Health inequalities profile (2025)

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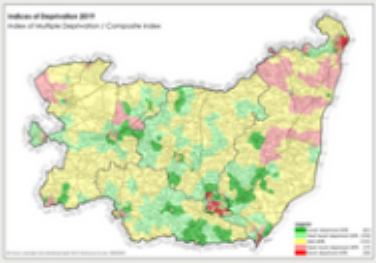
Population and deprivation



According to the 2023 mid-year population estimates, there were 776,442 people living in Suffolk

Approximately **80,000 people in Suffolk** live in areas ranked among the **20% most deprived** in England

The most deprived areas are concentrated in **Ipswich, Lowestoft and Haverhill**

Life expectancy gap

Male life expectancy at birth in Suffolk by decile, 2021-23

Average life expectancy in the most deprived areas of Suffolk was **8.2 years shorter for men**, and **7.4 years shorter for women** than in the least deprived areas of the county in 2021-23

Employment and income

Suffolk has a statistically similar percentage of people in employment (75.8%) compared to England (75.7%). **Given Suffolk's ageing population and lower average wage levels, individuals may have to remain in employment longer and retire later.**

Average weekly earnings in Suffolk were £538.20 in 2023, £27.50 lower than the England average. In-work poverty is growing, especially in sectors such as retail, care, and hospitality

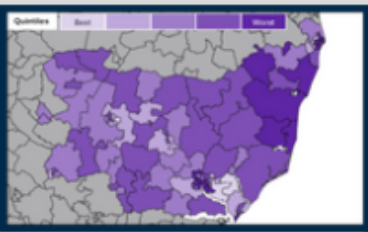
Education and skills

Boys (60.6%) were less likely than girls (74.9%) in Suffolk to reach **expected standards in reading, writing, and maths**, at the end of Reception (4-5 years of age) in 2023/24. The gap between boys and girls in Suffolk was similar (14.3 percentage points) to the gap across England

This gap widened for children eligible for free school meals: half of these children (49.4%) were achieving a good level of development at the end of Reception in 2023/24. Of the children eligible for free school meals, 40.7% of boys, and 57.7% of girls in Suffolk achieved a good level of development

Housing and living conditions

Modelled estimates of the proportion of households in fuel poverty (%) Suffolk Middle Super Output Areas, 2020



To be classed as fuel poor, a household must be living in a home rated band D or below for energy efficiency, **and** when they spend the amount required to heat their home, they are left with a residual income below the poverty line

Almost **40,000 households in Suffolk in 2022 (11.5% of all households) were classified as fuel-poor**

Fuel poverty is most prevalent in **coastal and rural areas** within the county

Access to services

Almost 1 in 10 **(8.7%/72,142 people registered to Suffolk GPs) cannot reach their closest GP practice** within a reasonable 30-minute travel time **via public transport on a weekday morning in March 2025**

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Summary

Health inequalities are avoidable and unjust differences in health outcomes between groups of people. These differences can be influenced by a range of social, economic, and environmental factors—such as income, education, housing, and access to services—as well as by experiences of discrimination or exclusion.

Health inequalities often reflect deeper structural issues that affect some communities more than others, contributing to poorer health and shorter lives for those who are most disadvantaged. Understanding and addressing these inequalities is essential to improving population health and improving equity across Suffolk.

Health inequalities can exert a cumulative impact across the life course, beginning even before birth and continuing into later life. Socioeconomic disadvantage in early childhood is linked to poorer educational outcomes, which can limit employment opportunities and lead to lower-paid, less secure work. These factors can also increase exposure to health risks and reduce access to protective factors (such as access to quality healthcare, or safe and stable housing), contributing to poorer physical and mental health in midlife. Over time, these disadvantages compound, leading to a greater burden of ill health in later life and shorter average life expectancy.

This profile provides an overview of health variation and health inequality in Suffolk. It is intended as a summary, not a full health needs assessment. While it highlights key patterns and risk factors, it does not capture the full complexity of every issue. Some of the variation presented reflects demographic differences (e.g. age, geography), while other aspects represent health inequalities—unfair and avoidable differences in health outcomes. The overlap between these concepts reflects the real-world connections between risk, context, and inequality.

What are health inequalities?

Health inequalities are avoidable and unjust differences in health outcomes between groups of people.

Inequalities across society impact health outcomes. This profile focuses specifically on health inequalities, while acknowledging the role of wider societal factors.

The King's Fund notes that health inequalities are ultimately about differences in the status of people's health. However, the term is also often used to refer to differences in the care that people receive; the experiences people have while receiving care; and the wider opportunities that they have to lead healthy lives – all of which can contribute to their health status.

Health inequalities can involve differences in:

- health status, for example, life expectancy
- access to care, for example, the provision of given services such as vaccinations or cancer screening; or people's ability to attend healthcare settings
- quality and experience of care, for example, levels of patient satisfaction
- behavioural risks to health, for example, smoking rates
- wider determinants of health, for example, quality of housing

Health outcomes—and the factors that shape them—can vary between different groups of people.

In England, health inequalities are commonly explored and tackled through policy using four key types of factors:

- socio-economic groups, for example, income
- geographies, for example, region or whether urban or rural
- specific characteristics including those protected in law, such as sex, ethnicity or disability
- socially excluded groups, for example, people experiencing homelessness

Multiple impacts: A note on intersectionality

People can experience different combinations of these factors (known as intersectionality), which has implications for the health inequalities that they are may experience. Intersectionality is a way of understanding how these overlapping factors can interact to amplify disadvantage and lead to poorer health outcomes.

This also means that people identified by a single characteristic—such as disability or ethnic background—do not form a uniform group. There will be variation in health profiles, and in the health inequalities and risk factors that may be present within any given population group[1].

Sex and gender identity and inequalities

Both sex and gender identity influence health inequalities in different ways—while sex relates to physiological differences that affect disease risk and treatment responses, gender shapes exposure to risk factors, access to services, and how individuals experience health and care.

This means both sex and gender identity influence health outcomes. As an example, a global health gap analysis reports that women live longer than men, but experience more years in poor health, underlining an urgent need for action to boost women's health[2], and continuing to

promote research to reduce the burden of disease and achieve greater health equity between males and females.

It is important to recognise that both sex and gender identity intersect with other factors, such as age, ethnicity, disability, and socioeconomic status, in shaping people's health and lived experiences. These influences are complex, dynamic, and not always captured well in available data. This profile provides only a high-level overview and does not explore the full depth of how sex and gender identity impact health outcomes across populations.

Risk factors and inequalities

This profile looks at health inequalities in Suffolk but also looks at some of the contributing risk factors.

Risk factors are conditions or behaviours that increase the likelihood of experiencing poor health outcomes e.g. smoking or eating a poor diet (either not getting enough nutrients or getting more nutrients than needed[3]). These risk factors are often present at an individual level but can also be influenced by broader societal factors (e.g., access to healthcare or socioeconomic status).

Risk factors can contribute to health inequalities. For example, people from lower socioeconomic backgrounds may be more likely to smoke or have poor diets due to a number of factors (such as limited access to healthy food, health information, or services). Higher smoking rates in lower socioeconomic groups are both a health inequality and a symptom of deeper structural disadvantage, reflecting the complexity of unequal conditions that shape health behaviours and outcomes. All these risk factors can then lead to poorer health outcomes, reinforcing existing inequalities.

In summary, risk factors are the conditions or behaviours that raise the risk of poor health, while health inequalities are the unfair differences in outcomes between groups—often driven by unequal exposure to those risks.

How can we measure health inequalities?

Health inequalities can be measured in several ways. One key approach is to look at how health outcomes vary between different population groups—for example, by age, income, ethnicity, or geography.

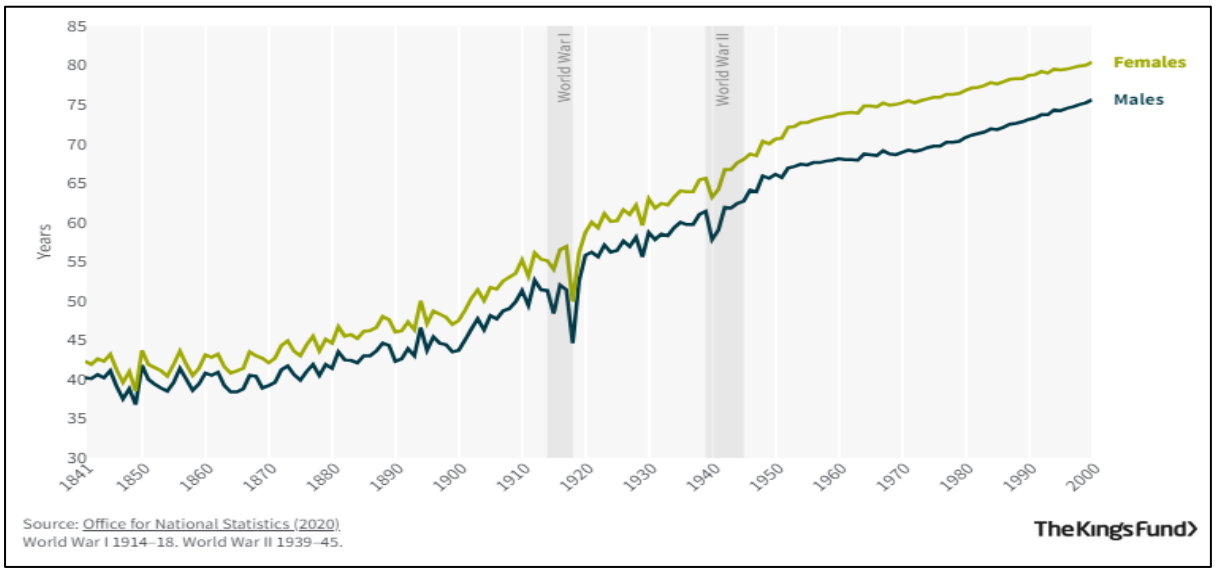
Health inequalities can also be measured through examining differences in healthcare access, social determinants of health, health behaviours, and quality of care across various population groups. This also includes factors such as income, education, and treatment experiences, providing an understanding of the ways health disparities manifest in different communities.

Life expectancy

Life expectancy is a key measure of a population's health status. Inequality in life expectancy is therefore one of the foremost measures of health inequality. Life expectancy is highly influenced by socioeconomic status.

Overall mortality in England and Wales has declined since the 19th century, leading to a long-term rise in life expectancy. Declines in mortality were in part due to reductions in infant and childhood mortality rates, as well as improvements in nutrition, hygiene, housing, sanitation, control of infectious diseases and other public health measures.

Figure 1. Life expectancy at birth, England and Wales, 1841-2000



Source: The Kings Fund (2024)

More recently, England's life expectancy trends have experienced two significant changes - a slowdown in life expectancy gains from 2011 after decades of steady improvement, followed by a more significant turning point in 2020 when the Covid-19 pandemic triggered a sharp decline in life expectancy unseen since World War II. Life expectancy in England has not yet recovered to pre-pandemic levels. In England in 2023, life expectancy for males at birth is 79.3 years, and 83.2 years for females.

Future improvements in life expectancy for England look unpromising due to the deteriorating health of the population[4]. Key challenges that need to be addressed include poor childhood health[5], a significant and increasing number of people waiting for healthcare (which became even worse during the pandemic), almost 3 million and rising working-age adults unable to work because of long-term sickness, ongoing limitations in NHS capacity, and widening inequalities in health between different groups. Overcoming these significant obstacles is crucial for enhancing life expectancy going forward[4].

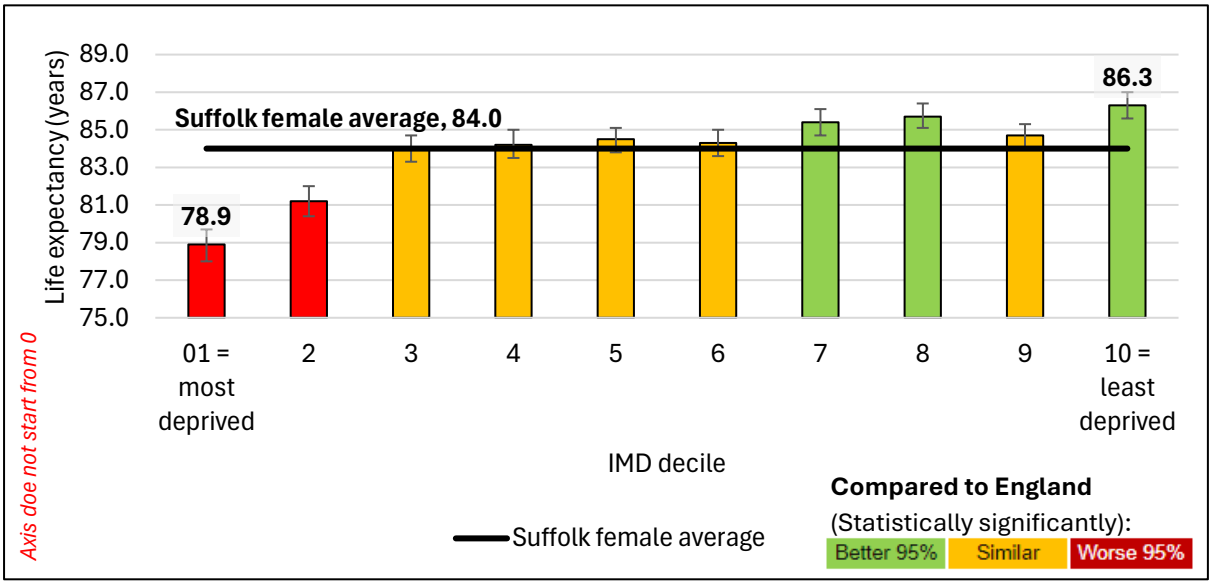
> 2021-2023 Life expectancy in Suffolk was 80.5 years for males and 84.0 years for females. Both these values are statistically significantly higher compared to England (79.1 years for males and 83.1 years for females).

Both nationally and in Suffolk, people living in more deprived areas may live significantly shorter lives than those in more affluent areas. The concept of deprivation is widely used to describe areas or populations facing multiple social and economic disadvantages, with the Index of Multiple Deprivation (IMD) typically employed as a standardised tool to quantify these challenges and their potential impact on health outcomes.

- Nationally, one-third of the inequalities in life expectancy between the most and least deprived decile of areas are caused by higher mortality rates from heart and respiratory disease, especially lung cancer, in the most deprived areas[6].
- The sex difference in life expectancy is greater in more deprived areas: females live an average of 4.3 years longer than males in the most deprived decile of local authorities, compared with 3.3 years longer in the least deprived decile6.
- Life expectancy in Suffolk shows stark inequalities, with those living in the most deprived areas of the county having a significantly lower average life expectancy of 7.4 fewer years for females and 8.2 fewer years for males compared to those in the least deprived areas during 2021-2023.

Overall average life expectancy for females in Suffolk between 2021-23 was 84.0 years. However, in the most deprived areas, the life expectancy was only 78.9 years, while it was 86.3 years in the least deprived areas. This means there is a 7.4 year life expectancy gap between the least deprived areas and the most deprived areas for females in the county.

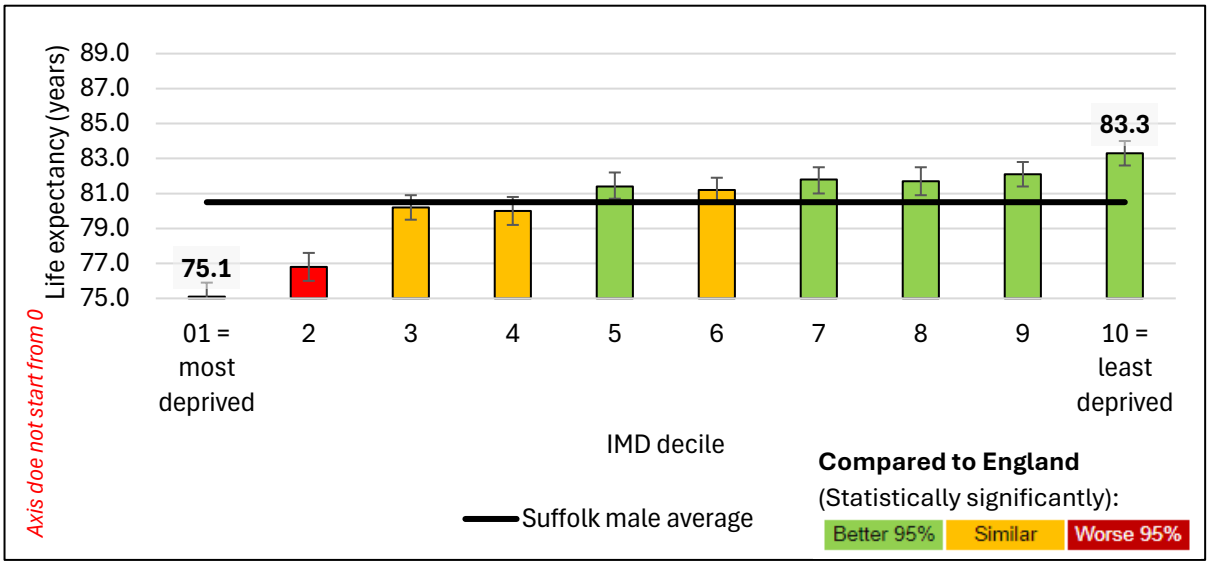
Figure 2. Suffolk female life expectancy by IMD decile, 2021-23



Source: Office for Health Improvement and Disparities (2025)

Similarly for men in Suffolk, the overall average life expectancy between 2021-23 was 80.5 years. In the most deprived areas of the county, average life expectancy was only 75.1 years, with men in the least deprived areas of the county living to an average of 83.3 years. This results in an 8.2 year average life expectancy gap for males in Suffolk between the most and least deprived areas of the county.

Figure 3. Suffolk male life expectancy by IMD decile, 2021-23



Source: Office for Health Improvement and Disparities (2025)

Healthy life expectancy

It is also important to look at healthy life expectancy—not just how long people live, but how long they live in 'good' health. The difference between healthy life expectancy and overall life expectancy can highlight the years people may spend living with illness or disability. This often disproportionately affects those in more deprived communities.

Despite having relatively high overall life expectancy, people in Suffolk spend a significant portion of their later years with disabilities or in poor health. This is likely to have been exacerbated in recent years by the Covid-19 pandemic's impact on delayed care and long-term sickness.

In England between 2021-23:

- While male life expectancy at birth was 79.3 years, healthy life expectancy was 61.5 years, meaning 17.8 of those years (22.4%) are spent in poor health.
- For females across England, life expectancy at birth was 83.2 years, however healthy female life expectancy across the country was 61.9 years, meaning 21.3 of those years (25.6%) are spent in poor health on average.

Healthy life expectancy at birth across England has statistically significantly decreased for males from 63.0 years in 2011-13 to 61.5 years in 2021-23. This national trend in healthy life expectancy at birth is also seen for females across England, with female healthy life expectancy statistically significantly decreasing from 63.9 years in 2011-13, to 61.9 years in 2021-23.

In Suffolk between 2021-23:

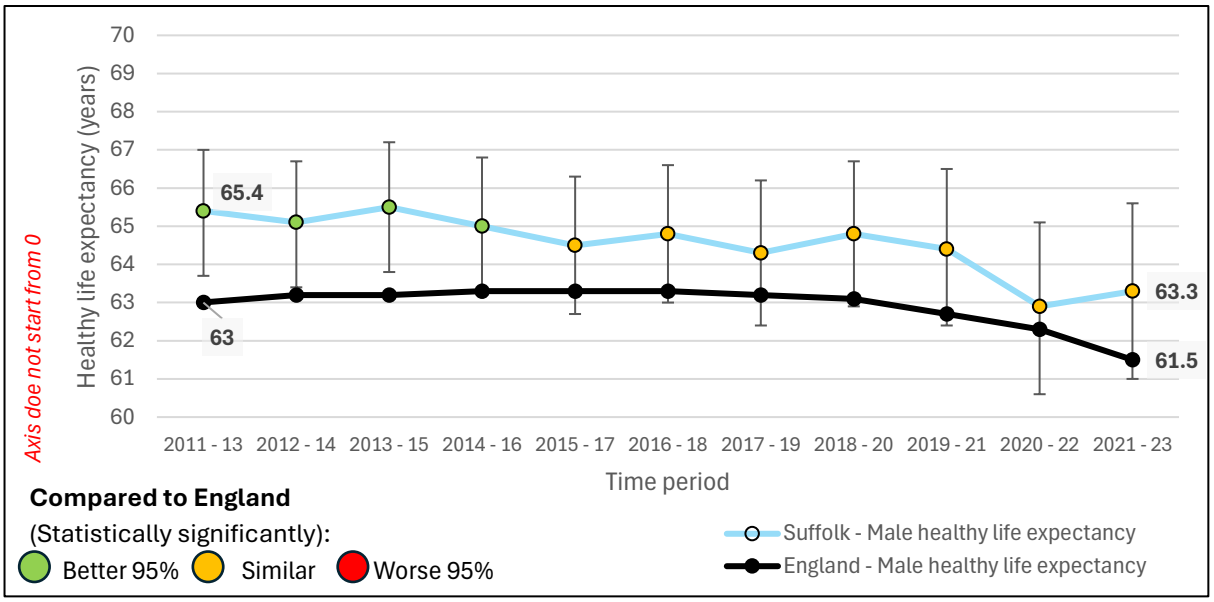
- Male life expectancy at birth in 2021-23 was 80.5 years, with healthy life expectancy 63.3 years. This means for Suffolk males, 17.2 years are spent in poor health (21.4%).
- For Suffolk females, life expectancy at birth in 2021-23 was 84.0 years, with healthy life expectancy 63.6 years, resulting in 20.4 years (24.3%) spent in poor health. Females live on average 3.5 years longer than males; they also spend a larger proportion and more years of their lives in poor health[8].

Healthy life expectancy at birth in Suffolk has remained statistically similar over time for men with male healthy life expectancy in 2011-13 at 65.4 years, statistically similar to 63.3 years in 2021-23. Female healthy life expectancy at birth has remained statistically similar from 66.2 years in 2011-13 to 63.6 years in 2021-23.

Healthy life expectancy at birth for males and females in Suffolk has stalled. This means that for both males and females there has been no improvement in how long they spend in poor health. It is also likely that the Covid-19 pandemic contributed to the fall in healthy life expectancy, with delays for non-Covid care and increases in long-term sickness following the pandemic.

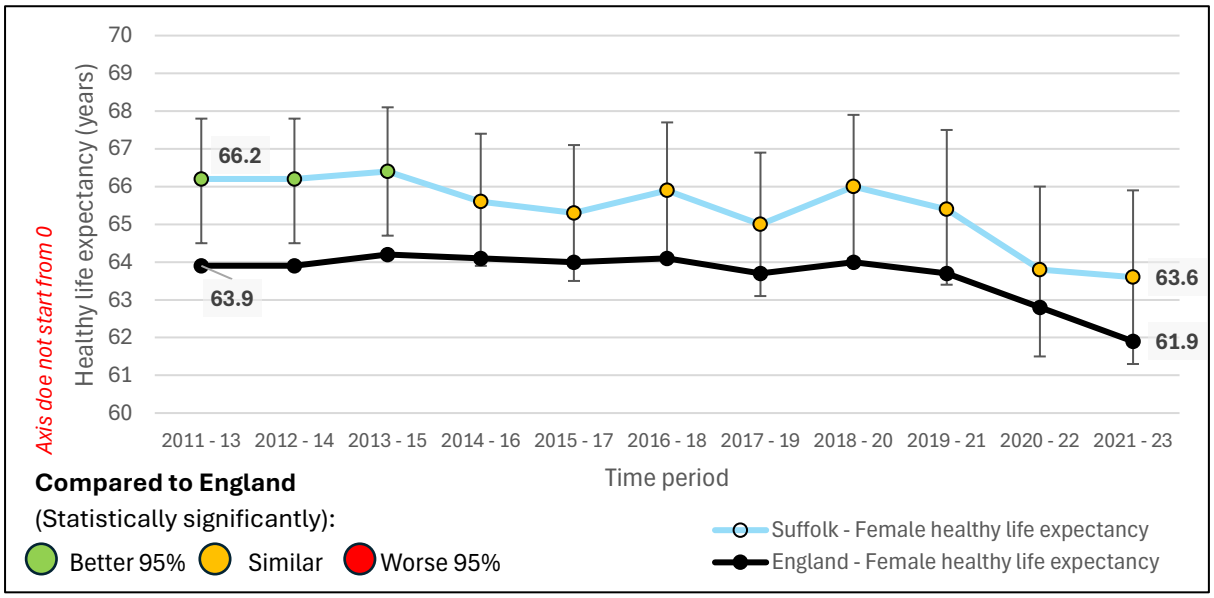
It is important to note in the below figure, confidence intervals show the range where a true value likely falls. Overlapping confidence intervals suggest the values may not be statistically different from each other, i.e. any differences which can be seen may be due to chance. While the Suffolk values for healthy life expectancy at birth for males and females have decreased between 2011-13 to 2021-23, as the confidence intervals overlap, the reduction is not statistically significant.

Figure 4. Healthy life expectancy at birth (Male), Suffolk and England, 2011-13 to 2021-23



Source: Office for Health Improvement and Disparities (2025)

Figure 5. Healthy life expectancy at birth (Female), Suffolk and England, 2011-13 to 2021-23



Source: Office for Health Improvement and Disparities (2025)

What are the causes of differences in life expectancy between the most and least deprived areas?

The Segment Tool (produced by the Office for Health Improvement and Disparities - OHID) is a public health analysis tool that helps users explore inequalities in life expectancy within local areas in England. It breaks down life expectancy gaps between the most and least deprived areas of each local authority, showing which causes of death contribute most to those differences.

The tool provides standardised inequalities metrics for key health indicators at national, regional, and local authority levels, enabling health professionals and policymakers to identify priority areas, track progress in reducing health disparities, and develop targeted interventions based on evidence of socioeconomic, demographic, and geographic variations in health outcomes.

Data from the Segment tool for 2020-2021 shows how different causes of death contribute to the overall difference in life expectancy between the most and least deprived communities in Suffolk. Please note, the Segment Tool data covers a different period (2020-21) compared to the earlier life expectancy estimates (2018-20 for life expectancy, 2021-23 for healthy life expectancy). This means that the exact size of the life expectancy gap differs slightly due to time period and methodological differences.

Different causes of death contribute to the overall difference in average life expectancy between the most and least deprived communities in Suffolk. The gap was 7.0 years for males and 5.4 years for females in 2020/21.

> In Suffolk the largest contributor to the life expectancy gap between the most and least deprived areas is circulatory disease for males, accounting for 23.7% of the gap. For females, the largest contributor is cancer, which accounts for 22.1% of the life expectancy gap. For the reporting period, Covid-19 contributed to the life expectancy gap for both males (8.5%) and females (11.5%).

Using the Suffolk trend data (2014-16, 2017-19 and 2020-21) from the segment tool:

For males:

- Deaths from circulatory conditions were the leading contributor to the life expectancy gap across all time periods, followed by cancer.
- The contribution from external causes of death (including deaths from injury, poisoning and suicide) increased from 8.2% in 2014-16 to 16.7% in 2020-21. This substantial increase may reflect widening inequalities in how these deaths are distributed across deprivation groups rather than an increase in absolute numbers. The pandemic period likely exacerbated existing vulnerabilities among disadvantaged groups through

increased isolation, economic stress, disrupted support services, delayed care-seeking behaviours and limitations on care provision.

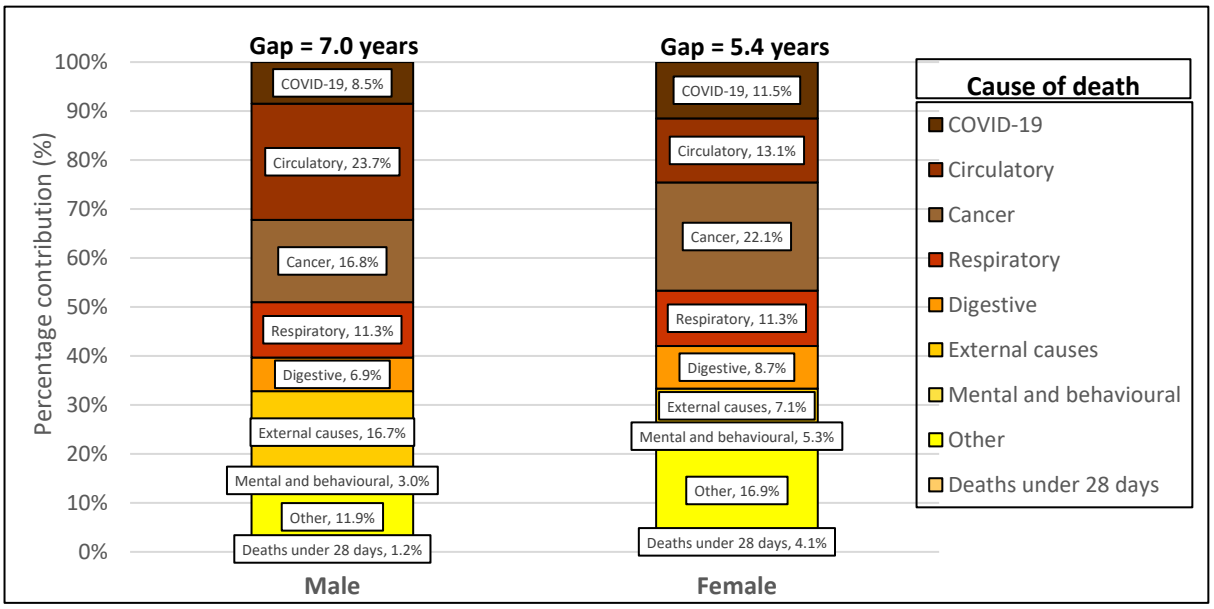
- The contribution to the life expectancy gap from respiratory diseases remained high, around 11-12% in all periods
- The contribution to the life expectancy gap from Covid-19 deaths was 8.5% in 2020-21[9]

For females:

- The leading contributors to the life expectancy gap were circulatory conditions, cancer, and respiratory diseases across all time periods
- The contribution from Covid-19 deaths was 11.5% in 2020-21.
- Contributions from mental and behavioural disorders (including dementia) and digestive diseases (includes alcohol-related conditions such as chronic liver disease and cirrhosis) remained relatively stable over time.

Targeting the causes of death and age groups that contribute most to the life expectancy gap could play a significant role in addressing health inequalities and improving health outcomes.

Figure 6. Breakdown of the life expectancy gap between the most and least deprived quintiles of Suffolk by cause of death, 2020 to 2021



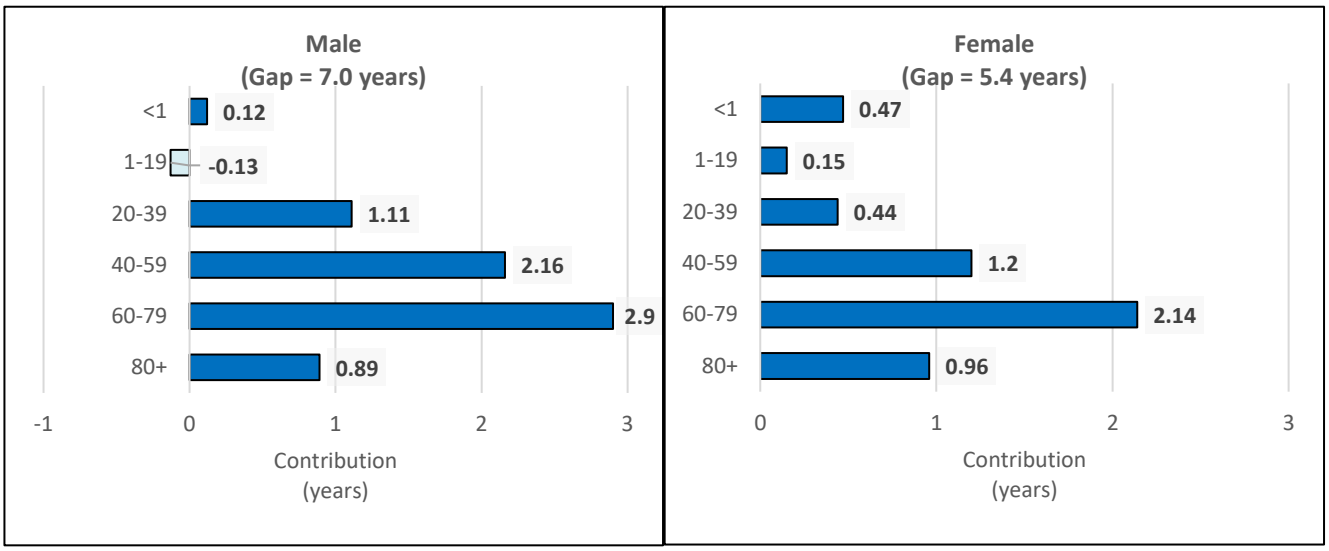
Source: Office for Health Improvement and Disparities (2023)

The OHID Segment tool also provides a breakdown of the life expectancy gap in Suffolk between the most and least deprived areas by age group. Only one age group for males (age 1-19 years) has higher mortality in the least deprived areas compared to the most deprived areas. For all other age groups for males and females, each age group has higher mortality in the most deprived areas, contributing to the overall life expectancy gap.

The largest contributing age group for both males and females in Suffolk is for 60-79 year olds, where deaths are occurring in those in mid-life and entering retirement. There are opportunities for prevention of poor health for individuals aged between 40-80 years of age, which could

reduce health inequalities within Suffolk, for example through uptake of NHS Health Checks and screening programmes.

Figure 7. Breakdown of the life expectancy gap between the most and least deprived quintiles of Suffolk by age group, 2020 to 2021



Source: Office for Health Improvement and Disparities (2023)

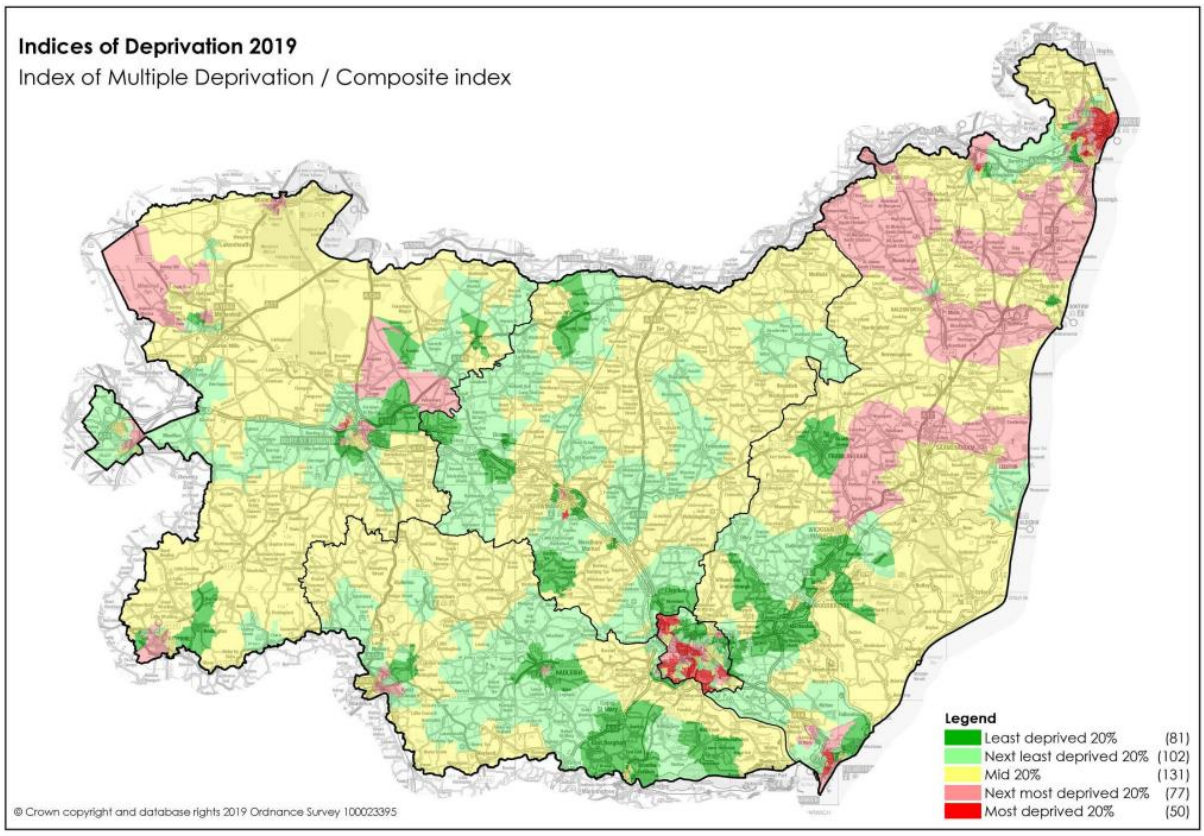
Where are Suffolk's most deprived areas?

The previous section explored how life expectancy varies between the most and least deprived areas of Suffolk. But where are these areas located? To understand this, the following section uses data from the 2019 Index of Multiple Deprivation (IMD) to explore how levels of deprivation vary across the county.

The Index of Multiple Deprivation (IMD) is the official measure of relative deprivation in England. It combines data across seven key domains—income, employment, education, health, crime, housing, and the living environment—to rank every neighbourhood (or Lower Layer Super Output Area - LSOA) in the country. Areas are then grouped into national deprivation deciles, from the most deprived 10% to the least deprived 10%. This data can also be viewed in quintiles (20% splits rather than 10%). The IMD provides a broad picture of disadvantage and is widely used in public health to identify communities at greater risk of poorer health and wellbeing outcomes.

Suffolk's most deprived communities are largely concentrated in urban coastal areas, particularly in parts of Ipswich and Lowestoft. These neighbourhoods often face challenges such as lower incomes, higher unemployment, poorer housing conditions, and lower educational attainment—all of which contribute to poorer health outcomes. In contrast, rural and more affluent parts of the county, such as areas in Mid Suffolk, tend to experience lower levels of deprivation. Approximately 80,000 people, or 10% of Suffolk's residents, live in the 20% most deprived areas in England.

Figure 8. Map of Suffolk Lower Super Output Areas (LSOAs) and their corresponding national Indices of Multiple Deprivation quintile, 2019



Source: Ministry of Housing, Communities & Local Government (2019)

Inequalities through the life course

Health is shaped by a complex mix of social, economic, and environmental factors that interact across a person's life. The life course approach recognises that health inequalities are not random—they begin before birth, build through childhood and adolescence, and continue to influence wellbeing into adulthood and later life.

Early disadvantage can set the foundations for poorer health outcomes later on, while opportunities to protect and promote health may vary depending on a person's circumstances at each stage of life. The following sections explore key health inequalities both nationally, and in Suffolk across the life course, from childhood to older age.

Child health

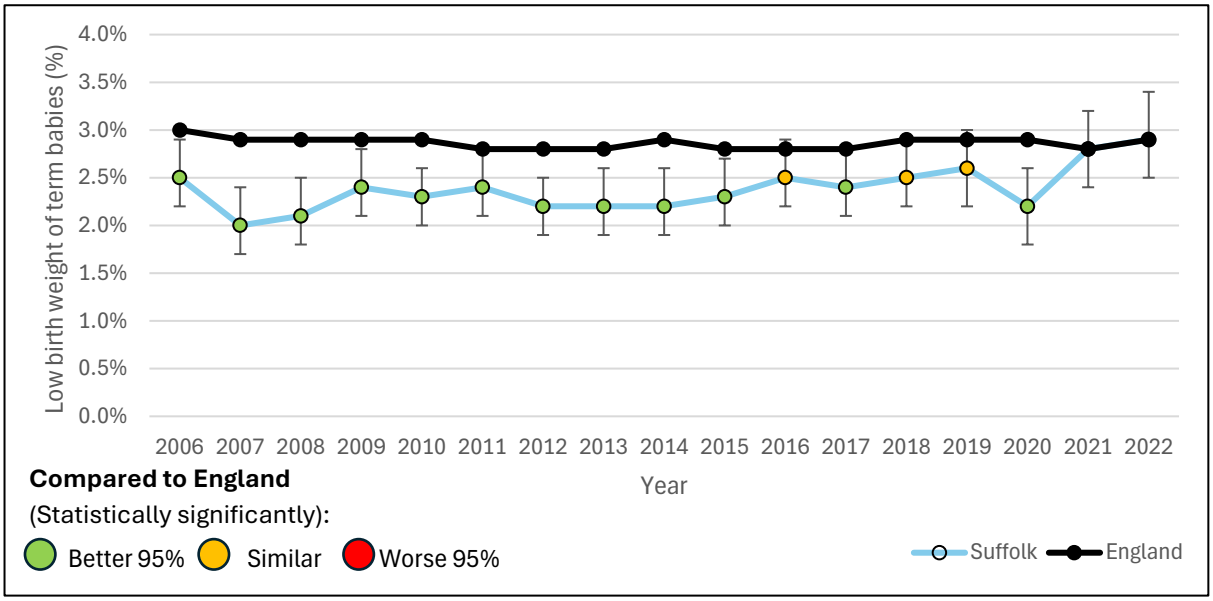
Health inequalities affecting children can occur pre-birth and can have lifelong effects, influencing a child's health, development, and future opportunities.

Low birth weight

One example of an indicator of the presence of health inequalities in early in life is low birth weight. On average across England, babies born in more deprived areas are more likely to be born at a lower weight.

The percentage of low-birth-weight term babies in Suffolk has remained statistically similar between 2006 (2.5%) and 2021 (2.9%). Prior to 2016, Suffolk had a statistically significantly lower proportion of low-birth-weight term babies compared to the England average for each year between 2006 to 2015. Since 2016, the trend in the percentage of low birth weight of term babies in Suffolk has been more varied, and in 5 of the last 7 years' worth of data Suffolk was statistically similar to the England average. This could be an indicator of worsening maternal and infant health in Suffolk, considering that Suffolk was statistically significantly better than the England average between 2006-15.

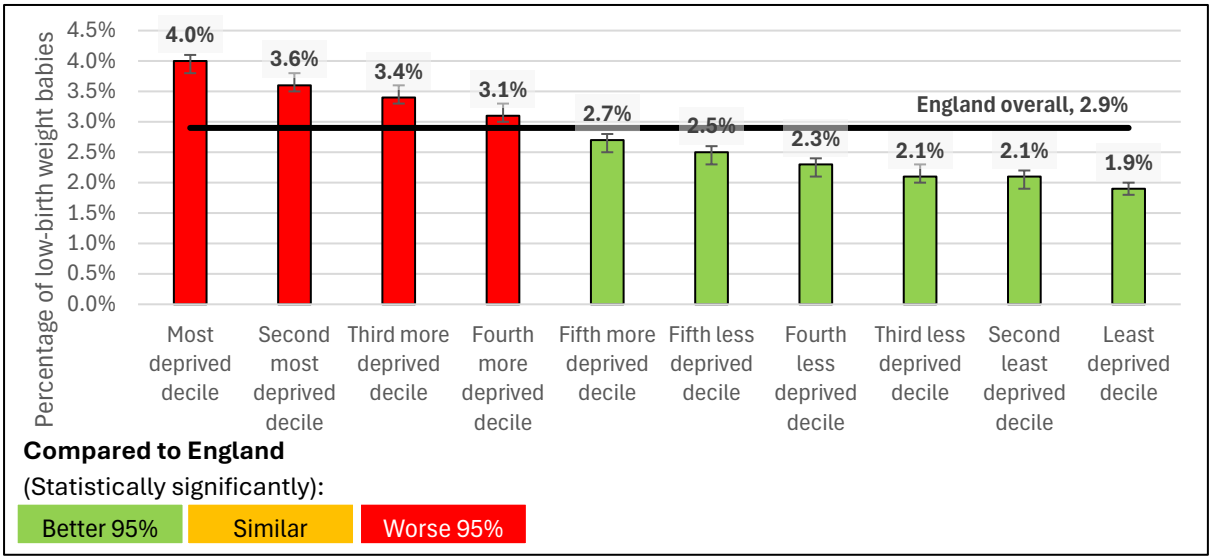
Figure 9. Low birth weight of term babies, Suffolk and England, 2006-21



Source: Office for Health Improvement and Disparities (2024)

Using data for England, babies born in the most deprived decile in 2022 (4.0%) were statistically significantly more likely to be born with a low birth weight when compared to the least deprived decile (1.9%).

Figure 10. Low birth weight of term babies by Index of Multiple Deprivation (IMD) decile, England, 2022

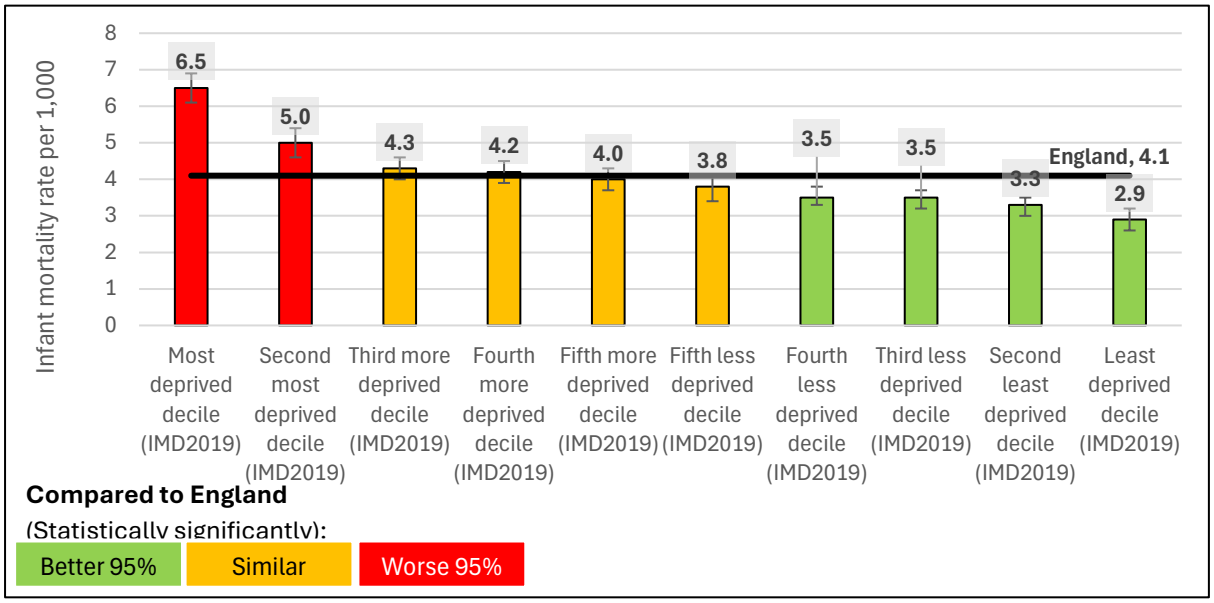


Source: Office for Health Improvement and Disparities (2024)

Infant mortality

Infant mortality rates (deaths occurring during the first 28 days of life) are a key indicator of health inequalities. National data shows that the infant mortality rate in the most deprived areas of England was 2.2 times higher than the least deprived areas in the most recent years' worth of data (2021-23).

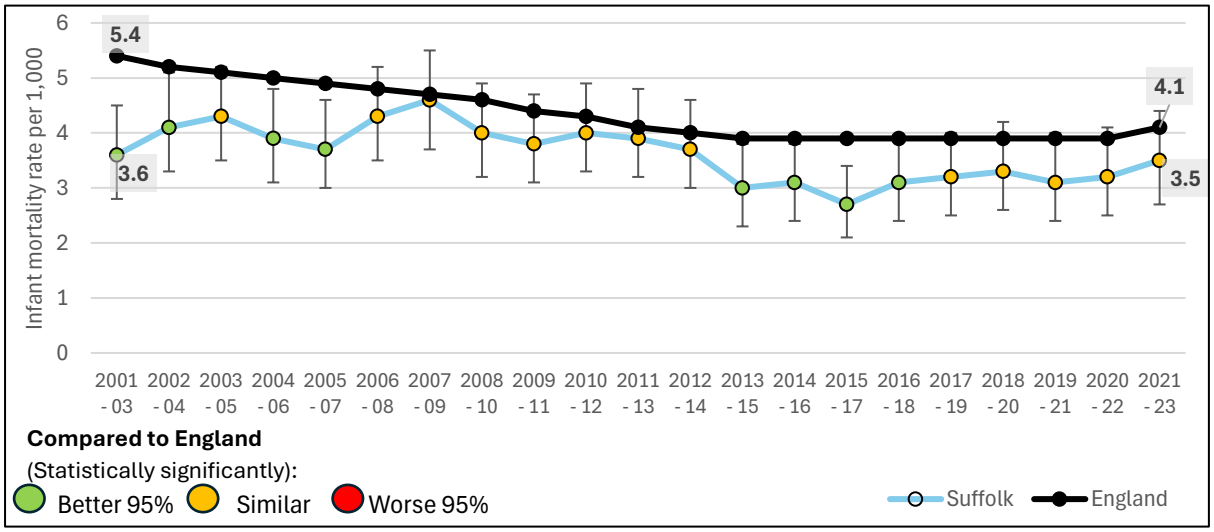
Figure 11. Infant mortality rate per 1,000 by Indices of Multiple Deprivation (IMD) decile, England, 2021-23



Source: Office for Health Improvement and Disparities (2025)

The rate of infant mortality in Suffolk has not statistically significantly changed since 2001-03 and remained at 3.5 deaths per 1,000 live births in 2021-23. It is notable that infant mortality rates in Suffolk have not improved as they have nationally – for comparison, the lowest infant mortality rate in England was 1.7 per 100,000 in Kensington and Chelsea in 2021-23.

Figure 12. Infant mortality rate per 1,000 for Suffolk and England, 2001-03 to 2021-23



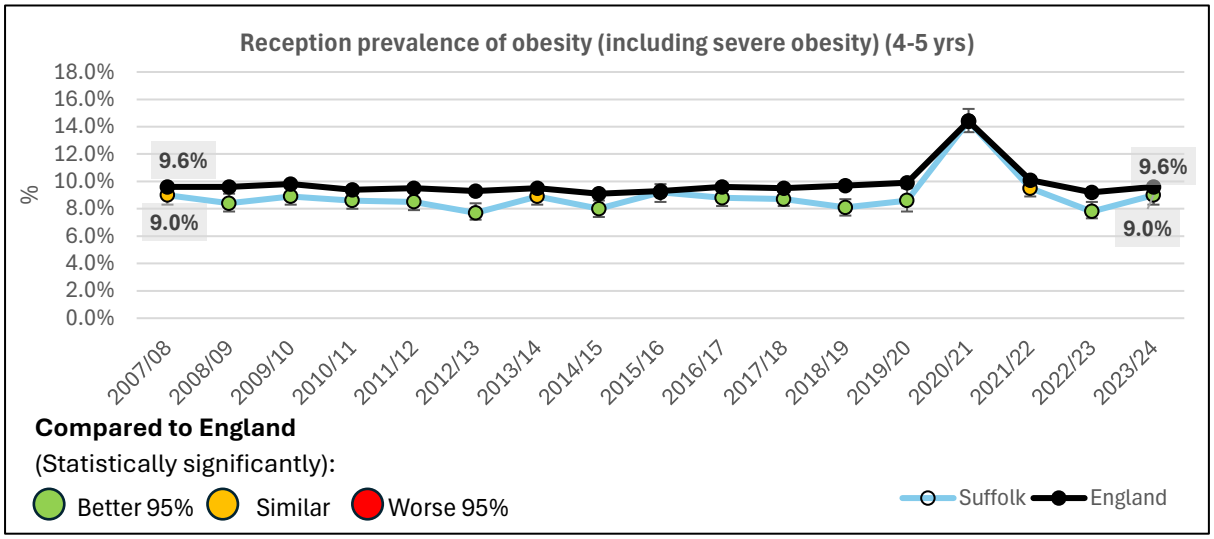
Source: Office for Health Improvement and Disparities (2025)

Obesity

The prevalence of children living with obesity is higher among children living in deprived areas and in certain ethnic minority groups. Childhood obesity in 10-11 year olds has statistically significantly increased over the last 15 years, both in Suffolk and England.

In Suffolk, when comparing 2007/08 (9.0%) and 2023/24 (9.0%) data on obesity (including severe obesity) for 4-5 year olds, there has not been a statistically significant change.

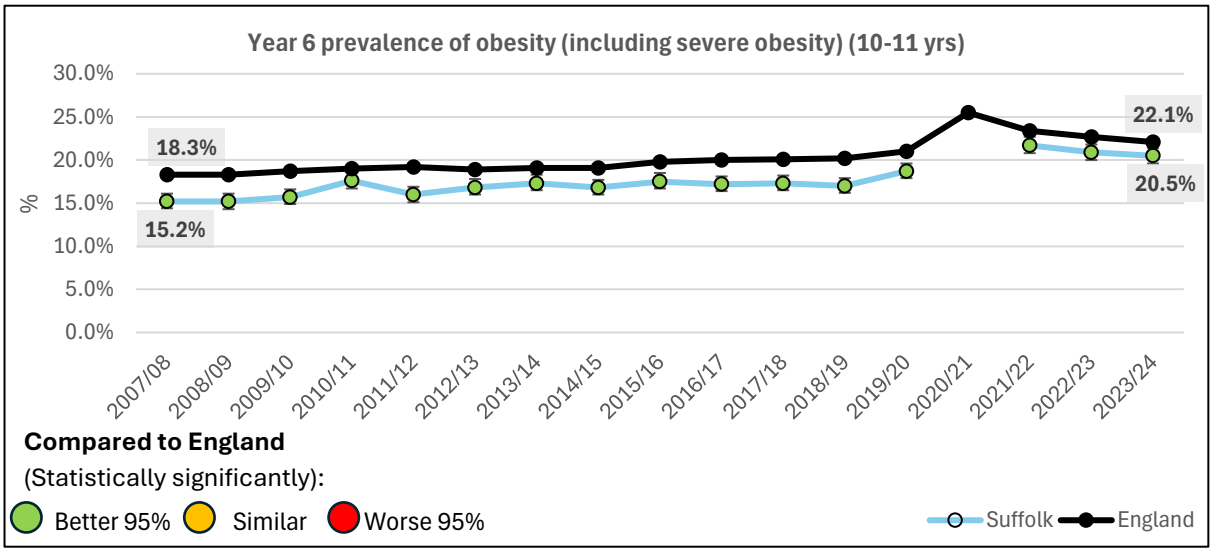
Figure 13. Reception prevalence of obesity (including severe obesity) (4-5 yrs), Suffolk and England, 2007/08 to 2023/24



Source: Office for Health Improvement and Disparities (2024)

For 10-11 year olds, prevalence of obesity (including severe obesity) in Suffolk has statistically significantly increased since 2007/08 (15.2%) to 2023/24 (20.5%).

Figure 14. Year 6 prevalence of obesity (including severe obesity) (10-11 yrs), Suffolk and England, 2007/08 to 2023/24



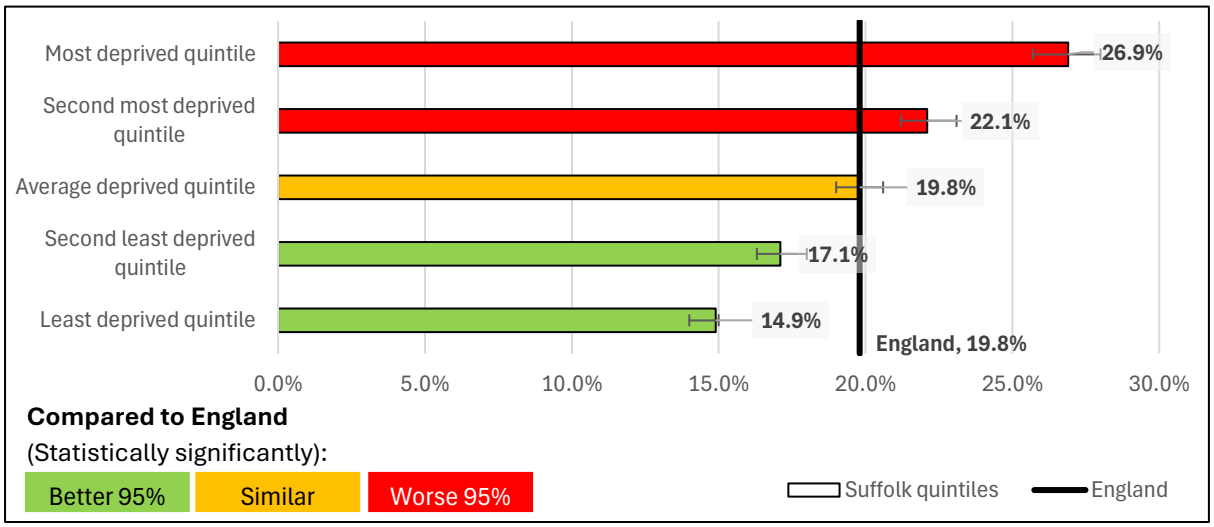
Source: Office for Health Improvement and Disparities (2024)

The prevalence of obesity appeared to peak for both 4-5 year olds and 10-11 year olds during the Covid-19 pandemic, but fell in 2021/22, but remained statistically significantly higher for 10-

11 year olds compared to before the pandemic. However, both nationally and locally, due to disruptions during the pandemic, the 2019/20 NCMP (National Child Measurement Programme – which measures the height and weight of children in Reception (aged 4 to 5) and year 6 (aged 10 to 11)) collection was limited to 75% of usual measurements and the 2020/21 collection relied on a weighted 10% sample. This potentially affected data reliability, particularly for 10-11 year olds where sample sizes were smaller than usual, and so these indicators must be treated with caution.

The prevalence of 10-11 year old children living with obesity in the most deprived quintile of Suffolk was almost twice as high compared to those living in the least deprived areas of Suffolk between 2019/20 to 2023/24.

Figure 15. Year 6 prevalence of obesity (including severe obesity) (10-11 yrs), 5 years data combined (2019/20 to 2023/24), Suffolk, by Indices of Multiple Deprivation (IMD) Quintile



Source: Office for Health Improvement and Disparities (2024)

10-11 year old boys (22.0%) were more likely to be obese (including severely obese) compared to girls (17.5%) across Suffolk between 2019/20 to 2023/24.

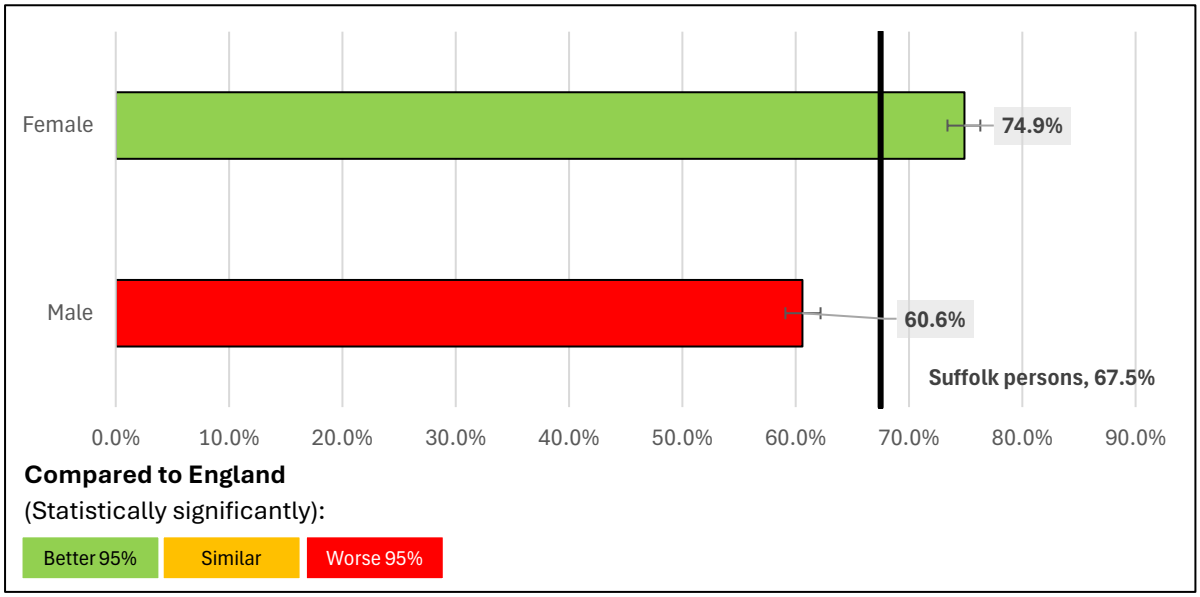
National data highlights that inequalities in obesity exist between ethnic groups: between 2019/20 to 2023/24, the highest levels of obesity in Suffolk for 10-11 year olds were in the Bangladeshi (35.5%); White and Black African (27.9%); Black African (25.5%); Any other ethnic group (24.6%); and Any other mixed background (24.4%) groups. The lowest prevalence was in the Chinese ethnic group (15.4%).

School readiness

There are significant inequality gaps in school readiness for 4-5 year olds in Suffolk and England, with boys, children eligible for free school meals, those from certain ethnic backgrounds, and those whose first language is not English, being less likely to achieve a good level of development at the end of reception year compared to their counterparts.

Fewer boys (60.6%) in Suffolk achieved a good level of development at age 4-5 years old (reception) compared to girls (74.9%) in 2023/24. This means many Suffolk boys begin primary education at a disadvantage compared to girls. Overall, 67.5% of Suffolk 4-5 year olds are achieving a good level of development at the end of reception in 2023/24 – statistically similar to England as a whole.

Figure 16. School readiness: percentage of children achieving a good level of development at the end of Reception (4-5 yrs), Suffolk males and females, 2023/24

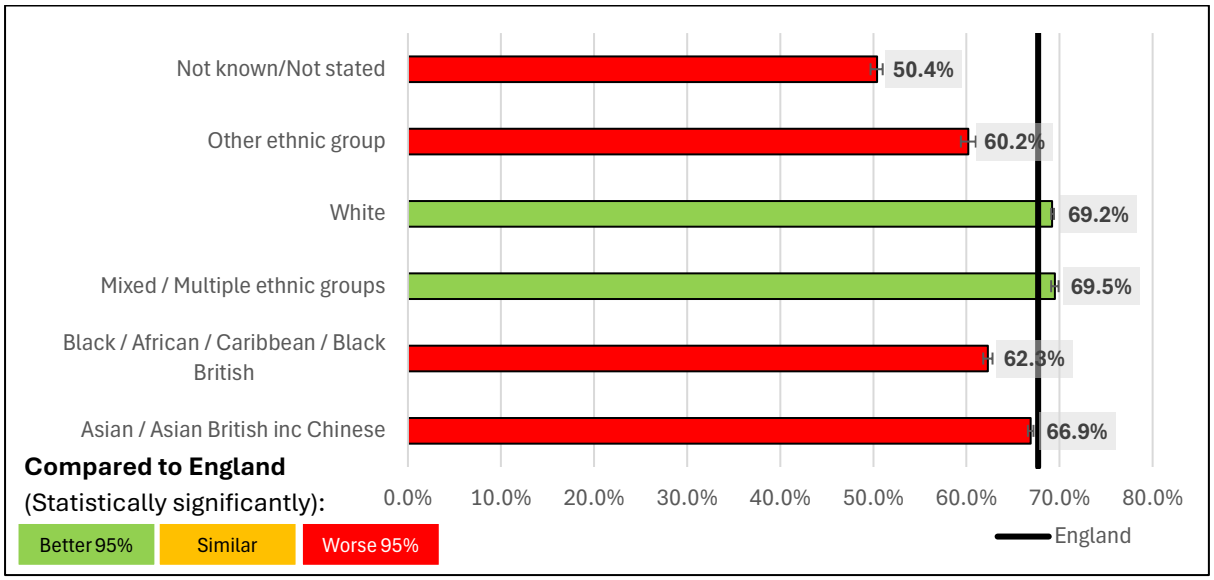


Source: Office for Health Improvement and Disparities (2024)

The gap widens amongst children who are eligible for free school meals. Half (52.2%) of children eligible for free school meals are achieving a good level of development at the end of reception in 2023/24. Of those Suffolk children eligible for free school meals, only 4 in 10 (40.7%) of boys are achieving a good level of development, compared to just under 6 in 10 (57.7%) of girls.

There are also inequalities in development outcomes for 4-5 year olds based on ethnicity. While data is not available for Suffolk, across England, children who were White or from Mixed/Multiple ethnic groups were more likely to reach a good level of development in 2023/24.

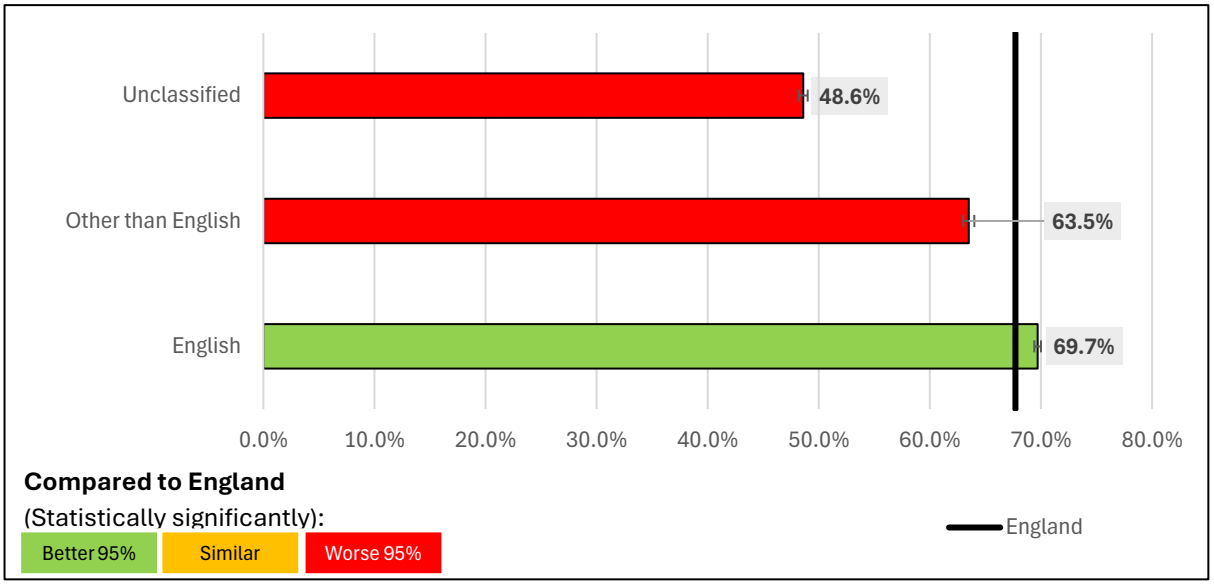
Figure 17. School readiness: percentage of children achieving a good level of development at the end of Reception (4-5 yrs) by ethnic group, England, 2023/24



Source: Office for Health Improvement and Disparities (2024)

For England in 2023/24, 4-5 year olds with a first language of English were much more likely to achieve a good level of development at the end of reception (69.7%). Children with a first language other than English (63.5%) or Unclassified (48.6%) were statistically significantly less likely to achieve a good level of development.

Figure 18. School readiness: percentage of children achieving a good level of development at the end of Reception (4-5 yrs) by first language status, England, 2023/24



Source: Office for Health Improvement and Disparities (2024)

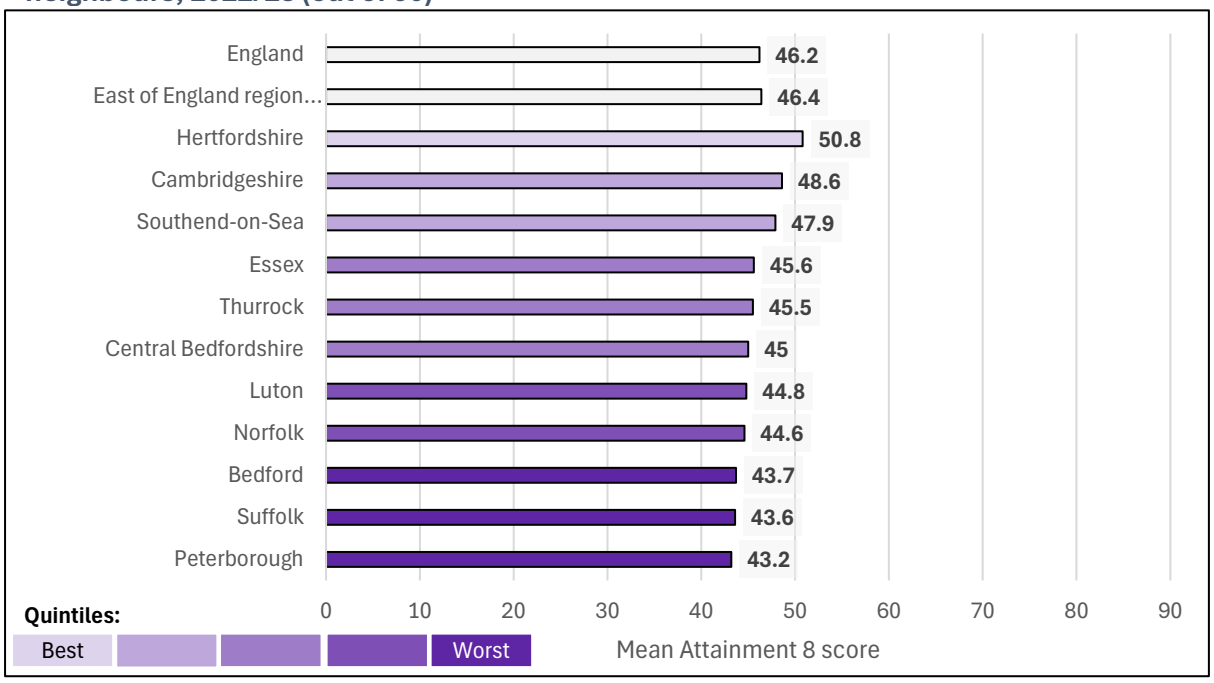
Educational attainment: Attainment 8

Educational achievement is fundamental to children's current and future wellbeing, influencing mental health, social development and life opportunities. There is a strong relationship between educational attainment and health inequalities - children with poorer mental health are more likely to have lower educational outcomes, while educational qualifications are significant predictors of adult wellbeing and access to employment, income and housing.

Educational outcomes are influenced by both the quality of education and family socio-economic circumstances, meaning educational inequalities often reflect broader social disadvantage. Attainment 8 scores measure educational achievement at age 16 across eight key subjects, providing insight into how well the education system serves all children, particularly those from disadvantaged backgrounds or in care.

In Suffolk in 2023/23, the average Attainment 8 score was 43.6, statistically significantly lower than the England average (46.2), and the East of England regional average (46.4). Within the region, Suffolk ranked among the lower performing areas, with only Peterborough (43.2) and Bedford (43.7) achieving lower scores in 2022/23. This places Suffolk's educational attainment outcomes significantly below higher performing areas in the region such as Hertfordshire (50.8) and Cambridgeshire (48.6).

Figure 19. Average Attainment 8 score for Suffolk and East of England regional neighbours, 2022/23 (out of 90)



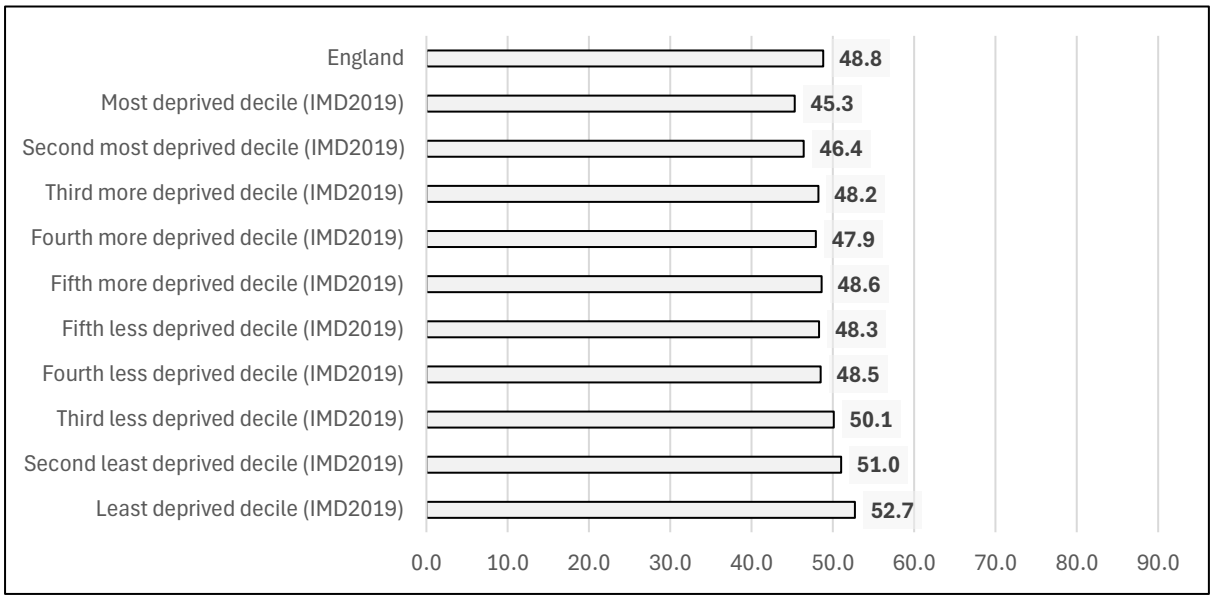
Source: Office for Health Improvement and Disparities (2024)

Educational inequalities by deprivation

Educational attainment across England shows a clear relationship with deprivation, with notable differences in Attainment 8 scores between the most and least deprived areas. In 2022/23, pupils in the most deprived decile achieved an average score of 45.3, compared to 52.7 for those in the least deprived decile - a gap of 7.4 points. The pattern shows a generally progressive increase in attainment across deprivation deciles, with the most significant improvements occurring in the least deprived areas. This demonstrates how socio-economic

disadvantage leads to educational disadvantage, with implications for future life chances among the consequences of health and social inequalities.

Figure 20. Average Attainment 8 score by IMD decile (2019), England, 2022/23 (out of 90)



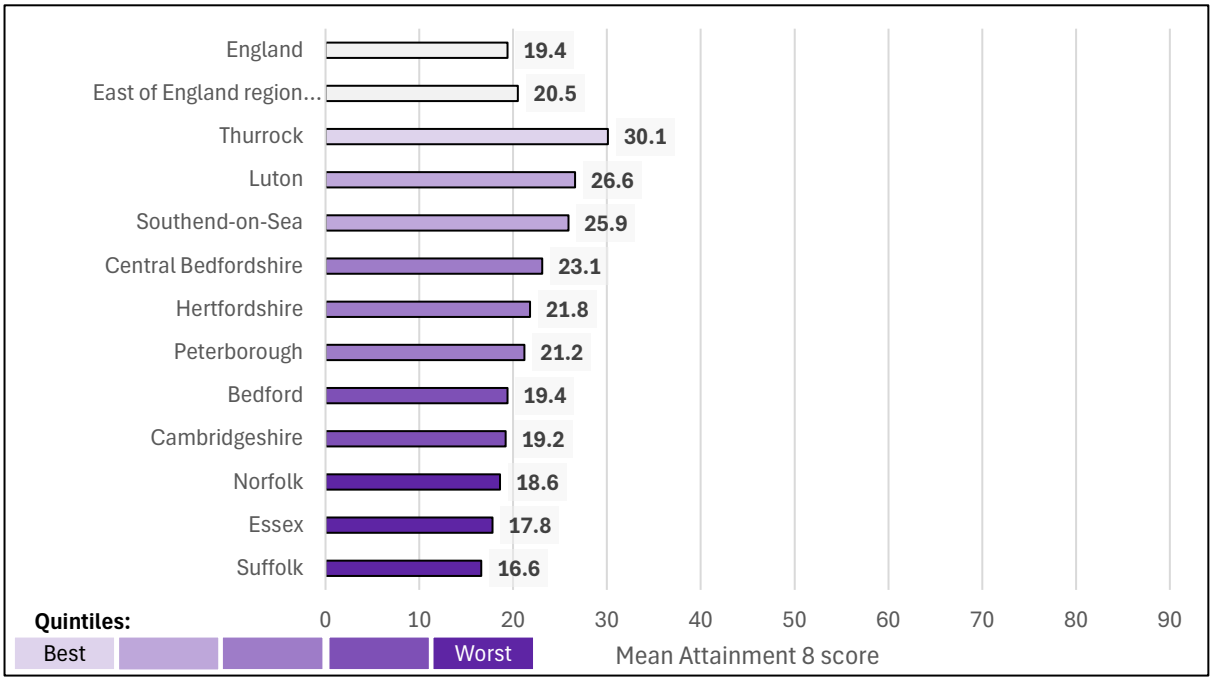
Source: Office for Health Improvement and Disparities (2024)

Educational outcomes for children in care

Children in care face particular educational challenges, often experiencing disrupted schooling and challenging personal circumstances that can impact their learning. The educational attainment of children in care provides an indication of how well support systems locally are working for some of the most vulnerable children and young people.

In Suffolk, children in care achieved an average Attainment 8 score of 16.6 in 2022/23, lower than both the England average for children in care (19.4) and the East of England regional average for children in care (20.5). This places Suffolk as the lo west performing area in the East of England for looked-after children's educational outcomes. The gap between general population attainment (43.6) and children in care attainment (16.6) in Suffolk – a difference of 27 points – highlights the additional educational challenges faced by this vulnerable group and the need for targeted support to improve outcomes.

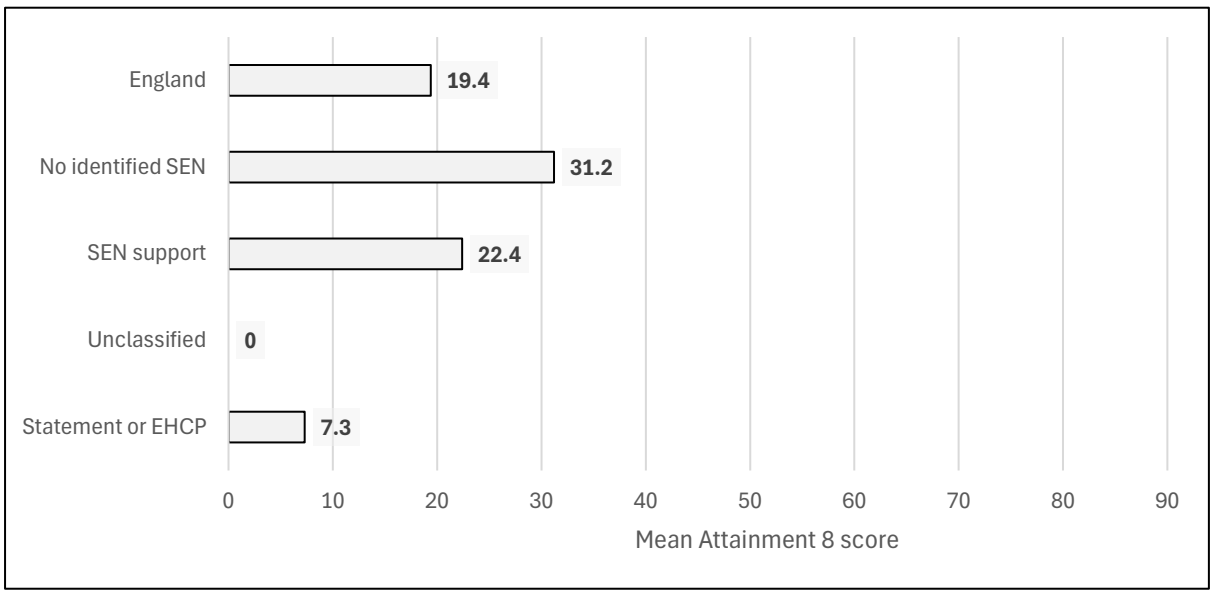
Figure 21. Average Attainment 8 score of children in care for Suffolk and East of England regional neighbours, 2022/23 (out of 90)



Source: Office for Health Improvement and Disparities (2024)

National data demonstrates further inequalities in educational outcomes for children in care who also have special educational needs and/or disabilities (SEND). Children in care with Education, Health and Care Plans (EHCPs) have the greatest need and lower attainment scores on average (7.3) than those who receive SEN support (22.4) or have no identified SEN (31.2).

Figure 22. Average Attainment 8 score of children in care by special educational needs status (SEN), 2022/23 (out of 90)



Source: Office for Health Improvement and Disparities (2024)

Wider determinants of health

The wider determinants of health are the social, economic and environmental conditions in which people live that have an impact on health. They include income, education, access to green space and healthy food, the work people do, and the homes they live in.

Children in relative low-income families (under 16s)

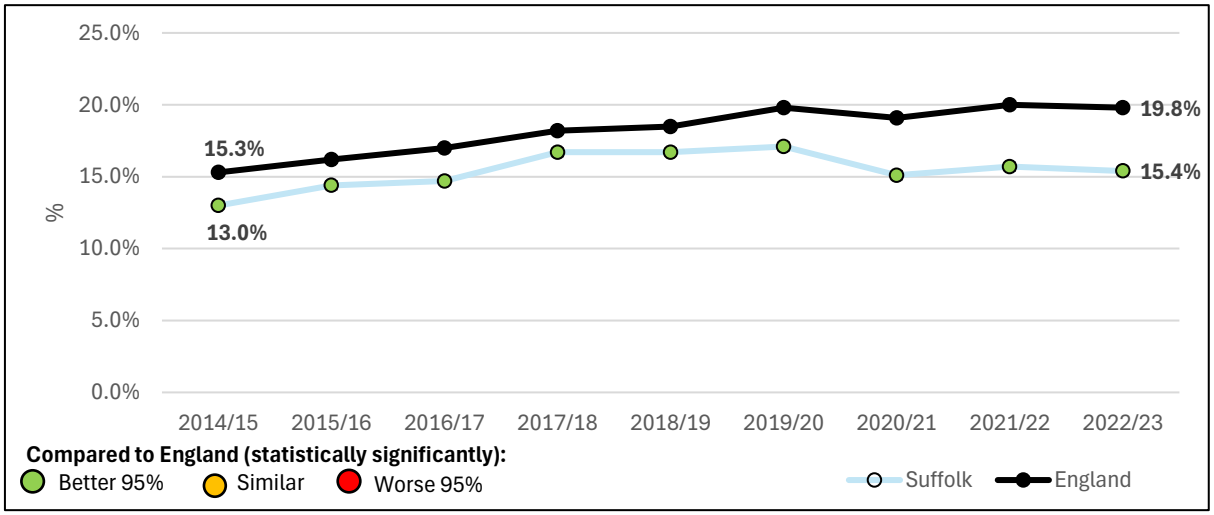
Child poverty is a critical determinant of health outcomes, with evidence from the Marmot Review demonstrating that childhood poverty leads to premature mortality and poor health outcomes in adulthood. Children living in poverty are more likely to be exposed to multiple risk factors that can have a serious impact their mental health[10], including educational disadvantages, social factors, and environmental stressors, making this a key measure for understanding health inequalities.

Since 2010, child poverty rates have increased across England, with over four million children now affected. This trend is particularly concerning given that many children in poverty live in families where parents are in work, highlighting the inadequacy of wages to meet basic needs. The highest poverty rates remain among children in workless families, affecting over 70% of this group.

This indicator measures the percentage of children under 16 living in families with relative low income, defined as households with income below 60% of the UK median before housing costs.

The data reveals trends in child poverty rates across Suffolk from 2014/15 to 2022/23 – during this period, approximately 17,000 to 23,000 children in Suffolk lived in relative low-income families each year. Suffolk has consistently had a statistically significantly lower proportion of children living in poverty compared to the England average throughout this period. Most notably, the percentage of children in relative low-income families increased in Suffolk from 13.0% in 2014/15 to a peak of 17.1% in 2019/20 – England's rate increased from 15.3% to 19.8% over the same period. Since, Suffolk's rate has declined to 15.4% in 2022/23, affecting approximately 20,200 children – still statistically significantly higher than the 2014/15 figure. Despite Suffolk's better performance compared to the England average, the indicator reveals that child poverty remains a substantial challenge, with more than 1 in 7 children in the county living in relative low-income families.

Figure 23. Children in relative low income families (under 16s), Suffolk and England, 2014/15 to 2022/23

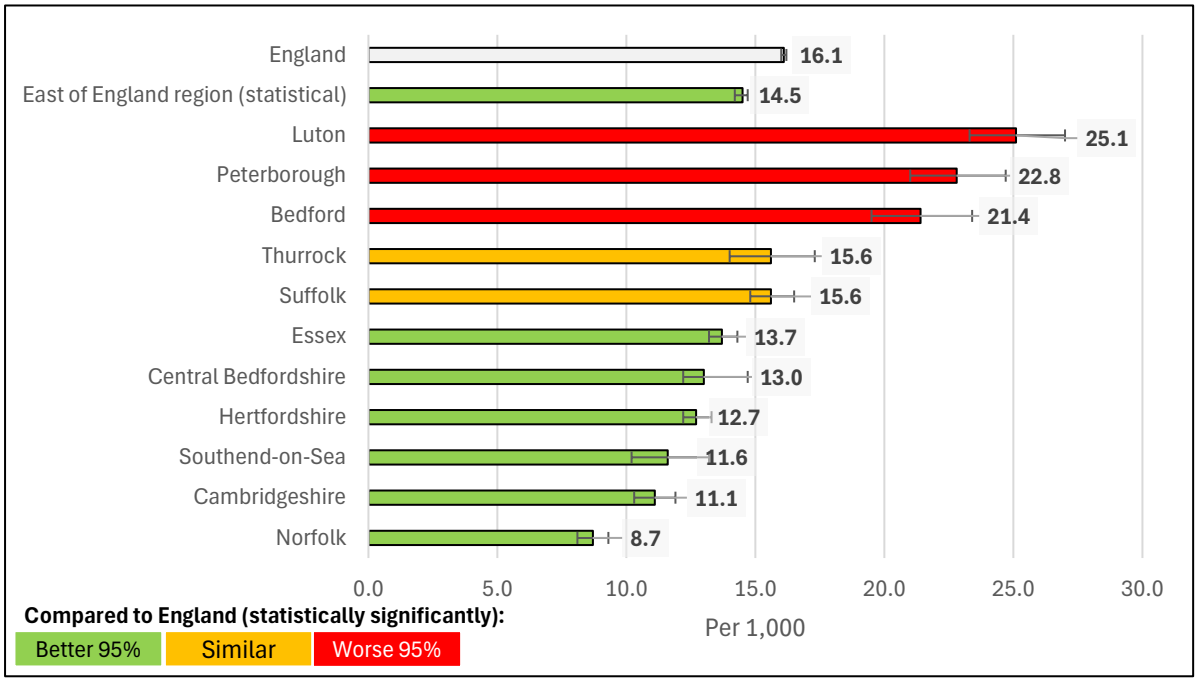


Source: Office for Health Improvement and Disparities (2024)

Homelessness is associated with severe poverty and often results from relationship breakdown, debt, childhood adversity, and ill health. For children, homelessness is particularly damaging, leading to poor health, education, and social outcomes than can have lasting impacts throughout their lives. The below indicator measures the number of households with dependent children who are owed either prevention or relief duties.

In 2022/23 there were 1,302 families in Suffolk with dependent children who were owed either a prevention or relief duty, a rate of 15.6 per 1,000 households with children. The rate for Suffolk was statistically similar to England's rate of households with dependent children owed a duty under the homelessness reduction act in 2022/23 (16.1 per 1,000), but almost double the rate

Figure 24. Homelessness – households with dependent children owed a duty under the Homelessness Reduction Act per 1,000, Suffolk and East of England Region, compared to England, 2022/23



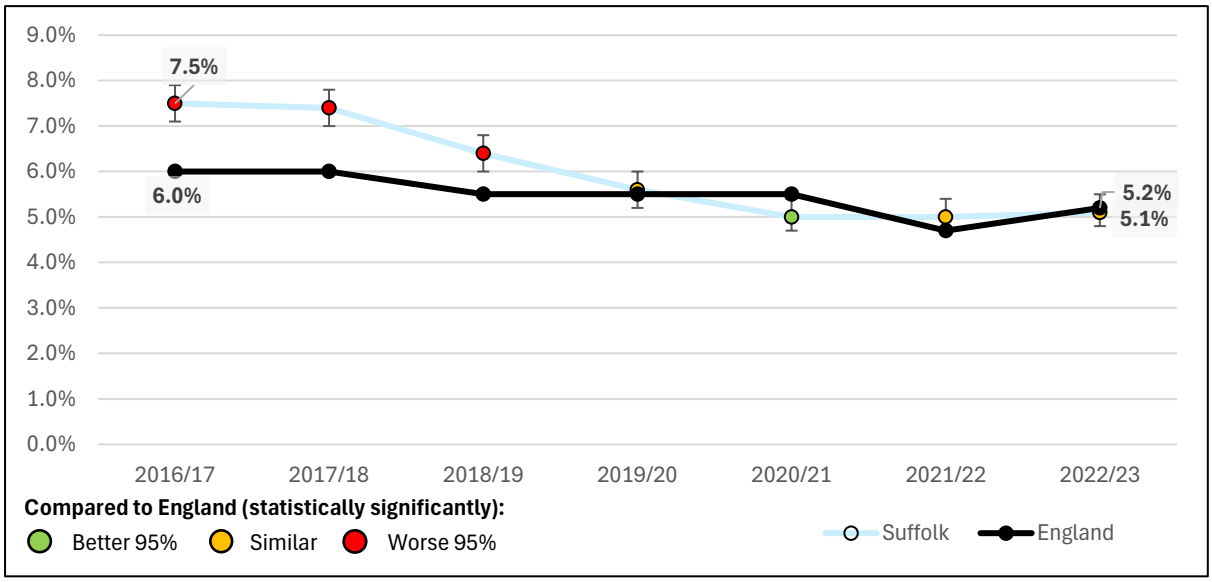
Source: Office for Health Improvement and Disparities (2024)

in Norfolk, a statistically similar Authority to Suffolk

Not in Education, Employment or Training (NEET)

Young people who are not in education, employment or training (NEET) are at greater risk of a range of negative outcomes, including poor health, depression or early parenthood. In Suffolk in 2022/23, 5.1% of 16-17 year olds (805 people) were not in education, employment or training. Suffolk previously had a statistically significantly higher proportion of NEET 16-17 year olds compared to the England average, however the percentage of NEET 16-17 year olds in Suffolk remained statistically similar to England between 2019/20 and 2022/23. The percentage of males classified as NEET in Suffolk in 2022/23 (5.5%) was statistically similar to the percentage of females classified as NEET (4.7%).

Figure 25. 16 to 17 year olds not in education, employment or training (NEET) or whose activity is not known, England and Suffolk, 2016/17 to 2022/23



Source: Office for Health Improvement and Disparities (2023)

Adult health

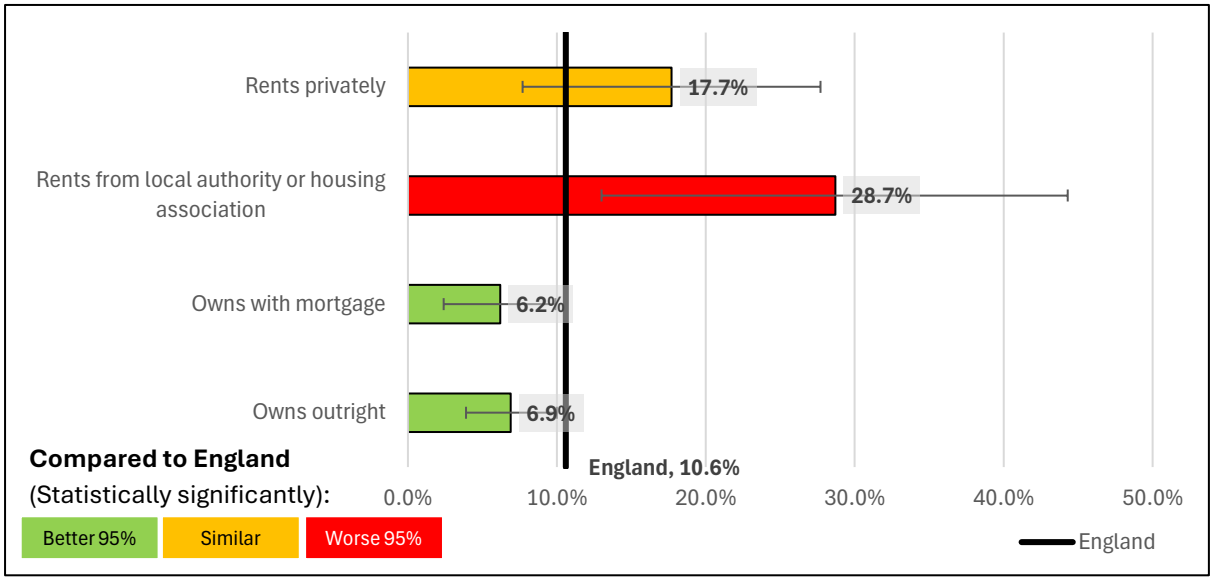
People's health behaviours are an important factor in determining health outcomes. They are often influenced by a range of social, economic, and environmental factors. Smoking, poor diet, physical inactivity and harmful alcohol consumption are leading risk factors that drive preventable ill health and premature mortality in England. Behavioural risks to health are more common in some cohorts of the population compared to others. The distribution is patterned by measures of deprivation, income, sex and ethnicity, and health risks are often concentrated in the most disadvantaged groups.

Smoking

Smoking prevalence for Suffolk adults has statistically significant decreased from 20.4% in 2011 to 10.6% in 2023. However, inequalities in smoking status clearly exist between certain groups. For instance, the smoking prevalence for adults working in routine or manual occupations was almost twice as high as the overall prevalence, at 20.8% in 2023.

In addition, the smoking prevalence for those who rent their properties from local authorities or housing associations in Suffolk was 28.7% in 2023. This prevalence meant those renting their properties through local authorities or housing associations were more than 4 times more likely to smoke than those who own their property either outright, or with a mortgage.

Figure 26. Smoking prevalence in adults (18+) - current smokers (APS) by housing tenure (Suffolk), 2023



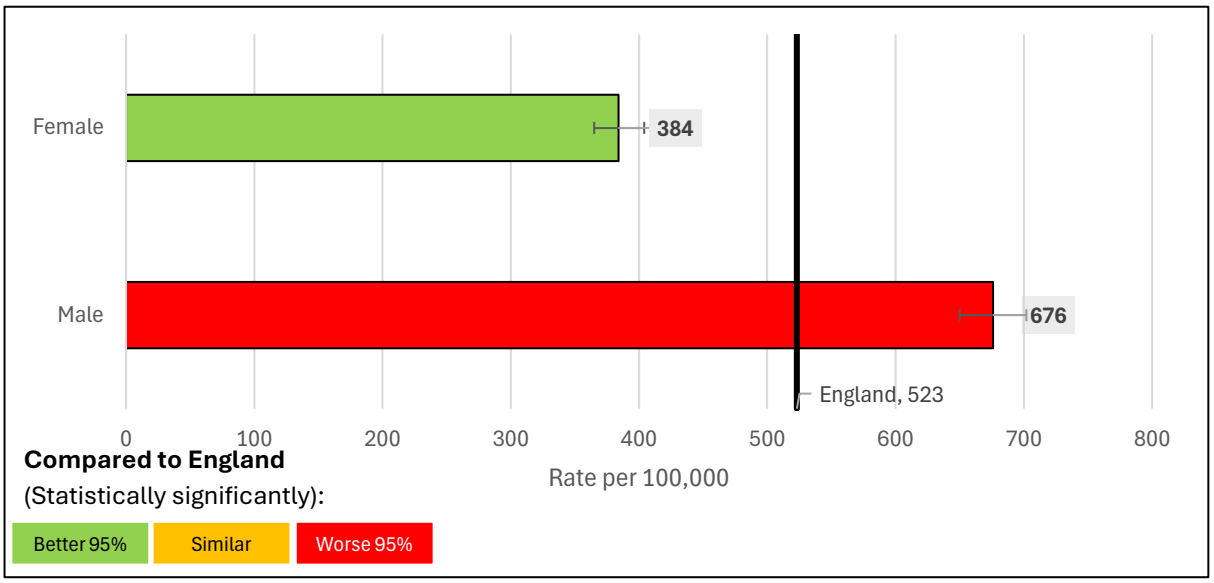
Source: Office for Health Improvement and Disparities (2025)

Alcohol

Alcohol-related mortality is statistically significantly higher for males in Suffolk (53.9 per 100,000) compared to females in Suffolk (19.8 per 100,000) in 2023. Males in Suffolk (676 per 100,000) are also more likely than females (384 per 100,000) to be admitted to hospital for alcohol-related conditions in 2023/24.

The rate for males in Suffolk (676 per 100,000) was considerably and statistically significantly higher than the rate for males across England (504 per 100,000), representing a 34% increase. Similarly, the rate for females in Suffolk (384 per 100,000) was also statistically significantly higher than the national rate for females (340 per 100,000), though the difference was smaller, at 13%.

Figure 27. Suffolk - Admission episodes per 100,000 for alcohol-related conditions (Narrow), by Sex, Suffolk, 2023/24



Source: Office for Health Improvement and Disparities (2025)

Obesity

Adult obesity and physical inactivity are associated with socioeconomic and demographic factors, reflecting underlying health inequalities. Individuals from certain ethnic groups, those who are unemployed or economically inactive, and individuals in routine occupations or with lower education levels are more likely to be obese, and less likely to be physically active.

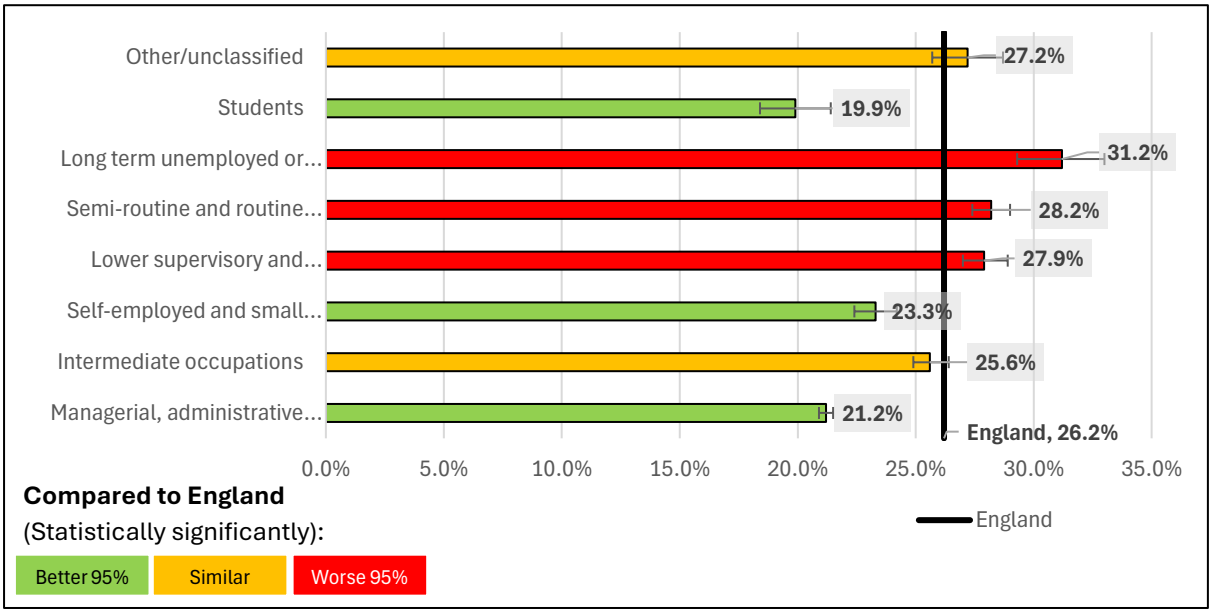
The prevalence of adult obesity in Suffolk remains statistically similar in 2022/23 (26.8%) compared to 2015/16 (24.5%).

Data on the proportion of adults classified as obese for England in 2022/23 by:

- **Ethnic group**: Black (34.8%) and White British (27.6%) adults were more likely to be classified as obese. Asian (19.7%), Chinese (6.3%), White Other (22.2%) and Other (22.8%) were statistically significantly less likely to be classified as obese.
- **Working status**: Unemployed (30.6%) and economically inactive (32.8%) people were more likely to be classified as obese.

- **Socioeconomic class**: Individuals working in lower supervisory and technical occupations (27.9%), semi-routine and routine occupations (28.2%) and long term unemployed or never worked (31.2%) were more likely to be classified as obese. Those working in managerial, administrative and professional occupations (20.8%) and self-employed and small employers (21.2%), self-employed and small employers (23.3%), and students (19.9%) were less likely to be classified as obese.

Figure 28. Percentage of adults (aged 18+) classified as obese, England, by socioeconomic class, 2022/23



Source: Office for Health Improvement and Disparities (2024)

Physical activity

Physical activity is defined as any bodily movement produced by skeletal muscles that requires energy expenditure. It takes many forms, occurs in many settings, and has many purposes (e.g. daily activity, active recreation, and sport)[11]. The Chief Medical Offer's physical activity guidelines for adults (19 to 64 years) in England state that each week, adults should accumulate at least 150 minutes (2 1/2 hours) of moderate intensity activity (such as brisk walking or cycling); or 75 minutes of vigorous intensity activity (such as running); or even shorter durations of very vigorous intensity activity (such as sprinting or stair climbing); or a combination of moderate, vigorous and very vigorous intensity activity.

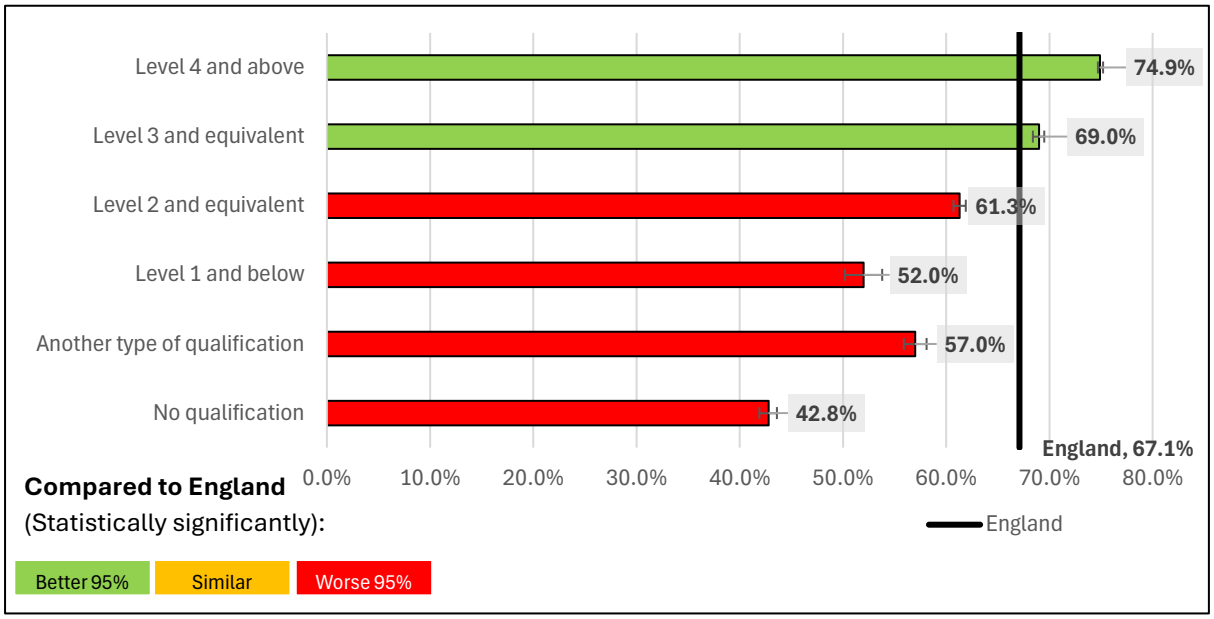
The proportion of physically active adults in Suffolk is statistically significantly higher in 2022/23 (68.8%) compared to 2015/16 (62.5%).

2022/23 data for the percentage of physically active adults in England show that by:

- **Ethnic group:** Mixed (71.9%), White British (69.3%) and White Other (68.6%) ethnic groups are more likely to be physically active, whereas Asian (56.1%), Black (55.2%), Chinese (58.7%) and Other (58.4%) were less likely to be physically active.
- **Working status**: Working individuals (71.4%) were more likely to be physically active, whereas economically inactive (59.4%) and unemployed individuals (54.7%) were less likely to be physically active.

- **Disability status**: Disabled people (52.7%) were significantly less likely to be physically active compared to individuals that were not disabled (72.1%).
- **Level of education**: Individuals with a level 3 qualification (A levels or equivalent) (69.0%) or a level 4 qualification (certificate of higher education/ level 4 NVQ) or higher (degree/master's degree/doctorate) (74.9%) were most likely to be physically active. Individuals with no qualifications (42.8%) were least likely to be physically active.

Figure 29. Percentage of physically active adults - by level of education, England, 2022/23



Source: Office for Health Improvement and Disparities (2024)

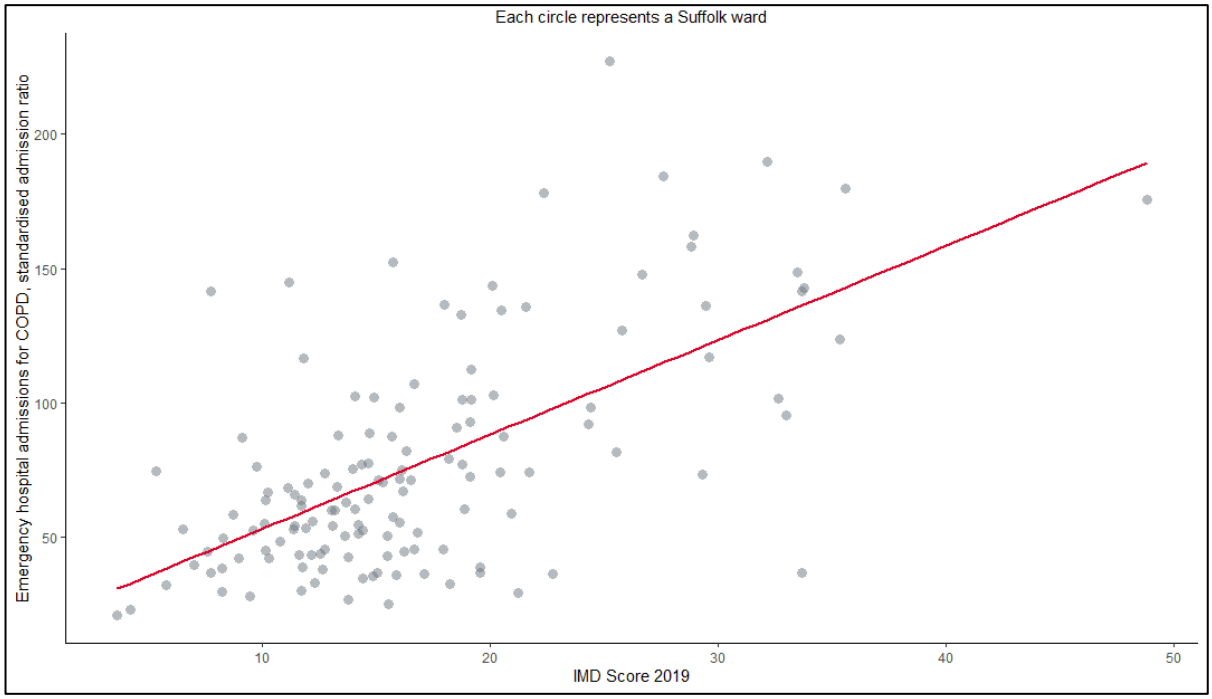
Long-term health conditions

Long-term conditions are a major cause of poor quality of life in England. People in lower socio-economic groups are more likely to have long-term health conditions, to develop these conditions earlier in life, and they may also be more severe than those experienced by people in higher socio-economic groups. Deprivation also increases the likelihood of having more than one long-term condition at the same time. On average, people in the most deprived fifth of the population develop multiple long-term conditions 10 years earlier than those in the least deprived fifth[12]. People from ethnic minority groups are more likely than white British people to report limiting long-term illness and poor health.

Long-term health conditions in Suffolk are marked by significant inequalities, with higher prevalence and earlier onset among deprived socioeconomic groups and ethnic minorities[13]. Key drivers in Suffolk include ischemic heart disease, Chronic Obstructive Pulmonary Disease (COPD), stroke, cancers and dementias.

The below figure displays the relationship between IMD score at Suffolk ward level and emergency hospital admissions for COPD over a 4 year period. This produces a correlation coefficient of 0.63, indicating a strong, positive relationship between hospital admissions for COPD and deprivation within Suffolk.

Figure 30. Relationship between Index of Multiple Deprivation (IMD) Score and Emergency hospital admissions for COPD 2016/17-20/21, Suffolk Wards



Source: IMD score (2019), Office for Health Improvement and Disparities (2024)

The GBD Compare tool analyses data about the world's health with trends from 1990 to 2021, using estimates from the Global Burden of Disease (GBD) study. The below table shows the top ten conditions causing the largest burden of disease from GBD 2021 in terms of the percentage of total Disability-Adjusted Life Years (DALYs) within Suffolk.

DALYs for a disease or health conditions are the total years of life lost due to premature mortality (YLL) and the years lived with a disability (YLD). One DALY = the loss of the equivalent

of one year of full health. This allows diseases that cause premature death but little disability (such as certain cancers or heart attacks) to be compared to diseases that do not cause death but do cause disability.

Table 1. Top 10 conditions causing greatest disease burden (Disability-Adjusted Life Years): Suffolk, 2021

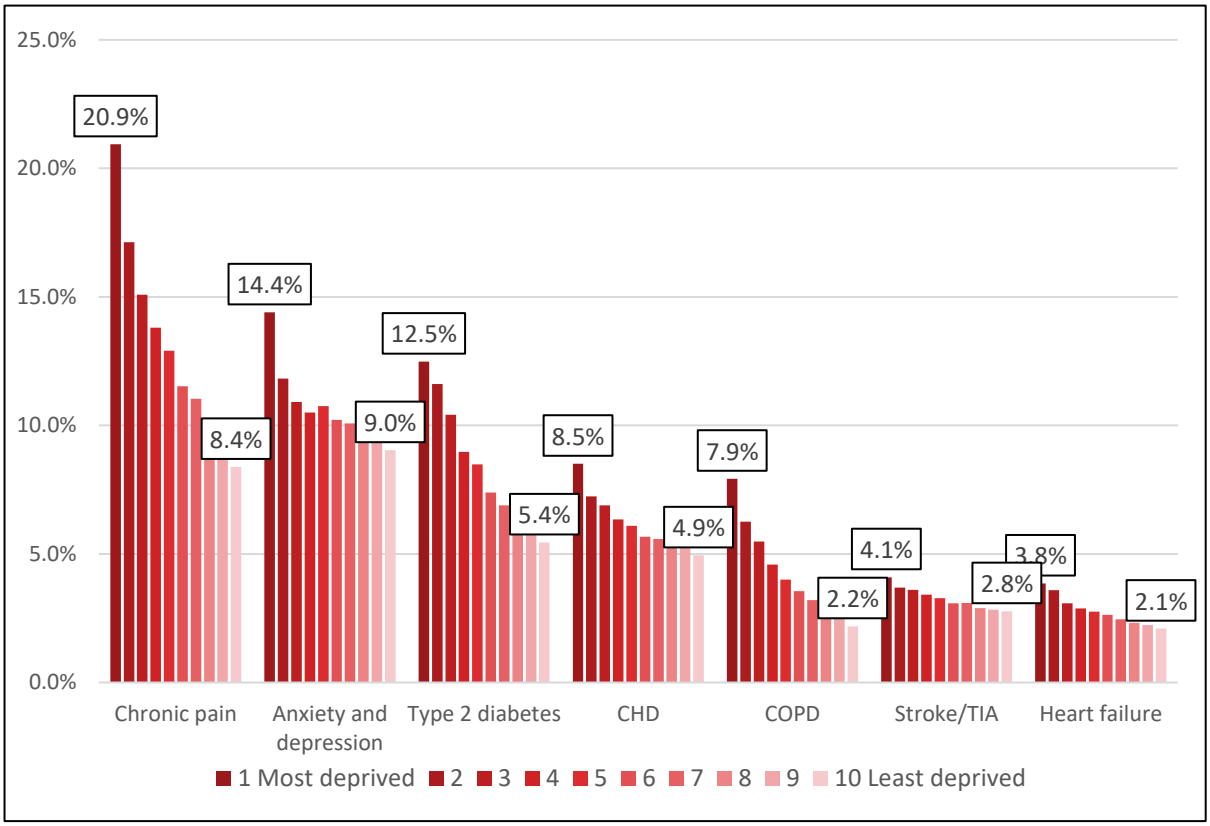
Cause name	Percentage of total DALYs in Suffolk
Covid-19	7.3%
Ischemic heart disease	5.9%
Injuries	5.8%
Chronic respiratory diseases	5.4%
Low back pain	4.7%
Other non-communicable diseases	4.6%
Diabetes and kidney diseases	4.4%
Unintentional injuries	3.9%
Digestive diseases	3.6%
Alzheimer's disease and other dementias	3.6%

Source: GBD Compare Tool (2024)

Health Foundation research in April 2024 found certain conditions are more common in deprived communities. These conditions are chronic pain, COPD, type 2 diabetes, cardiovascular diseases, and anxiety and depression[14]. Population health management (PHM) data for Suffolk reveals multi-morbidity occurs earlier in life and is more common within Suffolk's most deprived communities.

The below figure shows the share of people with these conditions (age-standardised prevalence) by the level of deprivation in 2019, for England. After age-standardisation, the prevalence of these conditions in the 10% most deprived areas are at least one and a half times that of the 10% least deprived areas. The largest difference is for COPD: in the most deprived areas, the prevalence is four times that of the least deprived areas.

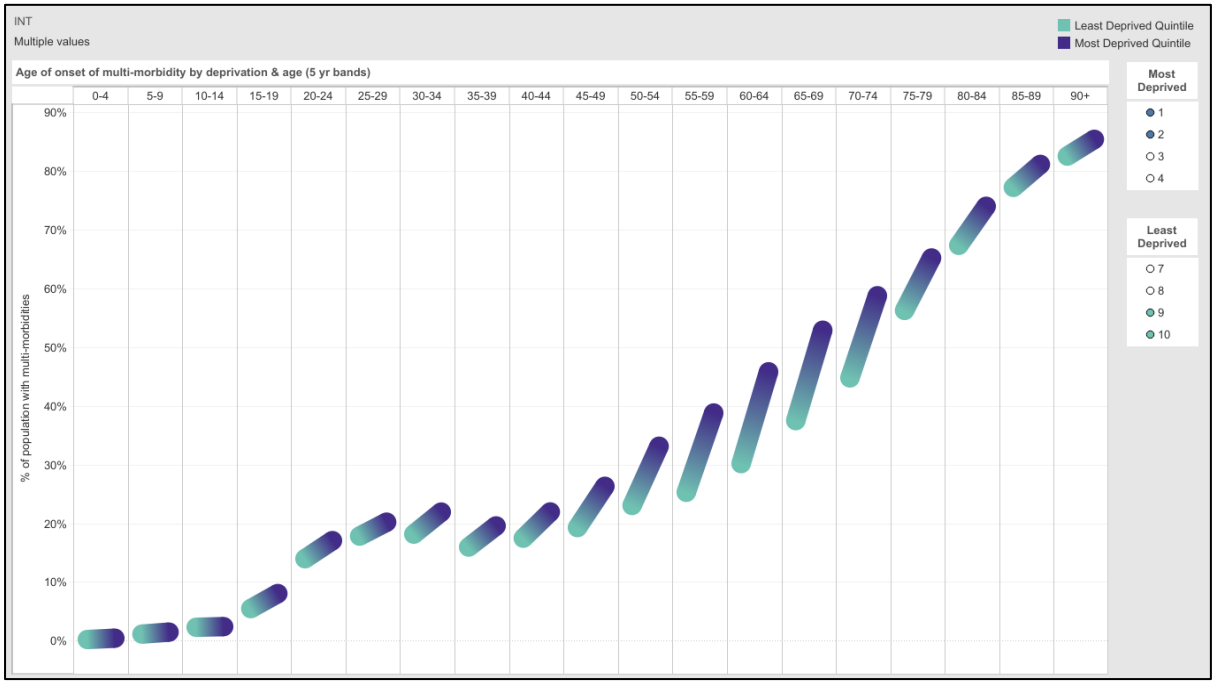
Figure 31. Prevalence of key contributing conditions to health inequality by decile of deprivation in England, age standardised, 2019



Source: The Health Foundation (2024)

Suffolk and North East Essex's PHM dashboard displays the age of onset of multi-morbidity (the presence of 2 or more long-term health conditions) and the difference in the prevalence between people in the most and least deprived populations of each age group. The below figure shows that multi-morbidity is more common and occurs earlier in the most deprived quintiles within Suffolk's integrated neighbourhood teams (INTs). The greater the height of the lozenge, the greater the difference in multi-morbidity between the most and least deprived quintiles for the selected age-group. Please note, PHM data for Suffolk does not include Waveney INTs.

Figure 32. Age of onset of multimorbidity by deprivation and age (5 yr bands), Suffolk INTs (excluding Waveney), reporting period Feb 23-Jan 24



Source: Optum Population Health Management Dashboard (2024)

Mental ill-health

Poor mental health can act as a risk factor contributing to or exacerbating existing inequalities. There are also inequalities in mental health. Certain groups, such as those from lower socio-economic backgrounds, ethnic minorities, or those facing discrimination, are more likely to experience poor mental health.

Across England, several socially excluded groups have been shown to experience higher rates of mental ill-health than the general population. For example:

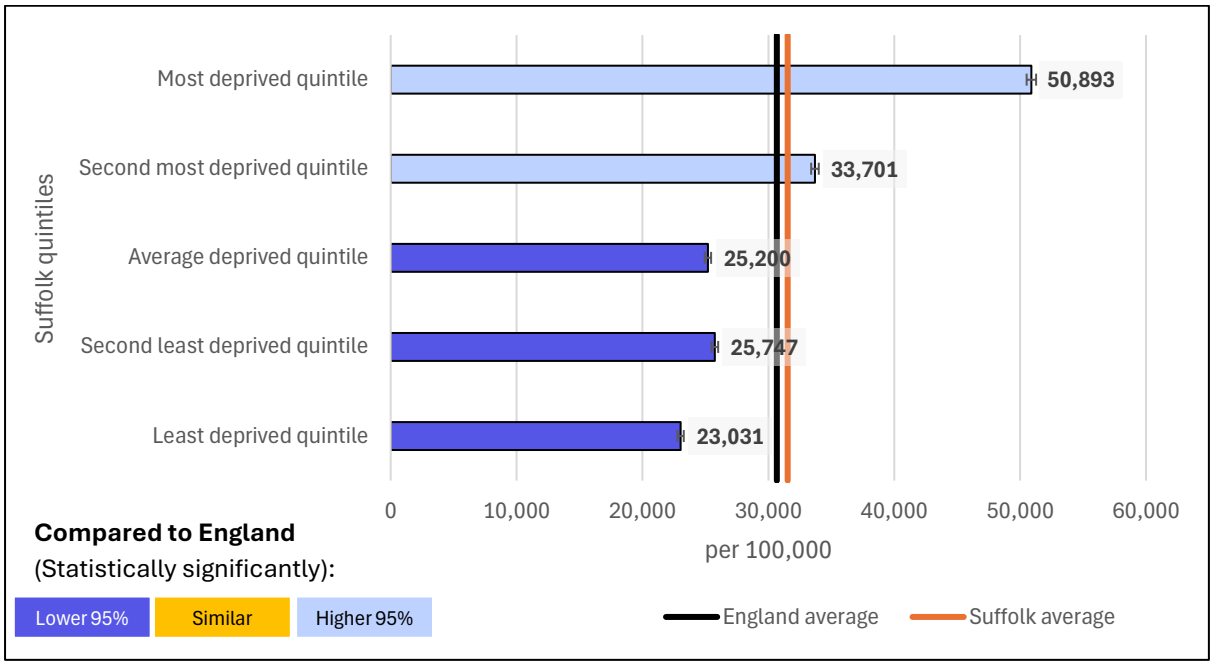
- More than 80 per cent of people experiencing homelessness report having a mental health difficulty
- Asylum seekers and refugees are also at increased risk of experiencing depression, post-traumatic stress disorder and other anxiety disorders

There is also a large body of evidence of ethnic differences in pathways into psychiatric care across England. In 2018/19, rates of detention under the Mental Health Act among the Black or Black British group were more than four times higher than the white group. A review from NHS Race and Health Observatory found evidence to suggest that there are 'clear barriers' for people from minority ethnic backgrounds to seeking help for mental health problems

Assessing differences in the prevalence of mental illness between social groups is challenging and complex, because rates of recognition, reporting and diagnosis are likely to vary between groups. Data from various sources highlights a range of differences in how mental illness and treatment for mental illness is accessed and experienced. In Suffolk in 2019/20, the rate of attended contacts with community and outpatient mental health services and the rate of inpatients stays in secondary mental

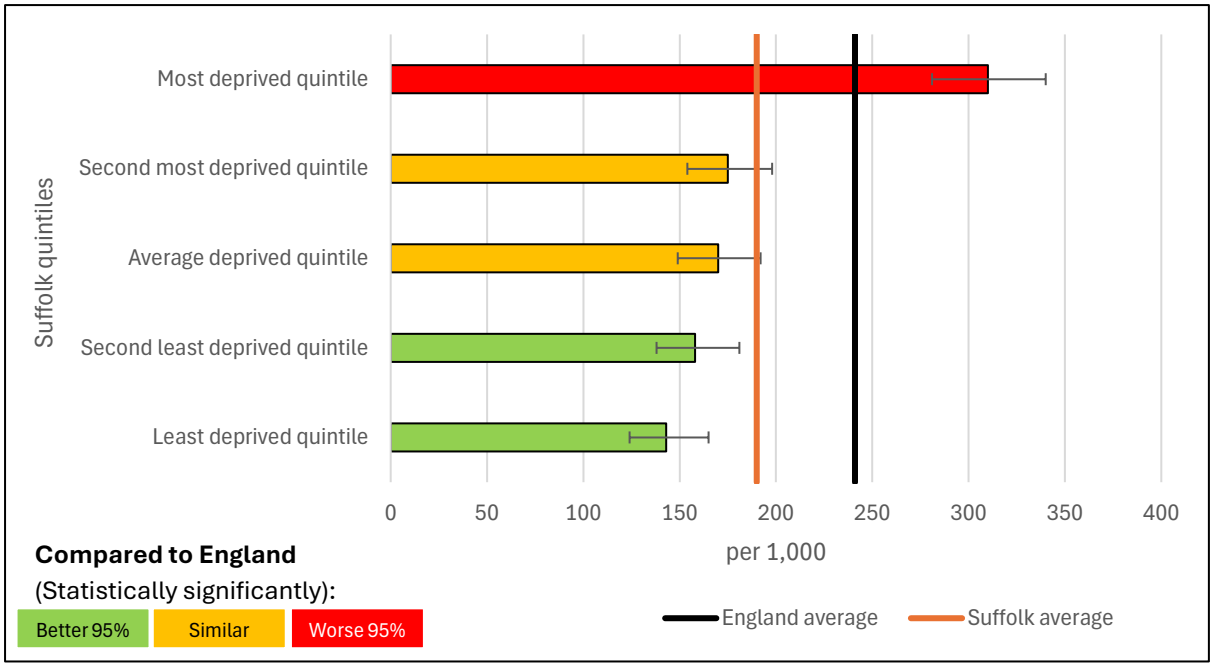
health services were higher among more deprived populations. The use of mental health services is highest among the most deprived areas of Suffolk[3].

Figure 33. Attended contacts with community and outpatient mental health services, per 100,000, Suffolk, 2019/20



Source: Office for Health Improvement and Disparities (2022)

Figure 34. Inpatient stays in secondary mental health services, per 100,000, Suffolk, 2019/20



Source: Office for Health Improvement and Disparities (2022)

Wider determinants of health

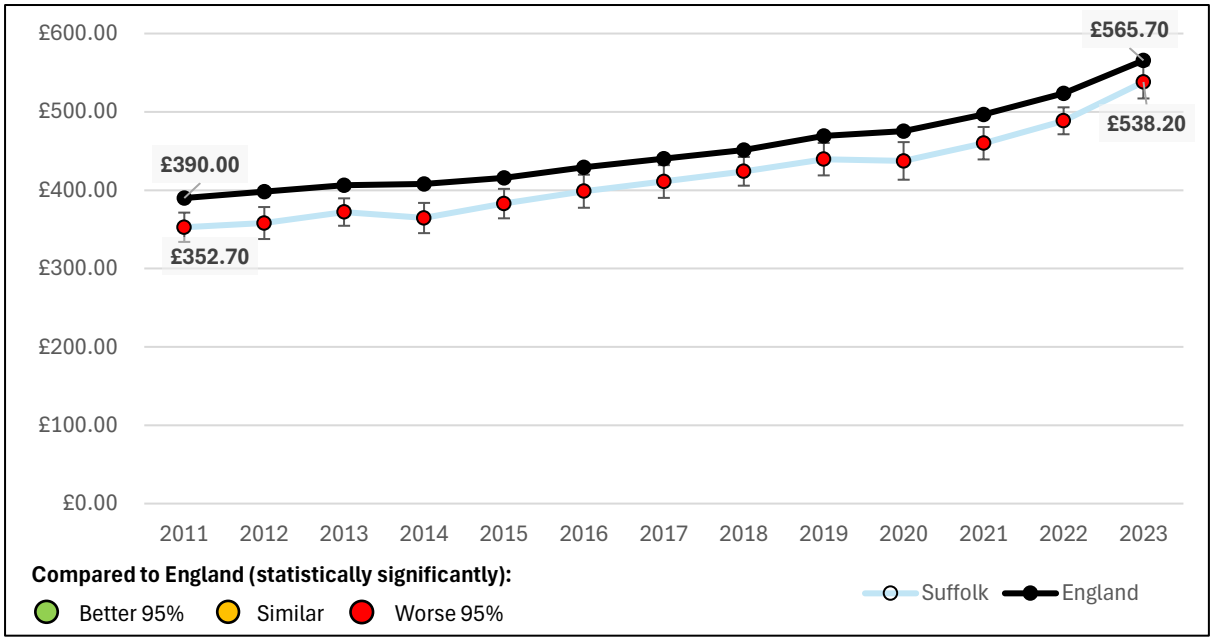
Wider determinants of health are the social, economic and environmental conditions in which people live that have an impact on health. They include income, education, access to green space and healthy food, the work people do, and the homes they live in.

Wider determinants of health contribute significantly to health inequalities in Suffolk. Lower average weekly earnings and a higher percentage of fuel-poor households in Suffolk compared to England are both examples of economic disparities that can lead to poor health outcomes in the county.

Average weekly earnings

Average weekly earnings in 2023 for Suffolk residents were £538.20, statistically significantly lower than the England average (£565.70). This has significant implications in terms of the amount of disposable income Suffolk residents have, as well as pressures on household finances, such as covering housing costs and being more likely to be in fuel poverty. Average weekly earnings for males in Suffolk (£615.80) were statistically significantly higher compared to females (£438.40) in 2023.

Figure 35. Average weekly earnings (median), Suffolk and England, 2011-2023



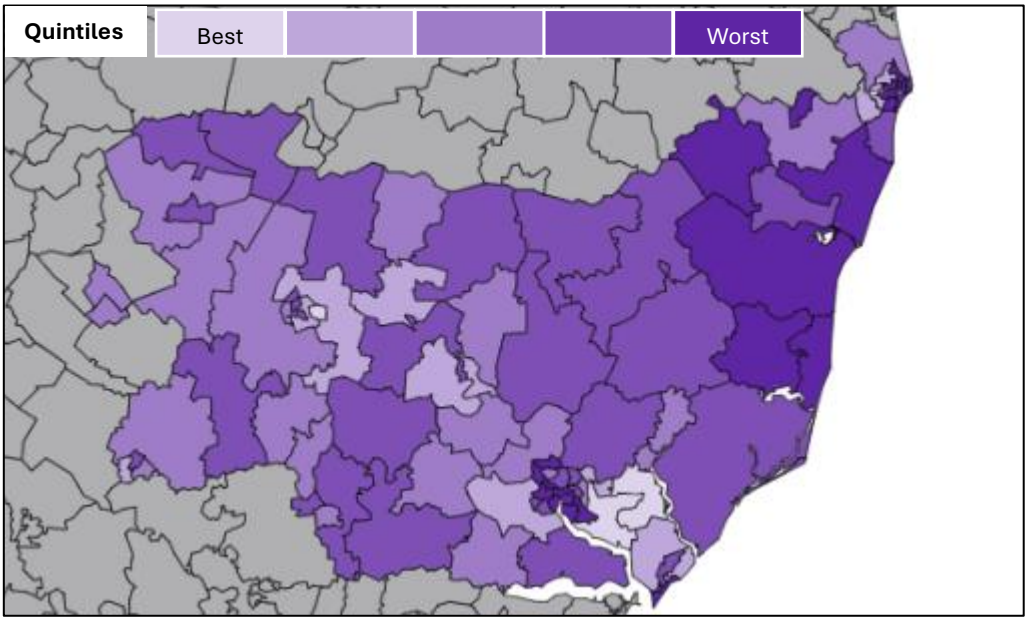
Source: Office for Health Improvement and Disparities (2024)

Fuel poverty

A household is considered to be fuel poor if they are living in a property with a fuel poverty energy efficiency rating of band D or below and when they spend the required amount to heat their home, they are left with a residual income below the official poverty line.

Evidence shows that living in cold homes is associated with poor health outcomes and an increased risk of morbidity and mortality for all age groups. Almost 40,000 households in Suffolk in 2022 (11.5% of all households) were classified as fuel-poor and at risk of the associated poor health outcomes.

Figure 36. Modelled estimates of the proportion of households in fuel poverty (%) Suffolk Middle Super Output Areas, 2020



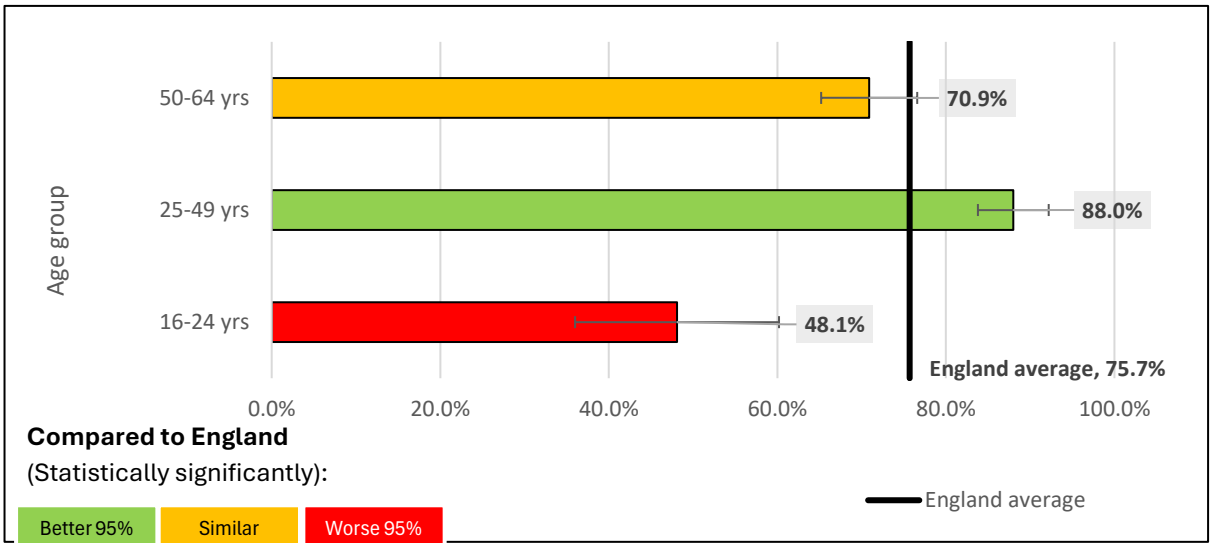
Source: Office for Health Improvement and Disparities (2022)

Employment

Suffolk has a statistically similar percentage of people in employment (75.8%) compared to England (75.7%). Within Suffolk, 48.1% of 16-24 year olds are in employment (many remain in education or training), compared to 88.0% of 25-49 year olds, and 70.5% of 50-64 year olds. The need for those aged 50 and over to be able to access good quality work, and to be supported in remaining or returning to such work is a key aspect of healthy ageing policy, included in the Consensus on Healthy Ageing Statement. Given Suffolk's ageing population and lower average wage levels, individuals may have to remain in employment longer and retire later, which may be difficult for many people to do given the many years in poor health which many older individuals are likely to experience.

Please note, this data is taken from the Office for National Statistics Labour Force Survey (LFS). While it is the official measure of employment and unemployment, response rates to the survey have decreased in recent years, leading to questions about the reliability of the data[16].

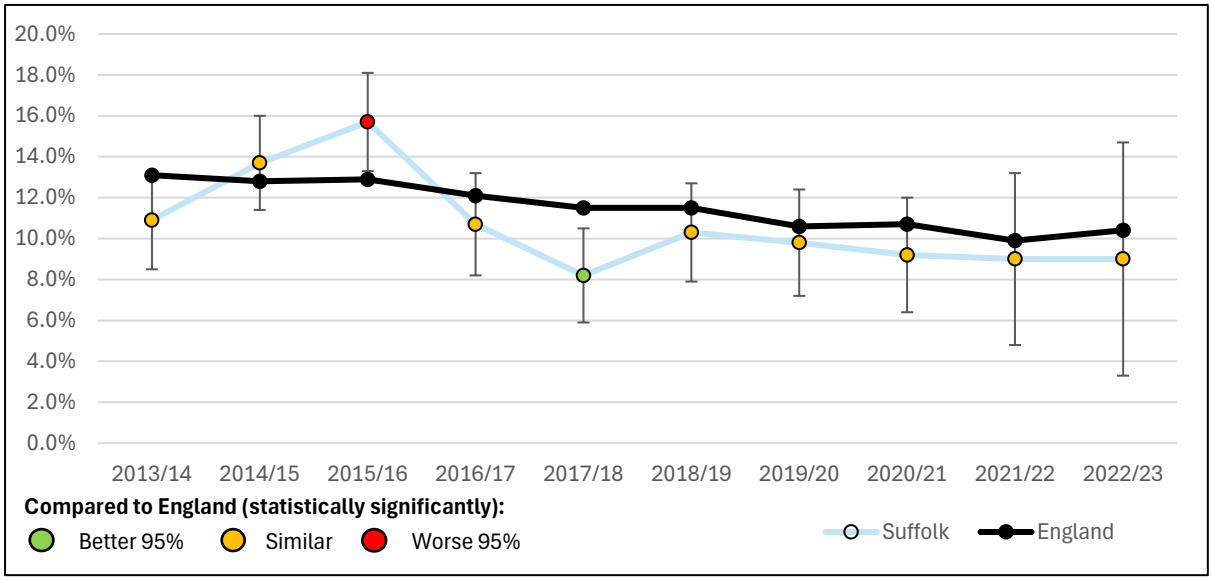
Figure 37. Percentage of people in employment by age group, Suffolk, 2023/24



Source: Office for Health Improvement and Disparities (2024)

Only around half of disabled people are in work, but many disabled people including people with long term health conditions want to work and could do so with the right support. The gap in the Suffolk employment rate between those with a physical or mental long term health condition and the overall employment rate is 9.0% in 2022/23. This rate remains statistically similar to the gap in 2013/14 (10.9 percentage points).

Figure 38. Gap in the employment rate between those with a physical or mental long term health condition (aged 16 to 64) and the overall employment rate, Suffolk and England, 2013/14 to 2022/23



Source: Office for Health Improvement and Disparities (2023)

4.4% of Suffolk residents report a low life satisfaction score, which is statistically similar to the England average (5.6%). Using the England data for inequalities in life satisfaction, statistically

significantly fewer working individuals have a lower life satisfaction score (3.6%) compared to economically inactive (8.7%) and unemployed adults (13.0%).

Variation in access to and experience of health services

Having access to health services means being able to get the right care at the right time, based on individual's needs and preferences. Poor access can lead some groups to receive worse care than others, resulting in poorer health outcomes.

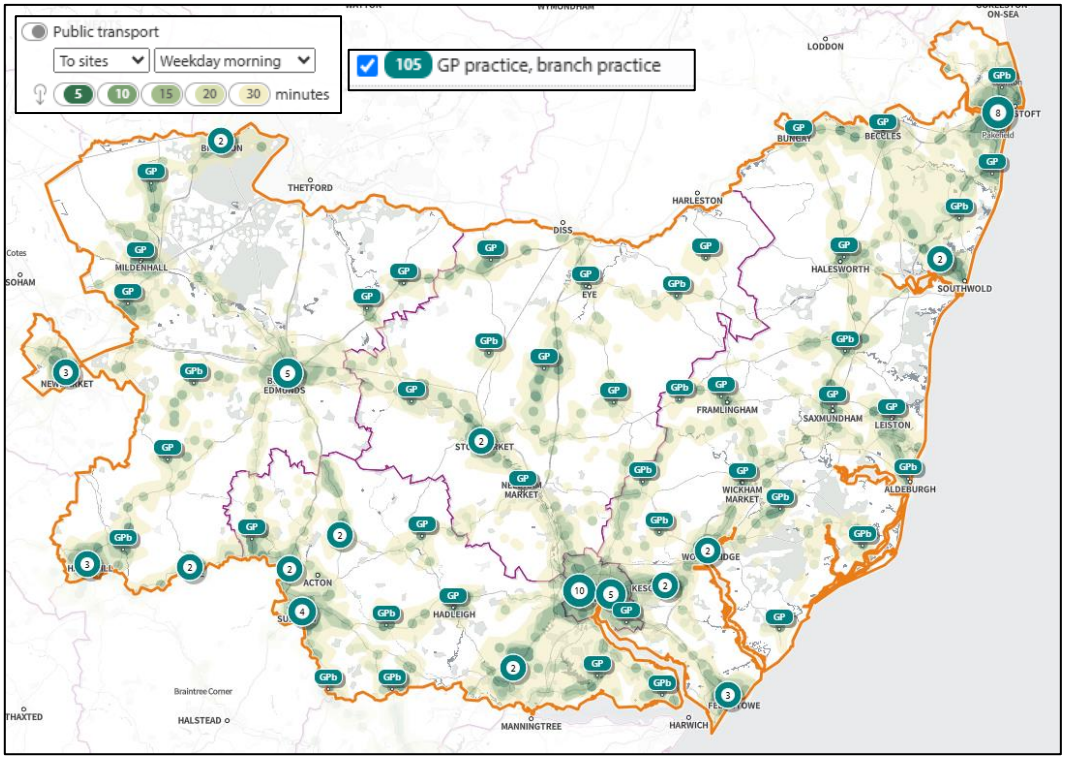
Inequitable access may mean a group faces barriers to getting the services they require, such as discrimination or language challenges, meaning information is not communicated or easily understandable[17].

Different social groups may face stereotyping, discrimination, and lack of cultural sensitivity when accessing health services, leading to unequal treatment and poorer quality of care, particularly for intersecting minority groups.

Access to health services is measured in terms of the availability of services, and their uptake. More deprived areas tend to have fewer GPs per head of population, and lower rates of admission to hospital for elective care than less deprived areas, despite having a higher disease prevalence[18].

There is variation in access to health services in Suffolk, with residents living in more deprived and rural areas facing greater barriers to accessing GP practices and elective care despite having higher disease prevalence compared to less deprived areas. Nearly 1 in 10 of the GP registered population (72,142 people/8.7% of all individuals registered with Suffolk GPs) especially those living in rural locations without access to private transportation, cannot reach their closest GP practice within a 30-minute travel time via public transport.

Figure 39. Access to nearest GP practice or branch practice within 30 minutes by public transport on a weekday morning, Suffolk, March 2025



Source: ShapeAtlas (2025)

The 2022 NHS England actionable insights guidance report 'Tackling inequalities in healthcare access, experience, and outcomes' suggests:

- Create an enabling system context with leadership commitment, governance focused on equity, and comprehensive data to identify inequalities
- Build shared understanding by analysing data, incorporating community lived experiences, and co-designing solutions with impacted communities
- Maintain urgency through awareness-raising, engaging leadership, appealing to fairness principles, dedicating resources, and continuously evaluating and adapting approaches

A recent initiative to tackle health inequalities: Core20PLUS5

Core20PLUS5 is a national approach developed by NHS England to systematically reduce healthcare inequalities across England. It provides a clear framework for Integrated Care Systems (ICSs) to identify and address disparities in health outcomes by focusing on specific population groups and clinical areas.

Core20PLUS5 is designed as the NHS contribution to a wider system effort by Local Authorities, communities and the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector to tackling healthcare inequalities – aiming to complement and enhance existing work.

The aim of Core20PLUS5 is that it will support Integrated Care Systems (ICS) to effectively prioritise energy, attention and resources enabling the greatest possible impact [13]. Even with changes likely to NHS England and ICSs, it offers a powerful way to identify and take action to reduce health inequalities.

The approach defines a number of groups in the population where taking targeted action may help to reduce health inequalities:

- The 'Core 20'% most deprived population in the area
- 'PLUS' Integrated Care System (ICS) chosen cohorts that experience worse than average health experiences, outcomes and/or access
- '5' nationally defined focus clinical areas requiring accelerated improvement, with the addition of smoking cessation as a thread running through the 5 areas

For adults:

There are five clinical areas of focus which require accelerated improvement. Governance for these five focus areas sits with national programmes; national and regional teams coordinate activity across local systems to achieve national aims.

- **Maternity**: Ensuring continuity of care for 75% of women from Black, Asian and minority ethnic communities and from the most deprived groups
- **Severe Mental Illness (SMI)**: Ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in learning disabilities)
- **Chronic respiratory disease**: A clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of Covid, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations
- **Early cancer diagnosis**: 75% of cases to be diagnosed at stage 1 or 2 by 2028
- **Hypertension case-finding and lipid optimal management**: To allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke

Whilst not included in the 5, smoking cessation is also included at this level of Core20PLUS5 as a cross-cutting theme. This is because stopping smoking has a positive impact on all five clinical areas of focus.

Greater deprivation is concentrated in urban areas such as Ipswich, where 28 of its 84 neighbourhoods fall within the 20% most deprived nationally, and in Lowestoft, which contains 18 of the 20 most deprived areas in East Suffolk[19].

As part of the 2022 Suffolk Annual Public Health Report which focused on Core20PLUS5, a guide was produced on Integrated Neighbourhood Teams (INTs) and what the data for each area indicates according to the Core20PLUS5 objectives. Some points are descriptive such as

coastal locations, and conditions are considered 'high' when compared to the England average.

For children:

There is also a Core20PLUS5 model for children, which looks to reduce inequalities for children and young people in the 20% most deprived areas, and within asthma, diabetes, epilepsy, oral health, and mental health.

Looking ahead: health inequalities in 2040

On current trends, health inequalities are projected to persist over the next two decades, with people in the most deprived areas likely to be diagnosed with major illnesses a decade earlier than those in the least deprived areas.

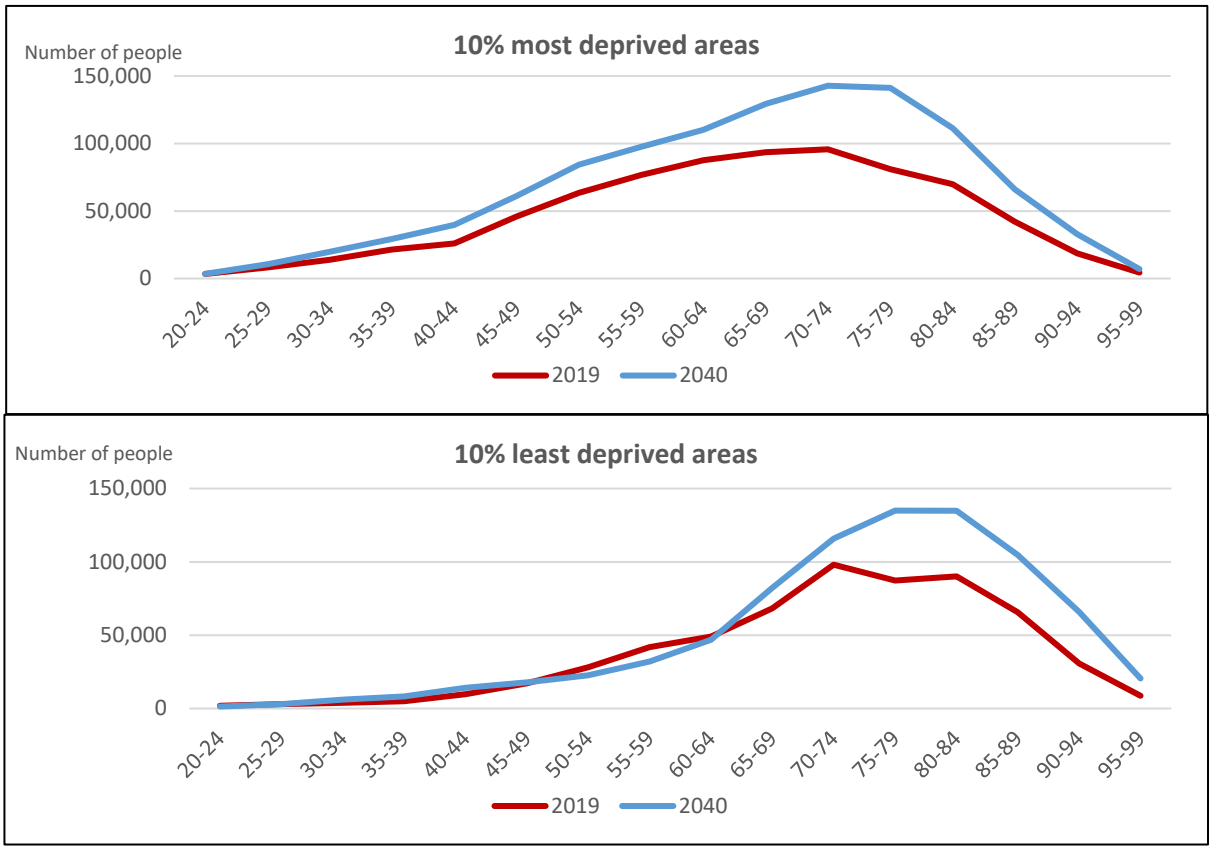
In the 10% most deprived areas across England, nearly 15% of people aged 20-69 lived with a major illness in 2019, more than double the rate in the 10% least deprived areas (6.3%). Chronic conditions like chronic pain, type 2 diabetes, and anxiety/depression are expected to increase faster in the most deprived areas when projected forward to 2040.

Inequalities in working-age ill-health are also projected to persist. 80% of the expected increase in the number of working-age people living with major illness across England between 2019 and 2040 (from 3 million to 3.7 million) will be concentrated in more deprived areas (deciles 1–5)[14].

Action focused on risk factors linked to major illness is essential but insufficient on its own to tackle health inequalities. Making progress on inequalities in major illness will also require long-term effort across government and the economy to address the underlying causes of health inequality, such as poor housing, low income and insecure employment[14].

The below figures show the estimated (2019) and projected (2040) total numbers of people with major illnesses for the 10% most and least deprived areas in England. There is a larger increase in the number of people living with major illness at all adult ages: 330,000 in the most deprived areas, compared with 200,000 in the least deprived areas.

Figure 40. Estimated (2019) and projected (2040) total number of people with major illnesses in the 10% most and 10% least deprived areas of England



Source: The Health Foundation (2024)

Conclusion

Suffolk's inequality profile highlights disparities across economic, health, education, and social dimensions, with certain areas and demographic groups experiencing greater disadvantage.

Health inequalities persist within Suffolk, with life expectancy varying significantly. Individuals in the most deprived areas can expect to live up to six years less on average than those in more affluent communities, and rates of chronic conditions such as cardiovascular disease and diabetes are notably higher among lower socioeconomic groups. Mental health concerns, particularly among young people and the elderly, have been on the rise, with social isolation and financial stress playing a role. Access to healthcare remains a challenge, particularly for those in rural areas, where travel times to GP services and hospitals are considerably longer, which could further contribute to health inequalities.

While employment rates in the county are broadly in line with the national average, wages for Suffolk residents remain below England averages. In some of the most deprived areas, average weekly earnings fall below both regional and national figures. Rural communities can face additional financial hardship due to limited job opportunities, lack of access to infrastructure such as the national gas grid, and poor transport connectivity.

Inequalities in educational attainment are also apparent within Suffolk. In some districts, the proportion of pupils eligible for free school meals achieving Grade 5 or above in GCSE English and Maths is 15% lower than their non-disadvantaged counterparts. Early years development data suggests that children from lower-income backgrounds are less likely to meet expected milestones, which in turn affects their long term educational and employment prospects.

Demographic shifts in Suffolk add further complexity to these inequalities, particularly with the county's ageing population. Housing affordability is another growing concern, as rising rental costs disproportionately impact low-income families, increasing the risk of housing instability and homelessness.

Health inequalities can exert a cumulative impact across the life course, beginning even before birth and continuing into later life. Socioeconomic disadvantage in early childhood is linked to poorer educational outcomes, which can limit employment opportunities and lead to lower-paid, less secure work. These factors increase exposure to health risks and reduce access to protective factors, contributing to poorer physical and mental health in midlife. Over time, these disadvantages compound, leading to a greater burden of ill health and shorter life expectancy.

Tackling these inequalities is therefore of upmost importance, and requires a holistic approach, with targeted interventions particularly aimed at those facing the most disadvantage. Achieving a more equitable Suffolk will need a collaborative approach across the Suffolk system, involving local authorities, healthcare providers, educators, and community organisations.

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