Breaking the Inverse Care Law

Working systematically in Wales to reduce inequalities in access to and outcomes from healthcare

1. Causes of health inequality

Professor Chris Bentley
HINST Associates
The Inverse Care Law

“.........the principle that the availability of good medical or social care tends to vary inversely with the need of the population served.”

Julian Tudor Hart 1971
Agenda

• The causes of health inequality

• The patterns of health inequality

• Achieving percentage change at population level

• Population level change through services
After Ronald Labonte

**Well being and Health**

- Physiological risks
  - High blood pressure
  - High cholesterol
  - Stress hormones
  - Anxiety/depression

- Behavioural risks
  - Smoking
  - Poor diet
  - Lack of activity
  - Substance abuse

- Psycho-social risks:
  - Isolation
  - Lack of social support
  - Poor social networks
  - Low self-esteem
  - High self-blame
  - Low perceived power
  - Loss of meaning/purpose of life

**Risk conditions** – e.g.:
- Poverty
- Low social status
- Poor educational attainment
- Unemployment
- Dangerous environments
- Discrimination
- Steep power hierarchy
- Gaps/weaknesses in services and support

**Health Seeking Behaviour**
“Social injustice is killing on a grand scale”

Sir Michael Marmot

2010

With thanks to Mike Grady
University College London/
Marmot Review Team
Female life expectancy at birth by social class, England and Wales, 1972-2005

Source: ONS Longitudinal Study
More people born into Social Class V die in early middle age than those with fathers in Social Class I.

Cumulative death rates 26 to 54 years by father’s social class men and women born in March 1946

Key
Social Class I
Social Class V

Kuh et al, 2003
Enable all children, young people & adults to maximise their capabilities & control their lives.

Effective evidence-based delivery systems.

Ensure social justice, health and sustainability are at heart of policies.

Create and develop healthy and environmentally sustainable places & communities.

Strengthen the role and impact of ill-health prevention.

Policy goals

Create an enabling society that maximises individual and community potential.

Ensure healthy standard of living for all.

Create fair employment & decent work for all.

Policy objectives

Give every child the best start in life.

Policy mechanisms

Ensure healthy standard of living for all.

Create an enabling society that maximises individual and community potential.

Policy mechanisms

Equality & health equity in all policies.

Effective evidence-based delivery systems.
Areas of action

Sustainable communities and places

Healthy Standard of Living

Early Years | Skills Development | Employment and Work | Prevention

Life course

Accumulation of positive and negative effects on health and wellbeing

Life course stages

Prenatal | Pre-school | School | Training | Employment | Retirement | Family building
Inequality in Early Cognitive Development of British Children in the 1970 Cohort, 22 months to 10 years

Per cent achieving 5+ A* - C grades inc Maths and English at GCSE by IDACI decile of pupil residence: England 2007

% achieving 5+ A*-C GCSEs inc Maths and English

Source: DCFS 2009
1) Give every child the best start in life

Priority objectives

1. Reduce inequalities in the early development of physical and emotional health, and cognitive, linguistic, and social skills.

2. Ensure high quality maternity services, parenting programmes, childcare and early years education to meet need across the social gradient.

3. Build the resilience and well-being of young children across the social gradient.
Standardised limiting illness rates at ages 16-74 in 2001 by educational level, 2001

Source: ONS Longitudinal Study
Low educational qualifications, low job prospects, low pay
2) Enable all children, young people and adults to maximise their capabilities and control their lives

Priority objectives
1. Reduce the social gradient in skills and qualifications.
2. Ensure that schools, families and communities work in partnership to reduce the gradient in health, well-being and resilience of children and young people.
3. Improve the access and use of quality lifelong learning across the social gradient.
Mortality* of men aged 16-64 by social class and employment status at the 1981 census

The social gradient in the metabolic syndrome - Whitehall II

Brunner et al. (1997) Diabetologia
3) Create fair employment and decent work for all

**Priority objectives**

1) Improve access to good jobs and reduce long-term unemployment across the social gradient.

2) Make it easier for people who are disadvantaged in the labour market to obtain and keep work.

3) Improve quality of jobs across the social gradient.
Figure 4.3 Taxes as a percentage of gross income by quintile 2007/08

Per cent

- All direct taxes
- All indirect taxes

Quintile of household equivalised disposable income

Bottom
2nd
3rd
4th
Top
Minimum income for healthy living – Morris et al

- Diet
- Physical activity/body and mind
- Psychosocial relations/social connections/active minds
  - Telephone
  - Social contact and network,
  - gifts for Grandchildren,
  - holiday,
  - TV set and licence.
- Travel
- Medical care
- Hygiene
- Housing
4) Ensure healthy standard of living for all

Priority objectives
1. Establish a minimum income for healthy living for people of all ages.
2. Reduce the social gradient in the standard of living through progressive taxation and other fiscal policies.
3. Reduce the cliff edges faced by people moving between benefits and work.
Living environment by neighbourhood income

Index: poor quality housing, air quality and road traffic accidents

Superoutput areas: Vintile on Income Indicator Score (IMD 07)
5) Create and develop healthy and environmentally sustainable places and communities

Priority objectives

1. Develop common policies to reduce the scale and impact of climate change and health inequalities.

2. Improve community capital and reduce social isolation across the social gradient.
Figure 2.16: Prevalence of obesity (>95th centile) by region and deprivation quintile for children 10-11 years, 2007/8
Alcohol-attributable hospital admissions by small area deprivation quintile in England, 2006/07

![Graph showing alcohol-attributable hospital admissions by deprivation quintile in England, 2006/07. The graph compares males and females, with a gradient of 2.6 for males and 2.4 for females.](image-url)
6) Strengthen the role and impact of ill-health prevention

Priority objectives

1. Prioritise prevention and early detection of those conditions most strongly related to health inequalities.

2. Increase availability of long-term and sustainable funding in ill-health prevention across the social gradient.
Creating the conditions in which individuals and communities take control over their lives

www.ucl.ac.uk/marmotreview
Marmot ‘Plus’ policy Objectives

Healthcare
Public Health

Give every child the best start in life.
Enable all children, young people & adults to maximise their capabilities & control their lives.
Create fair employment & decent work for all.
Ensure healthy standard of living for all.
Create and develop healthy and environment-ally sustainable places & communities.
Strengthen the role and impact of ill-health prevention.
Health Inequalities

Different Gestation Times for Interventions

For example intervening to reduce risk of mortality in people with established disease such as CVD, cancer, diabetes.

For example intervening through lifestyle and behavioural change such as stopping smoking, reducing alcohol related harm and weight management to reduce mortality in the medium term.

For example intervening to modify the social determinants of health such as worklessness, poor housing, poverty and poor education attainment to impact on mortality in the long term.
Task 1

Brainstorm the factors contributing to a particular health inequality
Non-spearhead and Spearhead regions - 1995 to 2010

Standardised Mortality from Digestive Causes; under 75

Binge drinking 1998 & 2008: Health Survey for England
Application of priority public health conditions analytical framework to alcohol-attributable harm

**Socio-economic content and position, etc.**
- Alcohol production, distribution, regulation
- Health and welfare systems

**Differential vulnerability**
- Gender
- Age
- Poverty marginalization

**Alcohol consumption**
- Volume
- Pattern

**Health outcomes**
- Chronic conditions
- Acute conditions

**Differential exposure**
- Drinking environment
- Drinking culture
- Alcohol quality

**Differential resources for recovery**
- Behaviour change
- Adherence to therapy
- Co-morbidities

**Socio-economic consequences**
- Loss of earnings, unemployment
- Stigma
- Barriers to accessing health care

After Schmidt LA et al. WHO 2006