WEB APPENDIX 1: SECONDARY PROPOSALS AND SUPPORTING EVIDENCE

Proposal 7: Improve the social and physical environment to make it easier for lower socioeconomic groups, and the population as a whole, to engage in physical activity

Supporting evidence: Regular physical activity can reduce the risk of CHD, obesity, depression and many other avoidable chronic diseases. Environmental factors are important in terms of promoting (or preventing) physical activity. Studies have found that the lowest socioeconomic group is most likely to be inactive regarding recreational walking. Those in lower socio-economic groups are more likely to suffer from a poorer built environment with higher rates of traffic accidents, higher rates of crime which discourages people from walking and cycling in their neighbourhoods, and less access to green space and other leisure facilities. For example, the English Department of Transport estimated that in 2007 there were 2500 “excess” pedestrian casualties in deprived areas. [24]

Proposal 8: Improve infant and maternal nutritional status

Supporting evidence: Women in lower socioeconomic groups are also more likely to have under- and over-weight babies (both of which are risk factors for later obesity) and are less likely to follow recommended breastfeeding and weaning practices (an additional risk factor for later obesity). Two systematic reviews found that breastfeeding support programmes can be effective for women in low income groups but that education alone had no effect. [51]

Proposal 9: Enhance the psycho-social wellbeing of lower socioeconomic groups.

Supporting evidence: Morris et al (2001) illustrated how gains in health and reduction in inequalities could be achieved through improved provision of basic and unmet needs relating to nutrition, physical activity, housing, psychosocial interactions, transport, and healthcare. Based on international comparisons of countries with developed economies, obesity prevalence is significantly correlated with higher levels on income inequality. [53]

Proposal 10: Extend use of contingency management within drug treatment programs.

Supporting evidence: The UK National Institute for Health and Clinical excellence (NICE) states that contingency management (giving incentives such as vouchers or cash to drug users to quit or reduce consumption) is the ‘only psychosocial intervention with clear evidence for effectiveness as an adjunct to detoxification’. There is strong evidence for its use. For instance, an evaluation of a US program which offered vouchers as incentives to cocaine users to abstain found significantly greater treatment retention and cocaine abstinence than usual care, with 68% of behavioural treatment patients achieving 8 weeks of continued abstinence during treatment compared with 11% of patients receiving standard care. [60]

Proposal 11: Widely extend 20mph maximum speed zones especially in residential and inner city/town areas.

Supporting evidence: In general, increased deprivation is associated with higher rates of injury or death from a road traffic accident. [61-63] There is good evidence that 20mph zones are effective in reducing traffic speeds and reducing injuries in the general population, and in children in particular. For example, a review of 20mph zones in London in 2003 found that the frequency of injury accidents in the zones had reduced by around 42%, and serious or fatal injuries by around 53% since their implementation. [66]

Proposal 12: Widely extend early-years interventions, in particular pre-school enrichment programmes and school-based social development programmes.
Supporting evidence: There is strong evidence from US-based studies that high quality pre-school enrichment programmes (early academic and social skills such as literacy and numeracy, socialisation, problem-solving and the development of self-esteem) targeted in deprived areas can have long-term positive impacts on participants, including reduced involvement in violence, better mental health and improved educational and work achievement.[67] Internationally, the evidence base for the effectiveness of school-based social development programmes (skills taught include anger management, behaviour modification, moral development, empathy, developing and maintaining healthy relationships, problem solving and conflict resolution) is robust with well-implemented programmes having been found to improve social skills and reduce aggression in young people [67].

Proposal 13: Improve prevention and treatment of childhood mental health problems across the whole social gradient, with a particular focus on disadvantaged groups.

Supporting evidence: Childhood mental health problems are strongly socially patterned, being several times more common amongst low income groups, and amongst other marginalized groups such as children in care and young offenders. [68-70] They also have profound consequences for a variety of outcomes in adult life. [71] NICE guidelines outline a number of effective treatment interventions. [70-72] However, only a quarter of those with a clinically diagnosable disorder have seen any mental health professional in the last year. [69-71] Given the social patterning of mental ill health in childhood, simply increasing the availability of evidence-based treatments should have an impact on health inequalities. There is also strong evidence that mental health problems can be prevented through the use of targeted interventions. [75] The cost-effectiveness of these interventions is high, with many more than paying for themselves in terms of reduced costs to society as a result of avoided health and social problems later in life. [76-77]

Proposal 14: Decrease the association between mental ill-health and unemployment through the use of both targeted support and broader health promotion approaches.

Supporting evidence: Research indicates a strong, bidirectional relationship between mental ill health and unemployment. [78] The most recent data indicates that 42% of people in the UK claiming Incapacity Benefits do so because of mental ill health. The most effective approach for supporting people with severe mental health problems into employment is provided by the Individual Placement and Support model. [79] Workplaces can also implement cost-effective health promotion approaches - responding better to mental distress among their staff and thereby preventing the downward spiral of mental ill health, job loss and long-term poverty and exclusion that plays such a key role in generating and maintaining health inequalities. [80]

Proposal 15: Implement a Minimum Income for Healthy Living (MIHL) in Older People

Supporting evidence: Based on the inextricable link between income and health, Morris et al (2001) illustrate how gains in health and reduction in inequalities can be achieved through provision of basic and unmet needs relating to nutrition, physical activity, housing, psychosocial interactions, transport, medical care and hygiene.[52] Recent analyses show that there is a deficit between the current state pension (supplemented with pension credit guarantee and winter fuel allowance) and the calculated MIHL. [81] The MIHL model would provide a template for conceptualising the relationship between income and health needs, thus helping to facilitate a shift in thinking towards upstream strategies to tackle pervasive patterns of inequity.
REFERENCES


62  Morrison D, Petticrew M, Thomson H. What are the most effective ways of improving population health through transport interventions? Evidence from systematic reviews. J Epidemiol Community Health 2003;57:327–33.


72 NICE. Attention Deficit Hyperactivity Disorder. Diagnosis and management of ADHD in children, young people and adults. NICE Clinical Guideline 72, 2008.


