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Why a health inequalities white paper is still so vital and should not be scrapped

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Health inequalities across the country have been widening for many years, and if they had ever not been obvious before, the covid-19 pandemic served to shine a spotlight on the health inequalities which are so keenly apparent in so many communities across the UK.

A significant and growing gap in life expectancy for people living in areas with the highest and lowest levels of deprivation means there is now an urgent need to create opportunities for health and care systems to drive improvements in population health outcomes at pace. So, if the rumours are to be believed and the new secretary of state for health and social care has decided to shelve the work of her predecessor and abandon the long-awaited health inequalities white paper this will deal a huge blow to the health and life chances of millions of people across the country.

The newly created Integrated Care Systems (ICSs) provide a fresh opportunity for central government and local leaders to share power locally in a flexible and dynamic way which, over time, should really help reduce inequalities in health outcomes. Through integrated care partnerships (ICPs), local leaders can embrace community power and they will have a mechanism to develop services according to the priorities of their local communities.

To improve population health, NHS, local government and social care leaders alike are urging the government not to perform such a significant and damaging volte-face, but to build on existing knowledge of what works and to consider holistically the social, economic, and commercial determinants of health when addressing inequalities. Their view is that a system-wide approach is fundamental and breaking down siloed ways of working within local systems will be crucial.

They say that the government must commit to this white paper which should consider action in four key areas to really shift the dial and reduce health inequalities once and for all.

First, leaders want to see health equity in all policies. Up to 80 per cent of what affects health—both physical and mental—is from outside of the health system, so the impact of a white paper that fails to outline a cross-government approach that looks beyond the remit of the Department of Health and Social Care (DHSC), will be drastically constrained.

The need to adopt a cross-Whitehall approach to reduce health inequalities is widely accepted. The NHS Confederation, as a member of the Inequalities in Health Alliance, a coalition of over 150 healthcare organisations, is calling for a cross-government strategy to reduce inequalities. They have written to the new Secretary of State urging her to keep the commitment to publish it before the end of this year. A health equity in all policies approach recommends action beyond the health sector, taking into account all the drivers of ill health and promoting actions that contribute to good health and wellbeing.

Secondly, leaders want prevention to be incentivised so that local systems can allocate resources according to health need and deprivation. This will require the government to make use of the structural and regulatory levers at its disposal, such as taxes and levies, to create a society where the healthy choice is the easy choice for everyone.

Last year's Government Spending Review which failed to commit to a real-terms increase in the public health grant and soaring inflation rates which currently stand at 9 per cent, mean the Spending Review's commitments represent a significant real-terms cut in funding. The white paper must reinstate real-terms funding increases at the level seen before 2015.

Thirdly inclusive innovation, integration, and access will be key to driving down national and local inequalities in health. The covid-19 pandemic showed that innovation in health and care services could be delivered including remote consultation. However, while very positive, there is a real risk that without concerted action to ensure these new approaches reach the country's most deprived areas and communities, they will exacerbate inequalities.

The white paper is needed and must set out funding proposals to close the digital gap, and a strategy for the provision of health services on the high street. A plan is also needed for a population health management approach to general practice data to enable primary prevention to begin in primary care.

Equitable innovation will mean that communities are involved and engaged in defining what it looks like and that results are monitored and evaluated over the long term. Deep partnership working with the voluntary, community, and social enterprise sector will also provide valuable links into those communities.

Finally, there needs to be real concerted action on the cost-of-living crisis for communities.

A record number of working families now find themselves living in poverty. Government support must be targeted towards those who need it most in our communities. For health and care staff, this means a fully funded, generous pay rise for healthcare staff on the lowest pay, and a national care workers' minimum wage of £10.50. The white paper must also encourage a flexible approach to the Apprenticeship Levy, using widening participation

principles to enable more people from disadvantaged or excluded communities to get into work.

With concerted action it is possible to make real inroads in tackling the increasingly disparate health outcomes experienced across the country to create the conditions for a healthier population, with no-one left behind.

Moving from silo to system in our approach to population health outcome improvement will not just allow local health and care leaders to mind the health inequity gap but will engage and empower them to mend and reduce it.

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