experience of different parts of our society are many and interrelated'. The impact of this has again been brought to the fore over the last 18 months.

The government's COVID-19 disparities review noted in October 2020 that 'a range of socioeconomic and geographical factors such as occupational exposure, population density, household composition and pre-existing health conditions'[9] were contributing to higher infection rates in some ethnic minority groups. Tackling these issues requires collaborative thinking and coordinated action across government.

> **'Generally speaking, it is not because of differences in treatment [for COVID-19] but because of differences in the infection rate, and the prior circumstances that mean some people are more likely to die as a consequence. For example, if you have diabetes – both type 1 and type 2 – you are at a much-elevated risk of dying if you contract COVID-19. It is a combination of occupational exposures, crowded housing, prior health risk, including obesity … and broader inequality. That has all compounded to create the differential [mortality rate] … Race and ethnicity is an independent explanation over and above those other variables as well.'**
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> **– Lord Simon Stevens, former chief executive of NHS England/ Improvement; oral evidence to the Health and Social Care Select Committee, January 2021**

With over 185 members representing patients, doctors, nurses, social care professionals, pharmacists, local authorities and others, the IHA has heard countless stories about the impact of non-clinical factors on the health of people across the country. One doctor said that they have a number of patients who cannot afford to come to the clinic regularly, risking a deterioration in their condition because they cannot benefit from regular clinical monitoring.

The clinic provides a number of bus passes to patients who cannot afford travel themselves to help them support their care. Without this, the affordability of public transport would impact patients' health as they would not be able to attend their appointments and get the treatment they need.

Another clinician told the IHA that they saw a patient in hospital who was extremely malnourished and dehydrated. The patient had been regularly missing meals so she was able to feed her teenage son. She did not call the GP when she was first unwell because she was unable to afford to pay someone to look after her son, and she was frightened that he would be 'taken into care' if she had to go to hospital for a long period of time. She was eventually admitted to hospital with sepsis.

Obesity is one of the biggest public health challenges the UK faces. 30% of COVID-19 hospitalisations in the UK were directly attributed to overweight and obesity. It is both a driver and a result of health inequality. It has therefore been given explicit focus by government. There is strong support in the health sector for government proposals in the Health and Care Bill to restrict advertising on high fat, salt and sugar foods. Yet eating healthy food comes second to eating at all for many who are living in poverty. Rates of severely obese children are around three times higher in the most deprived areas compared to the least deprived.[10] Genetics, other physiological factors and social factors can all drive weight gain and they should all be considered together for the most effective intervention.

> **'For the last 7 years I've looked after a patient… who was obese and had poorly controlled type 2 diabetes. I'd been seeing him [as his GP] for more than a year before he opened up to me about the reasons for his health problems. I learned that he and his family lived in a grossly overcrowded apartment with no kitchen and he was eating all of his meals in …fried chicken shops.'**

Health inequalities are not felt equally across the country. Some groups of people, and some regions, are hit harder than others.

Westminster	84.9	Blackpool	74.4
Kensington and Chelsea	83.9	Middlesbrough	75.4
Camden	83.3	City of Kingston upon Hull	75.8
Harrow	83.2	Burnley	76.0
Hart	83.1	Manchester	76.4
Rutland	83.0	Stoke-on-Trent	76.5
South Cambridgeshire	82.9	Liverpool	76.6
Elmbridge	82.9	Knowsley	76.8
Uttlesford	82.9	Hartlepool	76.9
Barnet	82.9	Hyndburn	76.9

Fig 1. 10 best and 10 worst life expectancies for men in England by council region.[1]

Blackpool has the lowest life expectancy in England – 74.4 years for men and 79.5 for women, compared with 84.9 years in Westminster (London) for men and 87.2 for women. The number of years spent in good health for those in Blackpool for men is 53.7 and 55.3 for women, compared with 65.7 for men in Westminster, and 64.4 for women. Rates of severe mental illness are also high in Blackpool, with the second highest suicide rates for men in the country.

The reasons behind the low life expectancy in Blackpool are complex, but low wages, low employment and poor-quality housing (often in houses of multiple occupation) are all acknowledged to be key.[11] As Blackpool's director of public health noted in the chief medical officer's recent report on health in coastal communities, 'the areas of highest concentration of failed private sector housing [in Blackpool] is now home to the worst health outcomes.'[11]

> I had a patient with stable asthma who had never had admissions previously. Their current private rented accommodation had mould and the agency wouldn't fix it. The council assessed the property as needing a rapid fix, which they tried to enforce on the agency. My patient was then served an eviction notice. I treated them for their first asthma admission where they were touch and go for an ITU admission, and required outreach intervention. This was just before the pandemic.

Local leaders in places like Blackpool are undertaking a huge range of approaches to improve health, and the NHS Long Term Plan and the NHS recovery from COVID-19 are focused on reducing health inequalities. But trying to prevent ill-health locally will only go so far unless the overarching determinants of health are addressed at national policy level. The factors which present a barrier to good health for so many are often beyond the control of the individual. They also often sit outside the remit of the Department of Health and Social Care. It's vital that these issues are tackled in a considered, joined-up way at a national level. If we want to level up and build back better, we need an explicit health inequalities strategy, with clear measurable goals, that considers the role of every department and every available policy lever in tackling health disparities.

While it may seem that health inequality is a matter for the Department of Health and Social Care or the NHS, health and social care services can only try and cure the ailments created by the environments people live in. If we are to prevent ill health in the first place, we need to take action on issues such as poor housing, food quality, communities and place, employment, racism and discrimination, transport and air pollution.

The IHA believes that a cross-government strategy to reduce health inequalities is the only way to address the underlying causes of avoidable disparities in ill health and health outcomes between different groups of people. The areas with highest need should be prioritised for action and funding, but a nationwide cross-government approach will identify the policy changes required on national issues that will be relevant for all communities.

Recommendation

The government must develop a cross-government strategy to reduce health inequalities. This should:

- **be led by, and have accountability to, the prime minister**
- **be underpinned by the necessary funding settlement**
- **include targets and metrics to measure progress.**

How can we create a cross-government strategy to reduce health inequalities?

Over the last year the government has made several promising commitments that signal a move towards a more joined-up approach to reducing health inequality. The Office for Health Improvement and Disparities (OHID), the cross-government ministerial board on prevention and the Levelling Up white paper all hold great potential to be the catalyst we need to tackle health inequalities.

We believe the government must now take the next step to strengthen and underpin this work with an explicit cross-government strategy to reduce health inequalities, involving all government departments, led by and accountable to the prime minister.

The OHID will officially launch on 1 October 2021. We welcome that the OHID will 'coordinate with government departments to address the wider drivers of good health'. We are especially pleased to see specific mention of employment, housing, education and the environment. The government also said in March 2021 that it would establish a cross-government ministerial board on prevention to work with the OHID. This could be a turning point for addressing health inequalities if the OHID and the ministerial board have the power to take action across government departments.

The announcement of the OHID referred to 'a new cross-government agenda which will look to track the wider determinants of health and reduce disparities', which could be the development of the strategy we need. If so, we look forward to the prime minister making that clear and laying out how all government policy will be assessed against the need to reduce disparities and improve population health.

The government's Levelling Up white paper is also due before the end of the year, led by the government's Levelling Up adviser, Neil O'Brien MP. Improving health should be central to this central government ambition – a healthy population and a healthy economy are two sides of the same coin. As the Confederation of British Industry has said, better infrastructure will benefit businesses as well as the wider communities of which they are a part.

As it needs to consider the role of every department and make use of all the policy levers available to government, the key to an effective cross-government strategy is prime ministerial leadership and accountability. The prime minister may devolve responsibility and authority for developing it via the Levelling Up white paper, the OHID, the ministerial prevention board, or in the Cabinet office. The key is that the prime minister places it at the heart of government policy and provides the funding necessary to implement it.

> **COVID-19 was a flag that united the whole system to fall behind. As we now emerge from the worst phases of the pandemic, we need a new flag. I believe that flag is health inequalities. Differences in health and health outcomes have never been as big in modern times as they are now. I, and the whole of the RCP, see this as one the biggest healthcare priorities that needs to be addressed in the immediate future.**
>
> – **Dr Andrew Goddard, president of the Royal College of Physicians**

What now?

The IHA has today (15 September 2021) written publicly to the prime minister to ask for the government to commit to a cross-government strategy to reduce health inequalities. The RCP will continue to push on this agenda, working with IHA members.

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Contact: **policy@rcp.ac.uk**
Website: **www.rcp.ac.uk**

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