

Tackling health inequalities: improving health and well being

Chair's address

The publication of *Healthy Lives, Healthy People* eight days ago signals a welcome commitment by the Coalition government to improve the lives of those who are disadvantaged. The White Paper represents the government's response to the Marmot review which argued that action on health inequalities is a matter of fairness and social justice. The consultation document explicitly recognises that health is determined by wider social influences which have an impact on people's health from childhood to older age. One of the commonly used indicators of health inequalities is that of life expectancy: a boy born in the wealthy borough of Kensington and Chelsea can expect to live 13 years longer than a boy born in the inner city area of Calton in Glasgow.

Although differences in average life expectancy provide a powerful illustration of health inequalities, they do not tell the whole story. Quality of life and freedom from debilitating conditions are characteristics of good health and amenable to preventative measures. Such measures might include reablement following a fall or reducing social isolation for older people, support for the physical and mental health of carers, the health of children in the care system, giving every child a sure start in life and tackling obesity. These are core concerns of social care. Yet *Healthy Lives, Healthy People* does not explicitly recognise the role played by social care in this endeavour. This is somewhat surprising as the social care workforce of 1 million people is approximately two thirds of the size of the NHS (1.5 million) and staff are often located in those communities where poor health is prevalent. This seems to be an overlooked resource. Moreover, it is the social, economic, political and environmental conditions which result in health inequalities at least as much as access to treatment and care meaning that social care is uniquely placed to make a contribution. To make such a contribution social care needs recognition as a significant player in the reduction of health inequalities and it needs to be adequately resourced to undertake the task. The White Paper's commitment

to tackling health inequalities is even more necessary in the current economic climate. Transferring the responsibility for public health back to local authorities might enhance the health prevention and promotion roles of social care but these services are profoundly threatened by the Comprehensive Spending Review and the front loaded reduction in Local Authority expenditure.

Two recent developments may have an impact on the implementation of the aims of *Healthy Lives healthy people*. The first is the current proposal to discontinue some routine data collection. There are concerns about the future of the General Lifestyle Survey (formerly the General Household Survey) which may cease to continue from 2012. The Department of Health is also consulting on the proposal to stop producing a report on the self-reported experience of patients from black and minority ethnic groups. These surveys provide important evidence for making public health decisions and for researchers in health inequalities. It is important that the data on which policy is based is robust and widely available. The second development is the Government's recent decision to collaborate with the food and drinks industry through five responsibility deal networks as part of efforts to improve public health, tackle obesity and reduce alcohol consumption. The alcohol responsibility deal network is chaired by the head of the Wine and Spirit Trade Association. It remains to be seen whether a meaningful convergence can be achieved between the interests of industry and public health.

For the first time in UK health policy, the White paper has recognised that health inequalities are not only a matter of income inequalities but of wider social inequalities including race, disability, age, religion or belief, gender, sexual orientation and gender identity. It was only in the last five years that the Department of Health has acknowledged that lesbian, gay, bisexual and trans (LGBT) people experience health inequalities and set up an advisory group to help bring about change. It commissioned a series of briefing papers for health and social care commissioners, service planners and frontline staff. Discrimination has a negative impact on the health of LGBT people in terms of lifestyles, mental health and other risks. Many people are reluctant to come out to health professionals with potential consequences to their health because they poor treatment. But there is relatively little research about their

health and social care needs. Primary Care Trusts have led the way in addressing this gap, through the Pacesetters Programme, commissioning research locally and in late November I met together with a London voluntary sector organisation and NHS Westminster to look at LGBT health inequality and consider ways of providing services in the borough of Westminster. My concern is whether this work will be squeezed in the reconfiguration of PCTs next year.

I am joint convenor of the Social Work and Health Inequalities Network, a collaboration of 200 academics and practitioners from more than 15 countries around the world. The Network was established in 2004 to raise international awareness and it aims to link social workers in different parts of the world who want to promote social work practice that actively combats health inequalities and to influence policy making.

The programme for today is tightly packed: we will benefit from the expertise of colleagues from perspectives as varied as researchers, policymakers, public health and general practice. The forum will identify the health and social care context for health inequalities and share case studies of good practice. I anticipate that the day will be both illuminating and enjoyable and hope that you will find it so too.

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