

**Reducing Health Inequalities Implementation Theme.
Briefing paper 1: Why health inequalities matter**

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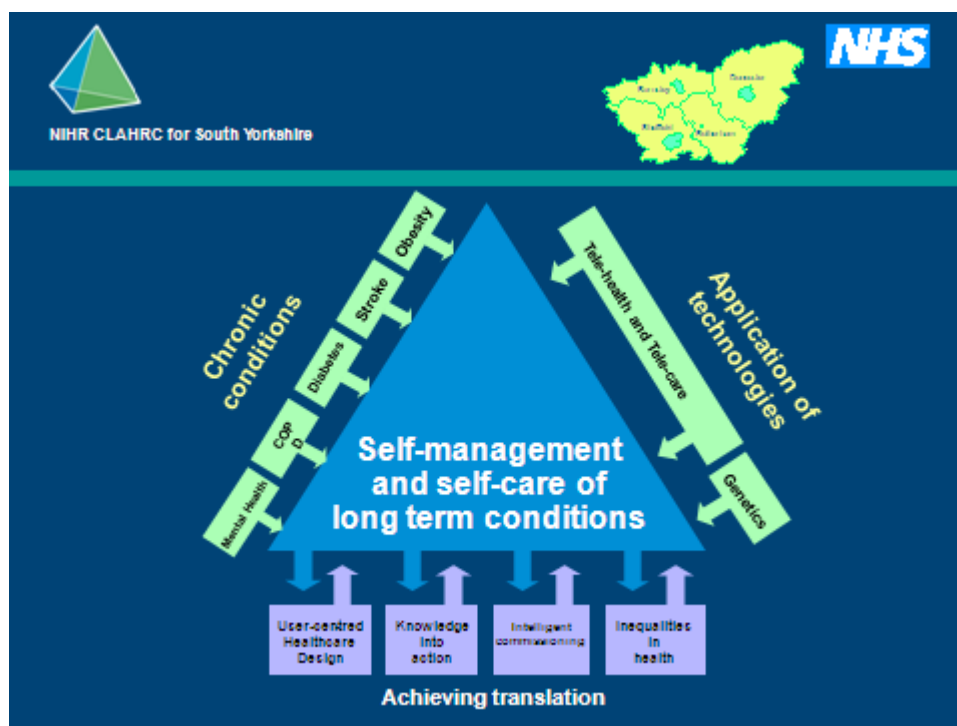
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Reducing Health Inequalities Implementation Theme

Briefing Paper 1: Why health inequalities matter



Introduction

The diagram above shows that *Inequalities in health* is one of four themes in the *Achieving Translation* segment of the CLAHRC for South Yorkshire. The overall purpose of the CLAHRC Inequalities theme is to promote evidence-based health policy and practice (at community, primary care and secondary care levels) that explicitly address inequalities in the prevalence and treatment of long-term health conditions and thereby to improve health outcomes for the disadvantaged populations in South Yorkshire. In order to achieve this aim, the Inequalities Theme will seek to both inform, and learn from, those working in the other themes of CLAHRC, particularly those doing empirical work in the *Chronic Conditions* and *Application of Technologies* segments. The intention is to identify ways of working collaboratively to increase the impact of CLAHRC (SY) on the health and wellbeing of the least advantaged sections of the population. As a first step towards that end two briefing papers have been produced: the first sets out an account of why health inequality matters; the second discusses how the issue of

inequality can be incorporated into the wider CLAHRC (SY) activity. In addition, short guidance notes and checklists have been produced for incorporation within the CLAHRC (SY) independent scientific review process.

This first briefing paper is an account of why health inequality matters and why health inequalities deserve consideration across all areas of CLAHRC (SY) activity. We begin by briefly reviewing the policy landscape and the prominence of 'inequality' as a growing focus of concern over the past 30 years. We then set out the type of philosophical and political considerations that may underpin the view that health inequality is a problem. Next we identify the main axes of inequality with which we suggest CLAHRC (SY) should concern itself. In the next section of the paper we set out the extent of health inequality in South Yorkshire, as far as available data allow. Finally, we show the relevance of health inequality across the CLAHRC (SY) themes and raise for discussion the implications for CLAHRC (SY) activity.

The current policy preoccupation with health inequality

Health inequality has not always been high on the policy agenda in the UK. The Black Report that was commissioned by a Labour Government was badly received by the Conservative Thatcher administration which had taken over by the time it reported.¹ In the main, the Black Report focused on health inequality that was correlated with social class. It found, for example, that death rates from various diseases in men from social class V were often twice that of those in class I. Furthermore, the relative gap between classes appeared to be increasing rather than decreasing. The independently-commissioned Whitehead Report had similar findings in 1987.² The Conservative Government was disinclined to act on these reports. For example, the White Paper of 1992, *The Health of the Nation* focused heavily on individual behaviour change as a route to better health and said little or nothing about the need for structural change to address health inequality; in this and related documents, the term "health variations" was used rather than "inequality".³

Towards the end of the period of the Conservative Government this attitude changed a little with some attention paid to the issue of inequality;^{4,5} and with the election of a Labour Government in 1997 there was a sea-change in the focus and language of policy. Donald Acheson led an independent enquiry into health inequalities that reported in 1998 and confirmed that, despite an overall downward trend in mortality between 1970-1990, improvements in mortality were not even across the social classes.⁶ The report contained many policy suggestions and informed the Government green paper *Our Healthier Nation: A Contract for Health*⁷ which had a stated aim of reducing health inequalities. The following quotes from

recent Government health documents illustrate the continued, current preoccupation with health inequality:

"Health is profoundly unequal. Health inequality ... exists between social classes, different areas of the country, between men and women and between people from different ethnic groups. The story of health inequality is clear: the poorer you are, the more likely you are to be ill and to die younger. That is true for almost every health problem" (page 41)⁵

The then Prime Minister, Tony Blair, said in the foreword to the White Paper *Choosing Health* [page 3]⁸

"This Government is committed to sustaining an ethos of fairness and equity - good health for everyone in England. We are already taking action throughout society to tackle the causes of illhealth [sic] and reduce inequalities. Choosing health sets out how we will work to provide more of the opportunities, support and information people want to enable them to choose health. It aims to inform and encourage people as individuals, and to help shape the commercial and cultural environment we live in so that it is easier to choose a healthy lifestyle"

And the Department of Health has its own health inequalities webpage from which is taken the following:

*"Health inequalities are unacceptable. They start early in life and persist not only into old age but subsequent generations. Tackling health inequalities is a top priority for this Government, and it is focused on narrowing the health gap between disadvantaged groups, communities and the rest of the country, and on improving health overall."*⁹

Specific actions taken at a national level as part of this drive to tackle health inequalities include (but are not limited to): the setting of explicit 2010 targets for reducing inequalities; the establishment in 2004 of so-called 'spearhead PCTs' to pilot new initiatives in 88 most health deprived areas in England; and the establishment of a National Support Team to provide support and guidance to PCTs, local authorities and other partners in addressing health inequalities.

This Government imperative to address health inequality is reflected at a regional level in, for example, the report from the Directors of Public Health in South Yorkshire (2005/6) *Improving Health, Narrowing the Divide*,¹⁰ as well as local policy and strategy documents, such as: Sheffield First Health & Wellbeing Partnership's action plan *Addressing health inequalities in Sheffield*;¹¹ Doncaster's *Reducing health inequalities in Doncaster: achieving sustained change*¹² which

follows the 'Achieving Early Impact' programme launched in June 2007; Rotherham's *Health Inequalities Action Plan*¹³ that was drafted following support from the National Support Team; and Barnsley's *Single Equality Scheme and Action Plan for health inequalities*.¹⁴

Although beyond the scope of this briefing paper, it is also worth alerting readers to the current international focus on health inequalities. In this context, the World Health Organisation's recent report, *Closing the gap in a generation: Health equity through action on the social determinants of health* is central.¹⁵

Why health inequality is a problem

Why, though, should CLAHRC (SY) be concerned about health inequality? The claim that inequality of any type is a problem is almost always a moral and political one. Roughly the thought is that there are desirable and undesirable things that need to be shared out in society. The desirable group includes education, fulfilling work, consumer goods and health care; the undesirable group, taxes, unemployment and drudgery. If one group is unduly benefited or burdened this seems unfair. There is an important distinction between the terms "equity" and "equality". Equality is an unproblematic term and it might perhaps be said that fairness is about people getting equal treatment or equal shares. This does not work, however. If health care were to be shared equally amongst the population then perfectly healthy people would get the same share as would those with serious illness. This would be equal but obviously unfair treatment: hence, the famous Aristotelian dictum that we should treat equals equally and unequals unequally.¹⁶

Thus far, there is little to disagree with. However, underlying the thought that distribution ought to be fair are many differences of view about fairness itself. There is an important area of controversy here between what we might term meritocrats and egalitarians. The former believe social goods should be shared on the basis of merit; for example, hard work and talent should be rewarded, laziness and criminality punished. What matters is that merit has the opportunity to shine; it is unfair that, say, an intelligent girl from a working class background is less likely to go to university than a not very bright middle class boy. For meritocrats, it is equality of *opportunity* that matters more than equality of *outcome*. By contrast, egalitarians are concerned with outcome. For them, a world in which some people appear to get far more of the good things and others far more of the bad is almost certainly unfair; issues of desert or merit do not enter into the equation.

You might feel some sympathy with both views; but it is worth being aware of the tension between them. The public health arena currently includes many policies and interventions that

aim to get people to change their behaviour; to eat less, stop smoking, take more exercise and so on. A popular argument, emphasised in the White Paper *Choosing Health*,⁸ is that people should have as much opportunity to make healthy choices as possible. The possible implication here is that if you are given such an opportunity and do not take it you are responsible for any ill-health that follows and may not deserve access to certain types of public resources. There is evidence from within the health service and beyond that, for example, obese people are denied health resources such as surgery and social goods such as adoption.¹⁷ This is consistent with a meritocratic view but not an egalitarian one. Similarly, a meritocrat might blame someone for an illness linked to lifestyle choices, or at least not seek to rectify the situation via allocation of resources, while an egalitarian might seek to understand and address the underlying causes of such choices. Indeed, the egalitarian might be more inclined to see such 'choices' as very constrained by the situation a person faces. Of course, notions of what particular individual characteristics or circumstances confer merit or deservingness are subjective so that meritocratic ideas of fairness can be highly variable and contentious.

In addition to the focus on inequality that stems from a concern for fairness or justice (whether driven by a meritocratic or egalitarian perspective), it is important to recognise somewhat different motivations for seeking to address health inequality. For some, the 'problem' with inequality lies in its potential to impact on 'all of us' particularly via the economic consequences of treating high levels of morbidity, but also via other routes such as the breakdown in community cohesion, high levels of work incapacity and so on. Of course in practice, the arguments put forward by Government and other stakeholders in favour of concerted action to tackle health inequality may draw on, and at times conflate, a number of these positions.

It is also worth saying that not everyone views health inequality as a problem. Some would argue that inequality per se is not troubling provided the poor/disadvantaged are not getting worse in absolute terms. Indeed, they might ask whether there is a danger that by focusing on inequality we end up closing the health gap but failing to improve health as much as we could have done.¹⁸

These are important debates. Our CLAHRC (SY) Reducing Health Inequalities Theme clearly indicates our position that inequality is a concern. Furthermore, the Inequalities Theme takes the view that health inequality is part of a general social inequality that is undesirable and which it is worth taking positive measures to reduce. The generation and application of research evidence can make an important contribution to this broader goal.

Which inequality?

The key factor in determining whether a particular inequality is a matter of fairness is whether or not it is within human control. The fact that there is a 10 year difference in life expectancy between the most and least deprived neighbourhoods in Sheffield is striking and alarming (although the gap has narrowed from a 14 year difference in 2001-5).¹⁹ It is likely that identical twins separated at birth and raised respectively in, say, Whirlow and Manor Top will have hugely different health outcomes. The difference in the outcome for the twins seems to be due to factors that are within society's control; we decide how income is distributed, what housing to build, which education to provide and so forth. As Whitehead puts it, these are differences in health that are unnecessary, avoidable, unfair and unjust.²⁰

There are several 'axes' along which these unfair differences fall in relation to health outcomes and receipt of healthcare. We have just mentioned one of the key ones, **class**. South Yorkshire is a fairly poor area: it has suffered industrial decline in recent years with mining and steel industries being badly hit. There are also large variations in income and other dimensions of socioeconomic status across the area. For instance, one area of Sheffield is among the most prosperous in the UK; many other areas in the city and beyond are deprived. Health follows these socioeconomic differentials closely; the poor suffer worse health.

A second important line of inequality is **race/ethnicity**. The diverse, complex and contested meanings that have been attached to the terms 'race' and 'ethnicity' make this a particularly challenging area for health researchers. In particular, there is a need to avoid the pitfall of appearing to support the pernicious and much-discredited, but unfortunately still ingrained, notion that discrete, naturally occurring human racial subspecies exist. Nevertheless, race/ethnicity is one of the major social divisions in modern societies²¹ and ethnic identities have important implications for people's lives.

Notwithstanding significant heterogeneity *within* ethnic categories (and substantial data limitations), available evidence indicates important diversity in morbidity and mortality profiles by ethnicity. Some 'groups', notably individuals identifying as 'Bangladeshi' and 'Pakistani' experience particular disadvantage, reporting much higher levels of 'bad' or 'very bad' general health than the population as a whole^{22,23}. Though health disadvantage among minority ethnic 'groups' is in part explained by their poorer socioeconomic status, ethnic disparities in health outcomes cannot simply be collapsed onto class disadvantage.²⁴ Ethnicity demands our explicit attention because it can have an impact on health via two important routes: first, as a result of how an individual's experience of their own ethnic identity informs their health-related attitudes, beliefs and behaviours; second, because processes of inclusion within and exclusion from ethnically-delineated 'groups' result in differential exposure to health-related risks and

resources (broadly defined) including appropriate health services. Inequality along the lines of religion/belief is also often closely related to race/ethnicity in the contemporary UK context.

A third significant line of inequality is **age**. While ageing and associated health problems are to an extent natural, it is increasingly argued that disease and disability do not have to be synonymous with growing old. Furthermore, attempts to reduce health inequalities have to-date given relatively little attention to older groups, focusing instead on the working age population. Indeed, the health needs of older people are commonly portrayed in catastrophic terms, as an inexorably growing drain on resources. There is strong evidence to suggest that older people are less likely to receive healthcare that is effective, appropriate to their needs, and delivered competently and with sensitivity.^{25,26} Further, there can be an important interplay with other axes of inequality so that older people who are poor, or of minority ethnic identity, may fare particularly badly. At the other end of the life-course, the health needs of adolescents and young adults are not always well understood and addressed, so that attention to age as a potential axis of inequality requires attention here too.²⁷

A fourth area of inequality that deserves attention is **disability**. There is substantial evidence to show that individuals with a disability are at increased risk of many other health problems, and have shorter life expectancy than those without such disability, and that these elevated risks exist for both physical and learning disabilities. The Disability Rights Commission is currently engaged in a formal investigation into health inequalities experienced by people with learning disabilities or mental health problems. Early findings indicate major concerns relating to: unrecognised and poorly managed health needs; heightened exposure to certain health risks; poor access to screening and preventive health services; inadequate communication with healthcare providers, and poor living conditions.²⁸ In addition, individuals with disabilities can be discriminated against within the health system because of the principles upon which access to care is determined. A particular problem has arisen in the past where quality of life measures have been used to determine access to resources. Disabled people can score lower on such measures and as a result find they are denied a resource they would receive if not disabled. The denial of access can also occur without such an explicit decision; institutional discrimination occurs if services are set up in such a way that they accidentally deny access. This can be anything from wheelchair access to the use of language incomprehensible to a person with a learning difficulty.

The fifth line of inequality with which the CLAHRC (SY) Inequality Theme is concerned relates to **sex and gender**. The health of men and women varies both because of underlying genetic and physiological differences between the sexes, but also because of the ways in which

masculinity and femininity are constructed by society. Gender structures life chances and opportunities in myriad ways with far-reaching implications for health. For instance, gender roles within the family and wider society mean that men and women tend to be exposed to different health risks. The ways in which men and women are socialised may mean differential perceptions of and responses to ill-health, as well as differences in access to health-promoting resources, and so on. Though for some time it was commonly accepted that women tend to live longer than men but suffer higher levels of morbidity, there is increasing recognition that sex and gender influences on health are complex and context-specific, and that the morbidity and mortality profiles of men and women deserve close scrutiny.²⁹

The above discussion has provided a brief overview of the main axes of inequality that are of concern to CLAHRC (SY) and has begun to illustrate some of the processes that create and perpetuate disadvantage among particular sections of society. Clearly this discussion is not exhaustive. Nevertheless, this restricted focus is both pragmatic and informed by the focus of CLAHRC (SY)'s activity (see below). It is, however, important to note that because socioeconomic deprivation tends to cluster in particular neighbourhoods or areas, health inequalities often take on a geographical dimension. Indeed, much recent analysis of patterns of health inequalities in SY has taken the approach of identifying and targeting geographical areas of particular health disadvantage.

Some concluding comments are warranted before we move on to examine the extent of inequality within South Yorkshire.

First, inequalities in health are the result of multiple factors operating at a number of levels across the life-course (as illustrated in the figure below). While structural factors including poor housing, low income and discrimination contribute importantly to poor health, so too do factors that are more readily open to health sector intervention including access to services and risky behaviours. Furthermore, health services, through both their taken-for-granted ways of operating and through the direct behaviour of health professionals, frequently reflect and reproduce the social hierarchies and discriminatory processes of wider society. This is important because it means that all CLAHRC (SY) activity, however far removed from a community or public health perspective, does nevertheless have the potential to ameliorate, or perpetuate inequality.

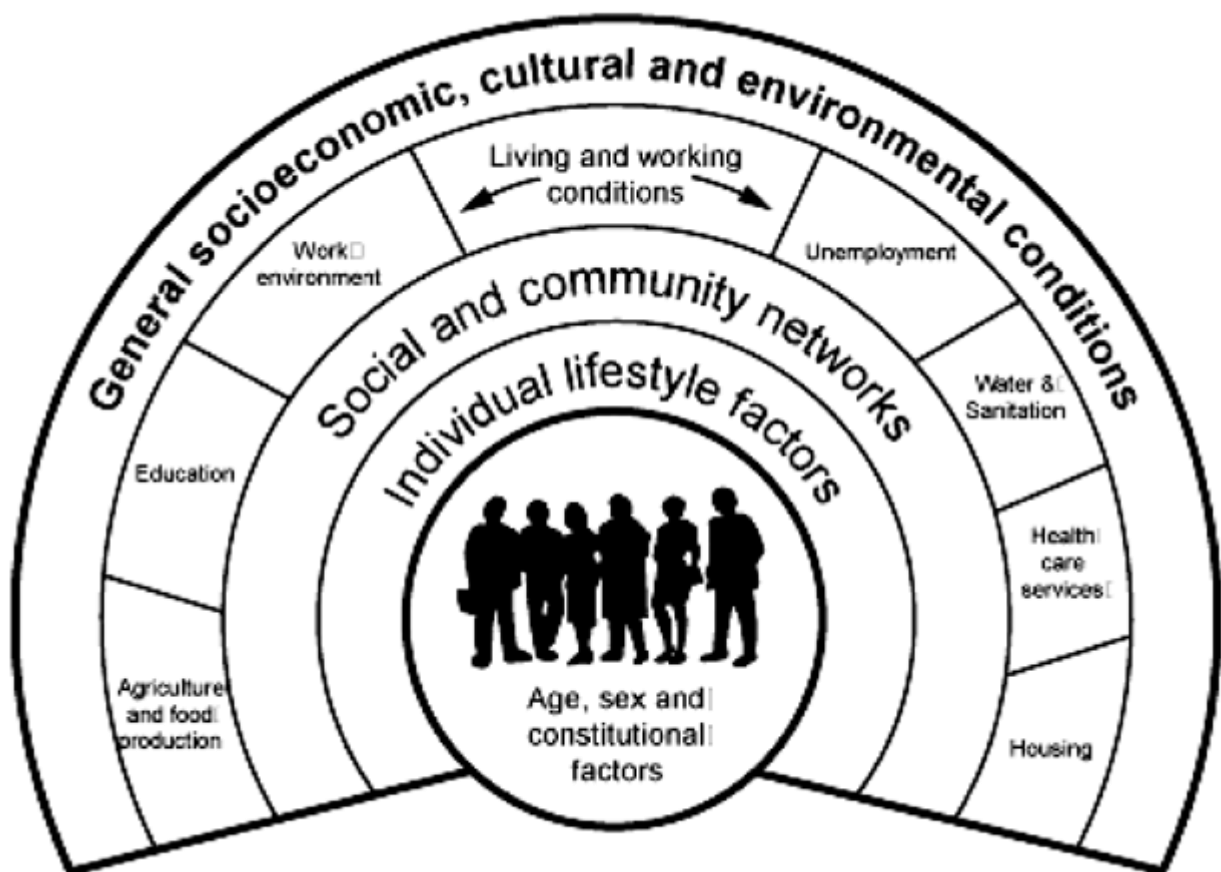


Figure taken from: Dahlgren, G. and Whitehead, M. (1991). *Policies and strategies to promote social equity in health*. Stockholm, Institute for Futures Studies

Second, the axes of inequality we have identified correlate with processes of inclusion within and exclusion from socially delineated 'groups'. These markers of difference organise people hierarchically within society and result in disparities in access to resources of all types. These key axes of inequality tend to reinforce each other - for instance the risks of unemployment following a long-term health condition are higher among those in lower occupational groups than higher groups - so that multiple disadvantage clusters among particular individuals, families and communities. Certain people, for instance individuals of minority ethnicity who have a learning disability, suffer extreme disadvantage. Important also is that less tangible resources, including deservingness, respect and sense of belonging are unequally available to certain 'groups'. The interplay between axes of inequality is important because research designs will often need to be sophisticated enough to deal with this complexity at the individual and population level.

Measuring inequality in health and health-care related outcomes

There are a number of different ways of measuring and conceptualising inequalities in health outcomes. Graham and Kelly³⁰ address principles behind different types of measures of

inequality drawing the distinction between "poor health of poor people", health gaps (most commonly the difference between groups of people identified as 'rich' and those as 'poor') and health gradients (which affect everyone in the population). In addition, there is a wide range of potentially appropriate measures of inequality in access to, uptake and outcomes of appropriate health care interventions and services.

For example:

- Measures of equal access for equal need : such as relative availability of free fruit in schools in deprived areas
- Measures of equal use for equal need : such as relative use of smoking cessation services among low-income smokers
- Measures of equal quality of care for all: such as provision of culturally appropriate and relevant maternity services for black and minority ethnic communities.
- Measures of equal outcomes for equal need: such as greater reductions in coronary heart disease mortality among lower socio-economic groups.

(Examples adapted from HDA³¹).

What is the extent of inequality in South Yorkshire?

In this section of the paper we provide a brief overview of the evidence available on health inequality in South Yorkshire along the five axes identified above. We also highlight data limitations as this information may help in setting research agendas.

Socioeconomic/class inequalities in health have received significant attention in South Yorkshire, particularly via the exploration of differences in health status between geographical areas characterised by area deprivation indices. The document *Improving Health: Narrowing the Divide* gives a summary.¹⁰ In this report comparisons are made between South Yorkshire and the England and Wales average and between cities in South Yorkshire. The report also uses an elaborate method to try to uncover pockets of deprivation; this method draws on a Health Inequalities Atlas published in 2002.³² The key finding of the report is that there has been some narrowing of the health inequality gap or, at least, no widening. Nonetheless, the gap remains large; the ten year difference in life expectancy mentioned above illustrates this.

Recent research provides examples of how socioeconomic health inequalities are expressed in the South Yorkshire communities. One example is in lung cancer. A recent study explored factors influencing delay in symptom reporting and diagnosis in lung cancer amongst areas of

South Yorkshire with the highest rates of lung cancer. Communities that experience the worst deprivation have the highest rates of lung cancer. This is due in part to smoking prevalence and the cultural acceptance of smoking in some populations. However, added to this inequality is an increased delay in diagnosis. The study revealed a complex network of issues that contributed to this including the stoicism of these communities, expectations of chronic ill health at a young age and difficulty detecting acute cough symptoms against a backdrop of chronic lung disease. In addition, many of those at highest risk had worked in the traditional heavy industries such as coal mining, steel and the rail plant. Participants revealed that they were unfamiliar with using primary care services as in the past had relied on industry based occupational health services.³³

Our understanding of the levels and patterns in health outcomes and receipt of health services by **race/ethnicity** is poor in South Yorkshire. The taxonomy developed and reported in the *Improving Health* report creates 19 types of neighbourhood and includes "percent non-white" as part of that taxonomy. However, the report itself says little about ethnicity and health other than a brief comment on HIV infection and the 'Black African' population. Across the region, monitoring of ethnicity in routine health statistics is acknowledged as an area in need of improvement and relatively few studies of access to and experience of, health services have engaged with race/ethnicity in any detail. While some useful lessons can no doubt be learnt from research conducted elsewhere in the UK, there is clearly a need for greater understanding of the issues facing our local minority ethnic communities. NHS Sheffield has produced a report profiling the health of black and minority ethnic communities in Sheffield, but the information presented is severely constrained by the limited data available.³⁴ Understanding and profiling the local ethnic minority communities is identified as a new area of work in Barnsley. The Barnsley's Equality Diversity and Inclusion Partnership (EDIP) has obtained support to look at obtaining data on the different communities of interest, build profiles and track changes over time. The project aims to establish a better understanding of what information is available, what the barriers are and where there are gaps. The outcomes will inform service delivery, policy and decision making.

Similarly, there has to-date been limited attention in South Yorkshire to health inequalities by **age** or **disability**. While routine statistics may be presented by age-group, analyses do not normally consider the extent to which observed differentials represent avoidable inequalities, or inequities. Similarly, we have little local information about how health care experiences may vary by age or disability status. NHS Sheffield are currently undertaking work to explore the uptake of cancer screening among individuals with a learning disability as well as other health needs assessment work for this group. Data for Barnsley indicate higher rates of claimants for Attendance Allowance, Disability Living Allowance, Incapacity Benefit / Severe Disablement

Allowance, Income Support and Job Seekers Allowance than the England average. Data for 2007 show that 11.7% of the working age population in Barnsley are claiming Incapacity Benefit / Severe Disablement Allowance compared to 6.5% in England. Due to the high levels of disability in the borough analysis of information by disability is considered very important for Barnsley.³⁵ Analysis of All Age All Cause Mortality data for Barnsley illustrates an increase in the excess number of deaths in the older age group than would be expected. Further work is needed to explore if this age group are accessing health services.

As elsewhere, life expectancy across the region is consistently higher for women than for men. The 2004 Yorkshire & Humber regional public health report, *Our Region, Our Health*,³⁶ highlights a number of areas where men are disadvantaged compared to women, particularly in terms of life-style related health risks including: smoking; alcohol; obesity; and healthy eating. Men and boys are also at higher risk of accidental injury than women and girls. Interestingly, however, statistics are not always routinely presented by **sex** in regional reports and there is a lack of in-depth work that explores the gendered barriers to better health, though there are some examples of useful work. An example from Sheffield suggests the need for further work in this area. A recent Health Equity Audit of access to revascularisation suggested a marked gender difference in the high risk South Asian group and work is now underway to develop a research proposal to investigate the reasons behind this.³⁷ Evidence from the 2008 Barnsley Health and Lifestyle Survey of Year 10 pupils (14 and 15 years olds) suggests that girls are participating in life-style related risk taking behaviours equal to that of boys or to a greater extent particularly in relation to smoking, drinking alcohol and sexual health.³⁸ Inequality between men and women continues to exist most notably in wages and life expectancy. On average men in Barnsley earn £10.41 per hour while women earn £8.65 per hour. Whilst male life expectancy is expected to increase in Barnsley to 76.7 years in 2010, this compares badly with the national average for men expected to be 78.5 years. Women's life expectancy in contrast is expected to be 80.6 years (although this still lags behind the national average at 82.2 years for women.³⁵ Barnsley's Fit for the Future health inequalities programme has used qualitative research to identify the key contributing factors affecting male obesity in selected deprived wards of Barnsley. The results of this work are being used to develop a social marketing intervention that would help deliver a Health Management Programme to the chosen target group to achieve a significant reduction in male obesity levels in men aged 50-64 years. Qualitative research has also been carried out in the harmful and hazardous drinking behaviours of women in Barnsley aged 18 – 35. Both qualitative and quantitative research has also been conducted in Barnsley in relation to the buying behaviours of smokers and behaviours around physical activity and is now being used to develop social marketing interventions.

Relevance of inequality across CLAHRC (SY) themes

What is the relevance of these various axes of health inequality to CLAHRC (SY)? The recommendation of the Inequality Theme is that all proposed research to be undertaken under the aegis of CLAHRC (SY) should consider the issue of inequality across all five axes. However, this is not to say that all such research must be about inequality. It is worth distinguishing three categories of research that might be undertaken within CLAHRC (SY). These are:

1. Research that directly addresses issues of inequality: examples include research that asks questions such as why health services are not taken up by people in certain areas, or which specifically tries to discover health information or health needs of certain groups. Such research might explore health information needs of minority ethnic patients, or the health needs of people with a learning disability, or of elderly women, for instance.
2. Research that indirectly addresses issues of inequality: here the research question is not directly related to health inequality but the researchers take measures to ensure the applicability and application of the research findings to groups that suffer a relevant health disadvantage. An example would be research assessing the utility of a device for delivering insulin. Given that the UK Bangladeshi population suffer disproportionately from diabetes, the researchers would be well advised to include Bangladeshis in the research sample and to ensure that the device is delivered in a way that is acceptable to that population at the end of the study (if that shows the device to be effective).
3. Research that does not pay attention to inequality: here the research does not relate to issues of inequality or at least not at this stage. An example of this might be the early development of a device or treatment.

Hence, the requirement of research undertaken within CLAHRC (SY) to address inequality will vary greatly depending upon which category it belongs to. We say more about this in the Briefing Paper 2.

Finally, looking at the overall CLAHRC (SY) programme, we must consider to what extent the axes of inequality we have identified are likely to be relevant to our work. It will be recalled that there are three overall headings of activity: Chronic Conditions, Application of Technologies and Achieving Translation. In terms of Achieving Translation, we suggest that our activity should address health inequalities wherever it can; the role of the Inequalities Theme is to help with this. In terms of Chronic Conditions, the relevance of health inequality is immense. All the conditions identified (mental health, COPD, diabetes, stroke and obesity) strike

disproportionately along one or more of the health inequality axes (class, ethnicity, disability and sex/ gender). We should, therefore, expect that much of the activity undertaken in the Chronic Conditions themes will address issues of inequality either directly or indirectly. With the Application of Technologies group there might be more variability, particularly in relation to early developmental work; hence there might be more research of the type that is not related to inequality.

Conclusion

Inequality in health is an aspect of wider inequality in society; those who suffer the worst social conditions generally suffer the worst health. Such inequality is undesirable. We have identified five dimensions of inequality that we would seek to address: class/wealth, ethnicity, age, disability and sex/gender. We also note that dimensions of disadvantage tend to cluster in particular communities and neighbourhoods so that understanding and tackling health inequality may often take on a geographical dimension. We suggest that research under the aegis of CLAHRC (SY) should address health inequality wherever appropriate and possible. In relation to this, we identified three categories of research, that which: 1. directly addresses issues of inequality; 2. indirectly addresses issues of inequality; 3. does not address issues of inequality at this stage. Finally, we suggest that inequality will be relevant to much of the CLAHRC (SY) activity.

References

1. Townsend P, Davidson N. *Inequalities in Health: The Black Report*. Penguin; London.1982.
2. Whitehead, M. *The health divide*. Pelican Books: London. 1988.
3. The Health of the Nation. DH: London. 1987.
4. Macintyre S. The black report and beyond what are the issues? *Soc Sci Med*;44(6):723-45. 1997
5. Department of Health. *Saving lives: our healthier nation*. HMSO: London. 1999.
6. Acheson, D. Independent Inquiry into Inequalities in Health Report. TSO: London. 1998.
7. Department of Health. *Our healthier nation: a contract for health*. TSO: London. 1998.
8. Department of Health. *Choosing Health: making health choices easier*. Department of Health: London. 2004. Online document last accessed 12/5/09 at:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4094550
9. http://www.dh.gov.uk/en/Publichealth/Healthinequalities/DH_149
10. Directors of Public Health in South Yorkshire. *Improving Health, Narrowing the Divide*: (2005/6). Online document last accessed 12/5/09 at:
<http://www.doncasterhealth.co.uk/phiu/DPHReport0506/index.asp>.
11. Sheffield First Partnership for Health and Wellbeing. *Addressing health inequalities in Sheffield: action plan*. 2009.
12. Doncaster PCT *Reducing Health Inequalities in Doncaster: achieving sustained change*. Online document last accessed 10/06/09 at:
<http://www.doncasterpct.nhs.uk/documents/AchievingSustainedChange.pdf>
13. Rotherham PCT *Health inequalities action plan*. Online document last accessed 10/06/09 at:
www.rotherhampct.nhs.uk/corporate/boardpapers/200907/.../D2%20-%20Action%20Plan%20National%20Health%20Inequalities%
14. Barnsley PCT *Single equality scheme and action plan for health inequalities*. Online document last accessed 10/06/09 at:
<http://www.barnsley.nhs.uk/about-us/single-equality-scheme.html>
15. World Health Organisation *Closing the gap in a generation: Health equity through action on the social determinants of health: Final report of the commission on the social determinants of health*. WHO: Geneva. 2008.
16. *Politics* 1287a12
17. Doyal L. Obesity and rationing within the NHS: Joint replacement surgery. *International Journal of Surgery*;4(3):146-9. 2006.
18. Le Fanu J. *The rise and fall of modern medicine*. London: Little Brown; 1999.
19. Sheffield Director of Public Health. *Report 2008*. Sheffield NHS; 2008.

20. Whitehead M. The concepts and principles of equity and health. *Health Promotion International*;6(3):217-28. 1991.
21. Anthias, F. 'The concept of 'social division' and theorising social stratification: looking at ethnicity and class' *Sociology*35: 835-54.2001.
22. Nazroo, J. The health of Britain's ethnic minorities. PSI: London. 1997.
23. Natarajan, L. 'Self-reported health and psychosocial wellbeing' in Sproston, K. and Mindell, J. (eds.) *The Health Survey for England 2004, Volume 1: The health of minority ethnic groups*. The Information Centre: London. Online document last accessed 09/01/09 at http://www.ic.nhs.uk/webfiles/publications/healthsurvey2004ethnicfull/HealthSurveyforEnglandVol1_210406_PDF.pdf
24. Smaje, C. *Health, "Race" and Ethnicity. Making Sense of the Evidence*. King's Fund Institute: London. 1995
25. The Acove Project *Developing quality of care indicators for the vulnerable elderly*. RAND. Online document last accessed 12/5/09 at: http://www.rand.org/pubs/research_briefs/RB4545-1/
26. Philip, I. *Better health in old age: Report from Professor Ian Philp*. Online document last accessed 10/06/09 at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4092957
27. Leon L (2001) Time to listen: the mental health needs of young people. *ChildRight*, June 2001.
28. Disability Rights Commission. *Equal Treatment: Closing the Gap: A formal investigation into physical health inequalities experienced by people with learning disabilities and/or mental health problems*. Online document last accessed 10/06/09 at: http://83.137.212.42/sitearchive/DRC/library/health_investigation.html
29. Annandale, E. and Hunt, K. *Gender inequalities in health*. Open University Press: Buckingham. 2000.
30. Graham H, Kelly M. Health inequalities: concepts, frameworks and policy. HDA Briefing Paper HDA: London. 2004.
31. HDA *Health Equity Audit Made Simple*. 2003. Online document last accessed 12/5/09 at: <http://www.nice.org.uk/niceMedia/documents/equityauditfinal.pdf>
32. <http://www.doncasterhealth.co.uk/syhlthineqatlas/index.html>
33. Tod AM, Allmark P, Craven J. Diagnostic delay in lung cancer: a qualitative study *Journal of Advanced Nursing* 61(3), 336-343. 2008.
34. Elhassan, M., Dhoot, P., Wilkinson, M. and Pintus, S. *The health of black and minority ethnic communities in Sheffield*. NHS Sheffield. 2006.
35. Barnsley Joint Strategic Needs Assessment – Technical document. Online document last accessed 06/06/09 at:

<http://www.barnsley.gov.uk/bguk/docs/CentralResearchTeam/Draft%201%20Barnsley%20SNA%20Report%2020080328.pdf>)

36. Regional Director of Public Health Y&H. *Our Region Our Health : A consultation report on the state of the Region's health in Yorkshire and the Humber*. 2004. Online document last accessed 09/06/09 at: http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_4082304

37. Skinner J. and Soady J. (2008) Access to revascularisation - a Health Equity Audit. NHS Sheffield.

38. NHS Barnsley (2008) A Health and Lifestyle Survey of Young People 2008. Available online at: <http://www.barnsleyfit4thefuture.co.uk/barnsley-young-peoples-health-survey.htm>

Further resources:

NHS toolkits and reference guides to measuring health inequalities and undertaking health equity audits can be found at: <http://www.nwph.net/nwpho/Lists/AuditTools/AllItems.aspx>

The Eastern Region Public Health Observatory has produced a useful guide specifically designed for use by Primary Care Trusts: <http://www.erpho.org.uk/viewResource.aspx?id=16969>

Guidance on ethnic monitoring (shortly to be updated and expanded to include attention to monitoring of disability and sexual orientation) can be found at:

<http://www.dh.gov.uk/en/Managingyourorganisation/Equalityandhumanrights/index.htm>

and at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4116839

Information about Delivering Race Equality, a special initiative focused on improving the delivery of mental health services to minority ethnic individuals, can be found at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4100773

Race for Health is a programme that supports PCTs to make health services in their areas significantly fairer for black and minority ethnic communities.

<http://www.raceforhealth.org/>

Findings from the DH commissioned study into gender and health access can be found at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_092042

Further information about gender equality issues in health can be found at:

<http://www.dh.gov.uk/en/Managingyourorganisation/Equalityandhumanrights/Genderequality/index.htm>

The UK Learning Disability and Health Network can be found at:

<http://www.learningdisabilities.org.uk/ldhn/>

Resources focused on better health in old age can be found at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4092840

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