2. Health inequalities and early years intervention

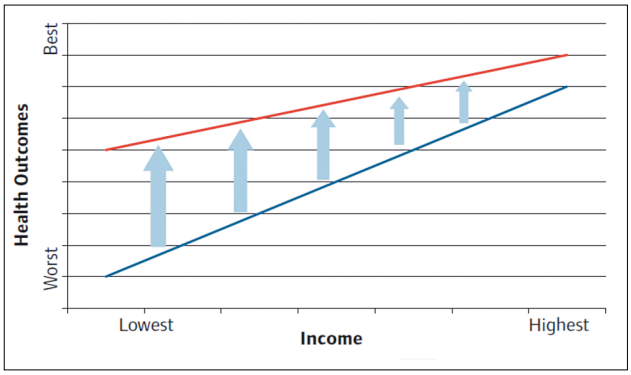
Health inequalities in London

Health inequality refers to the gap in the quality of health, in respect of life expectancy or the general state of health, across different groups of the population.

According to the House of Commons Health Committee[1] the health of all groups in England has improved over the last ten years. However the inequality in health between the social classes has widened with the gap increasing by four per cent amongst men and eleven per cent amongst women. This was found to be the case because the health of the wealthiest part of the population is improving more quickly than that of the less well off. This illustrates the need to improve the health outcomes across the social gradient, as depicted in Figure 1, with a particular focus on those on the lowest incomes.

Current evidence shows that a greater proportion of people in London live in deprived areas and the health of children is generally worse compared to the rest of England[2]. Eleven per cent of children in reception years and 21 per cent of Year 6 students are classed as obese in London, higher than any other region[3]. In addition, according to the NHS, levels of physical activity and teenage pregnancy are also worse in London than the average for the rest of England. Levels of drug misuse, violent crime, and new cases of tuberculosis are also higher in the capital than the rest of the country[4].

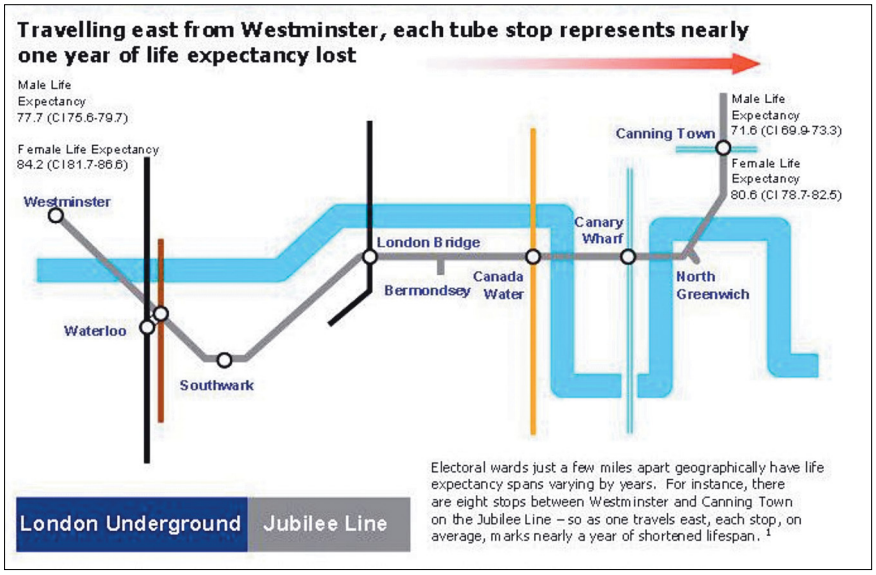
Figure 1: The Social Gradient of Health



Source: Mayor's Health Inequalities Strategy 2010

Average life expectancy is often considered to be a good indicator of the general health status of the population. While rates of average life expectancy at birth in London are slightly higher than the rest of the UK, there are significant disparities between boroughs and within boroughs across London. For example, a boy born today in Tottenham Green, Haringey can expect to live until the age of 71. This is seventeen years less than a counterpart born in Queen's gate, Kensington and Chelsea. Indeed, the London Health Observatory[5] calculated differences in life expectancies within a small area of London. They found that when travelling east from Westminster, each tube stop represented nearly one year of life expectancy lost. As a result, a man living in Westminster has a greater life expectancy (77.7 years) compared to a male living further east in Canning Town (71.6 years life expectancy).

Figure 2: Differences in Life Expectancy within London



Source: Analysis by London Observatory using Office for National Statistics data. Diagram produced by Department of Health

Other illustrations of the inequalities in health experienced within London include the fact that infant mortality rates vary significantly between different boroughs in London[6]. The highest rates (at over six per 1,000 live births) in deprived boroughs are more than double the rates experienced in more affluent areas. Evidence also shows a socio-economic gradient in the distribution of child asthma, the most common chronic childhood disease in London. The capital also has stark inequalities in oral health, with children in inner London having some of the worst levels of tooth decay in the country. The social gradient in mental health is particularly pronounced in childhood with a threefold variation in prevalence between the highest and lowest socioeconomic groups. Nearly one in five children living in a workless household suffers from mental health problems.[7]

Recent DH/London Health Observatory analysis modelled different evidence-based interventions. This was to show which approaches would most strongly narrow the gap of a higher prevalence of certain specific risk factors for infant mortality among the routine and manual (R&M) occupations group compared to the rest of the population. It was found that increasing breastfeeding rate by 16 per cent could have a four per cent reduction in the overall gap[8].

Indeed, it is widely acknowledged that breastfeeding can provide many long-term health benefits, for example it is a key protective factor for childhood obesity. However, the UK has one of the lowest rates of breastfeeding in the world and rates are particularly poor in disadvantaged families. This is highlighted as a key, effective intervention in the new C4EO report on early intervention[9].

Causes of health inequality

Health outcomes such as high rates of mortality, ill health and some disabilities can be caused by many factors. The Commission on Social Determinants of Health[10] concluded that inequalities in health arise because of inequalities in the conditions of an individual's daily life and the fundamental drivers/factors that give rise to them. Examples of these common factors that can cause health inequalities include the social economic environment of an individual (eg jobs, housing, education and transport), lifestyles/ health behaviours (eg diet, smoking, social networks) and access to effective health/social care (eg services that result in health benefits). Inequalities may also be observed across different genders, geography, age, ethnicity, socio-economic groups, sexuality and disability[11].

The House of Commons Health Committee illustrate in their report[12] how health can not only be described in socio-economic terms but can also be viewed as an investment that produces a flow of healthy outcomes over time. In this instance, children are believed to inherit an initial stock (or amount) of health 'capital' when they are born that is affected by genes and prenatal factors (ie the mother's eating/ drinking/smoking behaviours during pregnancy[13]). This initial 'stock' of health capital depreciates with age and can be increased with investment (ie healthy behaviours, education, medicine etc). The optimal stock of an individual's health can be considered to be when the marginal benefits (of health outcomes) are equal to the marginal costs (of health related investment). In a perfect world an individual will continue to invest in their health until the marginal benefits from investing are equal to the marginal cost[14].

However, there are a number of reasons why such 'optimal' investment does not occur (particularly amongst those living in poverty) which leads to inequalities in health outcomes. The 'market failure' in this case is likely to be both because many individuals do not have sufficient information about the full benefits of health related investment (so don't invest as much as they should in their own health) and because there are extra benefits to society as a whole from an individual's investment in health. One such example is that an individual vaccinating themselves benefits themselves and also society as a whole by reducing the spread of disease. This issue is explored in more detail in Appendix C.

Inequalities in health can also be passed from one generation to the next. This is in terms of both genetic factors (ie predispositions in certain individuals to particular diseases or health problems) and the parents' health behaviours during pregnancy (ie smoking, diet, medical check ups), circumstances (ie socio economic environment) and behaviour (ie healthy eating habits and physical activity) as they raise their child[15]. As a result, inter-generational[16] causes of health inequalities are significant.

As well as impacting on the individuals concerned, health inequalities have a significant financial cost. Marmot[17] illustrates that, for England as a whole, inequality in illness accounts for productivity losses of £31-33 billion per year, lost taxes and higher welfare payments in the range of £20-32 billion per year and additional NHS healthcare costs associated with inequality were found to be in excess of £5.5 billion per year.

Relationship between poverty and health

Birth cohort studies highlight the impact of poverty on life chances across the life course and between generations. People who experienced poverty in childhood are more likely to have low incomes and worse employment prospects than those who did not have poor childhoods. Children from poor backgrounds are, on average, less likely than other children to continue in school after age 16, or to attain educational qualifications. Meanwhile, women who experience poverty in childhood are more likely to become mothers at a young age and lone parents than those who did not. There is also a significant relationship between poverty, ill health and disability[18].

After accounting for housing costs, London experiences a higher level of income poverty than the UK as a whole. Child poverty, in particular, is a very significant issue in London. During 2006-2009, nearly two out of every five children (39 per cent) in London lived under the poverty line after accounting for housing costs. This compares to less than one in three (31 per cent) for the UK as a whole. Rates of child poverty are particularly high in Inner London, where 44 per cent of all children live in poverty.

According to population projections, the number of children living in London between the ages 0 and 4 will increase by 11.6 per cent from 2008 to 2033[19 20]. This compares to the UK average increase of 6.9 per cent over the same period. London has the greatest projected increase in the number of children aged 0 to 4 years old of all the regions in England. As a result, London will have many more very young children increasing the importance of investing effectively in the early years.

Given that children raised in disadvantaged environments are less likely to succeed in school, in their future economic and social life and are much less likely to grow into healthy adults, the level of child poverty in London is an important factor in addressing London's health inequalities. Moreover, indicators of poor socio-economic outcomes (or human capital) in adulthood, such as lower educational attainment, are strongly linked to poorer self-reported health[21], higher rates of mortality[22], poorer mental health outcomes[23], and more harmful health-related behaviours such as smoking, alcohol consumption, and unhealthy diet[24].

Accordingly, it is a reasonable assumption that early years interventions which impact positively on an individual's future socio-economic outcomes – in terms of, for example, education, employment and earnings – will also impact positively on the individual's health.

Therefore, early years interventions do not necessarily have to be health related interventions to have a positive impact on reducing health inequalities.

Appendix A provides more detail on poverty, particularly child poverty, in London.