HEALTH INEQUALITIES

EVIDENCE, POLICY AND IMPLEMENTATION
PROCEEDINGS FROM A MEETING OF THE HEALTH EQUITY NETWORK

Edited by Adam Oliver & Mark Exworthy

The Nuffield Trust
FOR RESEARCH AND POLICY
STUDIES IN HEALTH SERVICES

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INTRODUCTION

1. Background

Few readers of this volume will need reminding that the issue of health inequalities has been a central focus within the health-related research community since the publication of the Black Report more than twenty years ago. Nor will they need reminding that the development of health inequalities policy has been a concern of the New Labour Government ever since it was first elected back in 1997. However, many readers may not have a clear idea of the extent to which health inequalities policy has been (or indeed, whether it ought to be) directly informed by the available evidence on the effectiveness of health inequalities policy interventions. Moreover, those of us who are not directly engaged in implementing health inequalities policy (or, for that matter, any policy) may be unaware of the difficulties faced by those who are charged with this task. The engrained and widespread nature of health inequalities suggests that policy interventions will face particularly thorny issues in formulating and implementing policy at national and local levels.

The seminar on which these proceedings are based contained presentations by a number of leading academics and policy makers engaged in the health inequalities field, and was designed to throw light on exactly those issues mentioned above: i.e. the links between health inequalities evidence, policy and implementation. Mark Exworthy, a co-founder, advisory board member and perennial key supporter of HEN, devised the idea and planned the structure of the seminar, and recruited all of the speakers. Mark also undertook the rather laborious but necessary organisational duties to enable the event to take place.

2. The seminar

The seminar was held at the London School of Hygiene and Tropical Medicine on July 5th 2002. It was organised into four main sessions:

(1) Inquiries – collating the evidence, devising recommendations, making policy;

(2) Translating evidence into policy;

(3) Policy implementation – current issues and dilemmas;

(4) Panel discussion to offer some reflections on the day (with Don Nutbeam, Martin Powell and Rudolf Klein).

The programme for the seminar and a list of those in attendance are given in the Appendix. Each contribution is presented in this publication in the order in which it appears in the programme.

3. Acknowledgements

As always with HEN seminars, we are very grateful to all of the contributors to the seminar. It is always encouraging when extremely busy people are willing to devote so much time to the activities of HEN for no monetary reward. A special thanks goes to Anna Coote, another longstanding supporter of HEN, who stoically chaired the whole of this one-day seminar.

The seminar was sponsored by the Economic and Social Research Council (award number R451265135), and finally, we are grateful to the London School of Hygiene and Tropical Medicine, through the offices of Charles Normand, for offering the venue for this event.

Adam Oliver
LSE Health and Social Care

October 2002

APPENDIX

Programme

10.00: Welcome: Anna Coote, King's Fund, chair for the day

Inquiries – collating the evidence, devising recommendations, making policy

10.10: The 'Black Report': Interpreting History
Virginia Berridge, London School of Hygiene

10.35: The 'Acheson Report': The Aftermath
Mark Exworthy, University College London

10.55: Q&A

Translating evidence into policy

11.35: Evaluating the Evidence on Measures to Reduce Health Inequalities
Sally Macintyre, University of Glasgow

12.00: Practical Issues in Translating Evidence into Policy and Practice
Marie Armitage, Merseyside Health Action Zone

12.25: Q&A

Policy implementation – current issues and dilemmas

14.00: Implementing Policies at the Local Level
David Evans, Bristol North PCT

14.25: Implementing Policies Across Central Government
Don Nutbeam, Department of Health

15.10: Joining up the 'Big and Little Windows' of Implementation
Martin Powell, University of Bath

15.35: Q&A

15.45: **Panel discussion: reflections on the day and on policy directions**
Don Nutbeam (DoH), Martin Powell (Bath) and Rudolf Klein (LSE and London School of Hygiene)

Attendees:

Jean Adams
Shahed Ahmed
Ann Allen
Maria Allison
Simon Alvey
Fiona Andrews
Madhavi Bajekal
Deborah Baker
Ruth Barnes
Evan Bates
Virginia Berridge
Kristina Bird
Karen Blakey
David Blane
Bruce Bolam
Anthony Bone
Caron Bowen
Julie Bull
Sara Burke
Roy Carr-Hill
Vicky Cattell
Frances Chinemana
Anna Coote
Peter Craig
Tessa Crilly
Rona Cruickshank
Francis Dickinson
Angela Donkin
Ayesha Dost
Josephine Erwin
David Evans
Mark Exworthy
Vivien Fijten
Heather Finlay
Jill Fletcher
Rachel Flowers
Sarah Fogarty
Ian Gray
Sue Greig
Anil Gumber
Ulla Gustafsson
Barbara Hanratty
Margot Harbour
Angela Harden
Mary Hawkey
Andrew Healey
Baljinder Heer
Donald Hirsch
Paula Holland
Andrew Hutchings
Karen Jochelson
Joanna Kerr
Amanda Killoran
David King
Rudolf Klein
Sue Lambert
Jane Landon
Yuan Huang Lee
Paul Lincoln
Sally Macintyre
Rachel Makin
Tim March
Jonathan Mathers
David McDaid
Christine McGuire
Bill McKevitt
Eileen McLeod
Richard Mitchell
Kath Moser
Maura Muldoon
Jennifer Mussenden
Jennie Naidoo
Sarah Nettleton
Don Nutbeam
Alison O'Grady
Monica Oliveira
Adam Oliver
Judy Orme
Stephen Peckham
Francesca Perlman
Jean Peters
Sue Povall
Martin Powell
Rosalind Raine
Veena Raleigh
Elen Rees
Valery Ridde
Wendy Rogers
John Rooke
Sharon Rushworth
Shirley Russell
Alex Scott-Samuel
Valerie Seagroatt
Simon Shenton-Tan
Mike Simpkin
Melanie Sirotkin
Bryony Soper
Sandra Squires
Elliot Stern
Anu Suokas
Jane Thomas
Pamela Warner
Dale Webb
Simant Westley
Andrea Wild
Jane Wilde
Alan Williams
Gareth Williams
David Woodhead

THE BLACK REPORT: INTERPRETING HISTORY

Virginia Berridge
London School of Hygiene and Tropical Medicine

1. Conference and witness seminar

In 1999, the London School of Hygiene and Tropical Medicine held an international conference on inequalities and health (Leon and Walt, 2000). The conference was prefaced by a conference looking at the inequalities issue historically with papers by Roderick Floud, Simon Szreter, Charles Webster and others. The afternoon session was occupied by a 'witness seminar', a group exercise in reminiscence, at which we gathered together most of the original members of the Black committee, Sir Douglas Black, Peter Townsend, Jerry Morris, together with David Player and Margaret Whitehead, who had been involved in the follow up report, *The Health Divide*. There were two professional civil servants, Arthur Buller, who was Chief Scientist at the time, and Elizabeth Shore, the deputy Chief Medical Officer. Jill Turner, the journalist on *New Society* who originally broke the story of the report's publication also took part, as did John Fox from the Office of National Statistics. Stuart Blume, who had been Scientific Secretary to the committee, was to have been present, but sent a detailed memoir which helped to structure the seminar. Lord Jenkin, Secretary of State in the Conservative government of the time, also sent a memoir based on access to material from his time as a Minister. The full transcript of the seminar, and the papers given at the conference together with some additions, have been published (Berridge and Blume, 2002a; b). What follows in this short paper is a distillation from that day of new light shed on the Black Report. I reflect on what this history reveals about the relationship between science, researchers and policy, an issue which has become of more central interest in the intervening twenty years.

2. The post war context

Charles Webster's paper on inequalities as an issue before Black showed the shape of the issue (Webster, 2002). Although health inequality had been much discussed by some interests in the pre-World War two period, the coming of the NHS had seemed to offer a new start. Discussion of inequality died away, and key reports, for example Guillebaud, barely mentioned it. The 'rediscovery of poverty' came from two directions, from the work of Richard Titmuss and the Child Poverty Action Group, which drew attention in the 1960s to the intractability of inequality. Inequalities in health service provision also began to put the issue back on the agenda. The Resource Allocation Working Party (RAWP) reporting to Barbara Castle and David Owen in 1976, was the service equivalent of the Black Report.[1]

3. Two well known stories of government reaction; 1980 and 1987

The public story of the government response to Black is well known. The committee was appointed by David Ennals as Labour Secretary of State in 1977, but reported in 1980 to the incoming Conservative government. Publication was on the August Bank Holiday, with 260 copies made available. The consequent media furore was considerable. History repeated itself in 1987, when the Health Education Council's (HEC) report, *The Health Divide*, had its official press launch cancelled and rescheduled in a Soho office. This was part of a political reaction to the HEC which saw it transmuted into the Health Education Authority, a special health authority with responsibility for AIDS public education. These events are well known and have been detailed in the combined edition of the two reports. (Townsend *et al.*, 1988).

4. The 1999 witness seminar: a different picture

The Black Report has enormous symbolism as a case of suppression of a politically sensitive report. The picture which emerged from the witness seminar provided a more nuanced view. It threw light on the process of producing an agreed report and the attendant problems. It was clear that the members of the committee, and two in particular, Peter Townsend and Jerry Morris, had great difficulty in arriving at a consensus on recommendations. Stuart Blume's memoir shows how the committee moved slowly towards some analysis of existing data and towards agreement on what had to be done. A conference at the King's Fund in March 1978 added to the complexity. As Blume says, 'it was not easy to draw conclusions from so wide ranging and so complex a discussion.' A major issue for discussion also became the resources needed for the broad programme the report began to outline. Could they be freed up by cutting hospital expenditure? This point is taken up in the transcript, where both Jerry Morris and Peter Townsend refer to the disagreement between them on this point and meetings on the fourth floor of the London School of Hygiene and Tropical Medicine to iron out a compromise. Morris and Townsend came from different traditions of inquiry into health – from social medicine and from sociology. Morris refers to this:

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[1] At the meeting David Blane also referred to the Scottish dimension of the revival of the issue, in particular through a lecture given by Sir John Brotherston as Scottish Chief Medical Officer.

"… The way the committee discussed it, it was hospital services. And there developed a major difference of opinion between Peter and myself on this, which you can treat at various levels. At one level is a sort of Isaiah Berlin, two great values colliding which are incomparable, incompatible and you can't do anything about it…But this was a real difference. The idea that I should in any way support a suggestion that a penny less should go to the hospital services that already were inadequately funded was quite unacceptable…And, it isn't that, ex-Seebohm and all, I was unaware of the idea of community services, but that was not the point. You can actually have both …"

But this disagreement and delay led to poor political timing – the report was presented to an incoming Conservative government rather than to the Labour government.

The medical and scientific civil servants were exasperated at the delay. They were urging the committee on, and, sensing the change in the political wind, wanted something rather than nothing from it. Their focus was on the politically possible rather than the ideal. This exasperation came over clearly in the witness seminar. Elizabeth Shore said:

"I was very aware of the political situation. After all we nearly had a general election the previous autumn. Jim Callaghan, the Prime Minister, gave serious thought to it. I was metaphorically jumping up and down on the sidelines saying, can't we have some quick and dirty general recommendations to get going on? … The purity can come later on … And I felt very strongly that we had to start doing something at that point without waiting …"

After the Kings Fund meeting, she was in despair. "Were we ever going to get anywhere with the imminent possibility of a government of a very different complexion, a hostility to the working class who seemed to them to be the unions on the warpath again. I just felt we were going backwards."

Sir Arthur Buller was of a similar view:

"I can recall being urged to ring Douglas to ask 'How are things going? Can you speed it up?' Could I ask if the members were conscious of the manifestos of the two major political parties, and whether they had considered these relevant documents? Certainly the Conservatives, in their manifesto, made it absolutely clear that, if elected, they intended to reduce public expenditure … When the final report was produced my personal reaction was, 'What a time to produce *this* report' … You appeared to ignore 'The Art of the Possible.'"

But Black replied that they were more concerned with getting it absolutely right "with the long term, rather than with any political deadline." The scientists' perspective differed from that of the politically aware bureaucrats.

The report was thus presented to a government elected on a platform of reduction of public expenditure. Patrick Jenkin's memoir stresses the lack of enthusiasm for the report by officials, the resource implications of the recommendations, and advice given by officials about whether or not to publish. The advice he had was to publish in such a way that it clearly distanced the department and government from the conclusions of the report.

"I was initially sceptical about publication. There are many minutes by officials on the files arguing about whether to publish or not, and if to publish, how that might be done. By the time they were able to put a clear departmental view to me on this, they had concluded that the balance of the argument lay with publication, but in a way that clearly distanced the department from the recommendations. Interestingly, the department's medical advisers were rather less dismissive. They drew attention to a number of the minor recommendations, about better information, improved statistics and more research, and argued that there were certainly issues which should be taken up seriously by the department. They warned that the medical profession would certainly expect to see a proper follow up. The submission to Ministers reached me in May 1980. It reflected the wide ranging criticisms already rehearsed above, and described the report as a mixture of semi digested data and proposals for massive public expenditure. 'It reads like a policy manifesto from a party who do not expect the responsibilities of office.'"

In another sense, the report's impact was greater just because of the manner of its publication. John Fox's recollections showed that it led to an enormous growth of research interest in this area, the growth of networks of researchers, a kind of underground culture of inequalities research and debate which continued throughout the 80s and early 90s. Jerry Morris recalled the great interest shown by the Labour movement, trades councils and so on.[2] This was the background to the re-emergence of the issue in the later years of the Conservative government.

5. A case study of science, politics and policy

There are a number of ways of interpreting this sequence of events, which also relate to dominant modes of encapsulating the relationship between science, politics and policy (Berridge and Stanton, 1999). At one level, the story of the Black Report subscribes to a 'heroes and villains' view of policy – its symbolic importance as such has been considerable. There were other examples at the same period of political changeover: the Think Tank Report on alcohol likewise fell foul of political change. Black and its fate can also be seen as *rationality thwarted*. The ideal of a rational connection between research and policy making is a concept which has lain behind much of the 'evidence-based movement', but this is widely criticised in the literature.

The Black episode indicated a complex interaction, from which can be drawn more general conclusions about the operative factors in health and science policy making. Political change was significant, as it was for other areas of health policy making at this time. But the seminar also underlined the close relationships between civil servants and researchers, a 'policy community' which operated alongside the political lines of communication. A harbinger for the subsequent history of the science/policy relationship was the key role played in this series of events by the media. Ennals seems in part to have been spurred to action initially through a piece by Richard Wilkinson in *New Society*. Jill Turner's expose in the same magazine was important in promulgating the standard view of the report; and

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[2] Blane referred also to the role of the editor of the *British Medical Journal* in keeping the issue alive in the late 1980s and early 1990s.

David Player played to the media in the set up over *The Health Divide*. These types of relationships between researchers and research broking mechanisms have become increasingly important since. In being a 'media event' the Black report was prescient of future trends. And finally there is the question of timing. As Stuart Blume put it, "that question from 1980 still fascinates me. Why had we failed to agree in time? Is this now, two decades later, a matter for regret?" So far as the growth and consolidation of research into health inequalities was concerned, the Black Report's 'non publication' gave the area a greater impetus for development than it otherwise would have had. Its value as a symbol was considerable while in practical terms its recommendations remained to be implemented.

References

Berridge V, Stanton, J (1999) Science and policy: historical insights. Social Science and Medicine 49: 1133-1138.

Berridge V, Blume S (2002a) Contemporary British History. Special Issue.

Berridge V, Blume S (2002b) Poor health. Social inequality before and after the Black Report. London, Frank Cass.

Leon D, Walt G (2000) Poverty, inequality and health: an international perspective. Oxford, Oxford University Press.

Townsend P, Davidson N, Whitehead M (1988) Inequalities in health. London, Pelican.

Webster C (2002) Investing inequalities in health before Black. In: Berridge V, Blume S (2002b) Poor health. Social inequality before and after the Black Report. London, Frank Cass, pp. 81-106.

THE ACHESON REPORT: THE AFTERMATH

Mark Exworthy[1]
University College London and University of California in San Francisco

1. Introduction

Unlike the Black Report, the Acheson Report was published in a favourable policy climate which should have augured well for policy formulation and implementation. This paper summarises the background to the Acheson Report and its reception, and describes the policy context in the UK that has been associated with the Acheson Report.

2. History

The Independent Inquiry was one of the first actions by the in-coming Labour government. Elected in May 1997, the Inquiry was commissioned in June and began its work in July 1997 under the chairmanship of Sir Donald Acheson, the former Chief Medical Officer for England. The Inquiry's terms of reference were:

1. To moderate a Department of Health review of the latest available information on inequalities in health, using data from the office for National Statistics, the Department of Health and elsewhere. The data review would summarise the evidence of inequalities in health and expectation of life in England and identify trends.

2. In the light of that evidence, to conduct – within the broad framework of the government's overall financial strategy – an independent review to identify priority areas for future policy development, which scientific and expert evidence indicates are likely to offer opportunities for government to develop beneficial, cost-effective and affordable interventions to reduce health inequalities.

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[1] The research upon which this paper is based was funded by the Joseph Rowntree Foundation. I am grateful for their support.

3. The review will report to the Secretary of State for Health. The report will be published and its conclusion, based on evidence, will contribute to the development of a new strategy for health.

The Inquiry team comprised 6 individuals with backgrounds in epidemiology, public health and sociology, and was supported by scientific and administrative secretaries. The inquiry commissioned 'input papers' in 17 areas including policy sectors, social groups and disease categories. The Inquiry's report (here, termed the Acheson Report) was published in November 1998 (Acheson, 1998).

3. The Report's recommendations

The Acheson Report comprised 164 pages and over 500 references. It made 39 main recommendations. However, a total of 74 main and subsidiary recommendations were made; some contained more than one recommendation.

The first section comprised 3 recommendations which were considered by the Inquiry team to be 'crucial.' These broad ranging recommendations were:

- All policies likely to have an impact on health should be evaluated in terms of their impact on health inequalities;
- A high priority should be given to the health of families with children;
- Further steps should be taken to reduce income inequalities and improve the living standards of poor households.

The Inquiry's recommendations were included within 12 further sections:

- Poverty, income, tax and benefits,
- Education,
- Employment,
- Housing and environment,
- Mobility, transport and pollution,
- Nutrition and common agricultural policy,
- Mothers, children and families,
- Young people and adults of working age,
- Older people,
- Ethnicity,
- Gender, and
- NHS.

Only three of the 39 main recommendations were directed towards the NHS, indicative of the emphasis placed by the Inquiry on the wider determinants of health.[2]

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[2] Fourteen of the 74 main and subsidiary recommendations were directed towards the NHS.

4. The official reception and critiques of the Acheson Report

In contrast to the Black Report, the Acheson Report received a generally favourable reception by the government, practitioners and academics.

The government 'welcomed' the report but claimed that it was *already* implementing many of the Report's recommendations (DoH, 1998a). Published after the Green Paper (*Our Healthier Nation*; DoH, 1998b), the Acheson Report influenced the White Paper (*Saving Lives*, 1999). The *Action Report on Health Inequalities* (accompanying the White Paper) drew heavily on the Acheson Report. Subsequent references to the Acheson Report are also favourable. The DoH report (*From Vision to Reality*, 2001) described the report as 'groundbreaking' and claimed that it was 'the most comprehensive analysis of the evidence'. The Treasury's cross-cutting review on health inequalities (July 2002) also recognised the Acheson Report as an antecedent of its own analysis. The report is, however, less widely referenced in documents from other government departments.

The critiques of the Acheson Report identified potential shortcomings and pitfalls. The critiques have mainly been advanced by academics. They fall into five categories (Exworthy, 2002):

- No priorities,
- No mechanisms or processes,
- Mismatch between evidence and recommendations,
- Recommendations ranged from the general to the specific, and
- Evidence of cost-effectiveness and economic perspectives were absent.

First, the Report deemed the first three recommendations 'crucial' but made no further prioritisation. The number of recommendations may be inappropriate for full implementation but the terms of reference sought 'priority areas for future policy development.' The recommendations have been described as a 'shopping list' and a 'wish-list' (Davey-Smith *et al.*, 1998; Illsley, 1999).

Second, mechanisms for translating recommendations into action were left to the government. However, such mechanisms were not sought by the terms of reference (Marmot, 1999). Targets might have been one such mechanism; these were subsequently published in 2001. Margaret Whitehead (an Inquiry member) claimed that the government told the Inquiry to avoid target-setting (Mayor, 1998).

Third, the mismatch between evidence and recommendations reflects the uneven quality and strength of evidence (Klein, 2000). Few studies have demonstrated the effects of interventions designed to reduce health inequalities. Nonetheless, the Inquiry's evaluation committee concluded that "lack of evidence… is not an argument for inaction" (Macintyre *et al.*, 2001).

Fourth, recommendations ranged from the general to the specific. The former gave latitude for implementation whilst the latter might necessitate particular strategies although no mechanisms were offered (see above).

Fifth, cost-effectiveness data were absent and no economist sat on the Inquiry team (Williams, 1999; Oliver, 2001). Such evidence is scant but the terms of reference did require recommendations to be “affordable” and “within the government’s existing financial framework.” This framework comprised the previous government’s spending plans.

Overall, Birch (1999) concludes that “the 39 steps for policy direction are remarkably similar in scope and content to the recommendations of the Black Report.”

5. Interpreting the Acheson Report

Interpreting the influence and impact of the Acheson Report is problematic given the difficulty of ascertaining attribution, the broad remit of the recommendations and the coincidence with other related policies. However, Macintyre (1999) identified three possible impacts:

a. The Report influenced policy,

b. it chimed with the general policy direction at the time, and

c. policies would have been implemented anyway.

She concludes that none are verifiable but it is likely that (a) and/or (b) are the most probable explanations. Subsequent developments have enabled further insights into the impact of the Report. Four outcomes have been manifest:

1. It prompted new policies to tackle health inequalities;
2. It introduced a health inequality dimension to existing policies;
3. It encouraged or contributed to a climate of opinion in favour of tackling health inequalities;
4. It acted as a source-book or reference against which policies have been examined and tested.

Appraisal of these outcomes raises issues about attributing policies to the Report and explaining the counter-factual (of what would have happened if the Report had not been published). Inquiries have sometimes been a way of incorporating external perspectives into policy-making and delaying policy action (in the face of pressures or expectations) (Barker *et al.*, 1999; Brown, 2000). Appraising the outcomes highlights the relationship between research and policy (Davies *et al.*, 2000). Four types of relationship are evident:

- Pure: research impels policy.
- Engineering: policy drives research.
- Enlightenment: research diffuses into policy.
- Political: research is contested by political groups and processes (Booth, 1988).

6. Policy developments and implementation

The Labour government has demonstrated a commitment to tackling health inequalities in its overall policy direction and specific strategies. Five dimensions to the implementation of the government's policies to tackle health inequalities can be identified:

6.1. Wider determinants of health

Explicit and implicit links have been made with the wider determinants of ill-health generally and health inequalities specifically. Policies have focused on the early years of childhood and women of child-bearing age although policies are also evident across the life-span.

6.2. Targets and performance culture

The government has stressed the need for targets to stimulate action. Many of the Public Services Agreements between the Treasury and other government departments have direct implications for meeting health inequality targets related to infant mortality, life expectancy and further targets.

6.3. Area-based initiatives

Disadvantaged communities have been targeted through various Action Zones and Sure Start programmes although they do not include all people living in poverty. At its height (2004), Sure Start will still only cover one third of all children living in poverty.

6.4. Redistribution

Traditional forms of income redistribution through tax and benefits have been less prominent than initiatives like welfare-to-work (such as in-work benefits including tax credits). Redistribution has been limited but it has shown a social gradient from rich to poor.

6.5. Inequality and social exclusion

The government has sought to tackle inequality *and* social exclusion; the former assumes a social gradient, the latter a binary division. For example, targets in most departments are introducing *minima* and floor targets but these do not tackle inequality *per se*.

7. Outstanding challenges

The government's policy programme is on-going. Health inequalities are finally on the government's agenda but, alone, this is insufficient to guarantee implementation and eventual achievement of targets. The government has made significant strides but it faces three crucial challenges. These will be shaped by the wider economic and political climate; both have been recently favourable to tackling health inequalities.

First, the machinery of government is ill-equipped to deal with cross-cutting issues like health inequalities. The Treasury's cross-cutting reviews and joint units are positive developments but questions of accountability and scrutiny are inevitably raised. Joined-up government is still hampered by departmentalism. The careers of ministers and civil servants are still closely tied to departments, for example. Taskforces are introducing external views into the policy-making process but they may be unfamiliar with or detached from policy-making processes.

Second, health inequality targets have been introduced and will be supported by a 'basket' of indicators. Attributing policy interventions to targets will be difficult. Performance management systems for Primary Care Trusts (PCTs) need to be integrated so as to ensure that measures for tackling health inequalities are not overlooked by other PCT objectives.

Third, policy, planning and good practice in tackling health inequalities needs to be integrated into mainstream services. Many initiatives have been one-off projects; the largest benefits are to be gained through influencing mainstream services. However, existing priorities (mainly related to health care modernisation) may undermine this approach.

References

Acheson D (chair) (1998) Independent inquiry into inequalities in health. London, TSO.

Barker A, Byrne I, Veall A (1999) Ruling by taskforce. London, Politico's Publishing.

Birch S (1999) The 39 steps: the mystery of health inequalities in the UK. Health Economics 8: 301-308.

Booth T (1988) Developing policy research. Aldershot, Gower.

Brown AD (2000) Making sense of inquiry sense-making. Journal of Management Studies 37: 45-76.

Davey-Smith G, Morris JN, Shaw M (1998) The independent inquiry into inequalities in health. British Medical Journal 317: 1465-1466.

Davies HTO, Nutley S, Smith PC (2000) What works? Bristol, Policy Press.

Department of Health (1998a) Government committed to greatest ever reduction in health inequalities says Dobson. Press release 98/547. London, DoH.

Department of Health (1998b) Our healthier nation. London, TSO.

Department of Health (1999) Saving lives: our healthier nation. London, TSO.

Department of Health (2001) From vision to reality. London, TSO.

Exworthy M (2002) The 'second Black Report'? The Acheson Report as another opportunity to tackle health inequalities. In: Berridge V, Blume S (2002) Poor health. London, Frank Cass.

Illsley R (1999) Reducing health inequalities: Britain's latest attempt. Health Affairs 18: 45-46.

Klein R (2000) From evidence-based medicine to evidence-based policy? Journal of Health Services Research and Policy 5: 65-66.

Macintyre S (1999) Reducing health inequalities: an action report. Critical Public Health 9: 347-350.

Macintyre S, Chalmers I, Horton R, Smith R (2001) Using evidence to inform policy: case-study. British Medical Journal 322: 222-225.

Marmot M (1999) Acting on the evidence to reduce inequalities in health. Health Affairs 18: 42-44.

Mayor S (1998) UK report calls for policies to halt growing inequalities in health. British Medical Journal 317: 1471.

Oliver A (2001) Why care about health inequalities? London: Office for Health Economics.

Williams A (1999) Commentary on the Acheson Report. Health Economics 8: 297-299.

EVALUATING THE EVIDENCE ON MEASURES TO REDUCE INEQUALITIES IN HEALTH

Sally Macintyre
MRC Social and Public Health Sciences Unit

In 1997 I was asked by Sir Donald Acheson, chair of the independent inquiry into inequalities in health (Acheson 1998), to chair a group to:

"Examine the quality of the evidence underpinning the scientific advisory group's emerging recommendations, and to identify any gaps."

The conclusions of this group, which reported to Sir Donald in 1998, were that whereas there were lots of data documenting health inequalities, and lots of research attempting to explain health inequalities, there was relatively little information about the effectiveness of interventions, and even less information available about potential harms, costs, or priorities. What evidence that there was about effectiveness tended to be clearer for downstream, individually focused, interventions than for more upstream, population or community level, interventions (Macintyre *et al*., 2001). A recently published overview of policies to reduce inequalities in health in Europe also found that for many of the domains studied (for example, work policies, food policies, smoking, children, and access to health care) there was "little direct evidence that permits any definitive judgements" (Mackenbach and Bakker, 2002).

Given that socio-economic inequalities in health have been a major topic for health social sciences and public health researchers in the UK and many other countries in Europe since the publication of the Black Report in 1980 (DHSS 1980), the paucity of evidence about the effectiveness of interventions to reduce inequalities may seem surprising. In this paper I will speculate about the reasons for this lack of evidence.

Firstly, as I have argued elsewhere, following on the Black Report and the incoming Conservative government's rejection of its recommendations, much of the energy of inequalities researchers was taken up with arguing about the relative importance of a series of polarities: between artefact, selection, behavioural, and material explanations; between early life/critical stages models versus life course models of the generation of inequalities in health; and between material and psychosocial explanations (Macintyre, 1997; Macintyre, 2002). Arguments about the underlying explanations for inequalities in health were important because the type of strategy one adopts for reducing inequalities will depend on one's underlying model: for example, focusing exclusively on adolescent girls and young children if one takes an early life perspective, compared to focusing also on material circumstances and environments (income, housing, employment etc.) in adult life if one takes a life course perspective. However, bickering about the causes of socio-economic inequalities in health tended to divert attention away from conducting robust, empirical studies of the best means for reducing them. Furthermore, for many in this research field there was a perceived need to continually demonstrate the existence and magnitude of inequalities in health in the face of disbelief among politicians and the public.

Secondly, there is, perhaps surprisingly, a lack of good routine data with which to monitor inequalities in health and to assess whether they are decreasing or increasing. National data on social class or area deprivation are only available every ten years with the decennial national census. Thus, although it is possible between censuses to examine changes in mortality rates, any analysis by social class is only possible in the few years around a census. Many surveys which include health data are not large enough, or do not have a long enough time series, to assess trends in inequalities in health. Data on occupational social class, or other markers of social position such as ethnicity, are not routinely collected in NHS records. Many intervention studies, for example the recent randomised controlled trial of antioxidant vitamin supplementation in order to reduce the risks of heart disease and cancer, do not report whether or not there are differential effects by social class (Heart Protection Study Collaborative Group, 2002) (and indeed such studies are often underpowered to examine the existence of such differential effects).

Thirdly, although the incoming Labour government elected in 1997 stated that reducing inequalities in health was an overarching goal, this rhetoric was not always matched by a well argued or monitored strategy for doing this. In the case of the 1999 Scottish White Paper on public health, although great stress was given to the importance of reducing health inequalities, the priority topics and targets were all defined in terms of aggregate rates of health behaviours (e.g. smoking) or of ill health (e.g. deaths from coronary heart disease) (Scottish Office, 1999). Perhaps because all governments, particularly newly elected ones, need to be seen to be 'doing something now', much of the government focus was on inputs or throughputs rather than outcomes or effectiveness. For example, the government response to the Acheson report listed the amount of money being spent on a number of policies and programmes which might conceivably reduce inequalities in health, but without any information about whether they were doing so, or about the basis on which it was known that they would do so (Department of Health, 1999; Macintyre, 1999).

Fourthly, there is a considerable antipathy among public health and health promotion practitioners to what is often described, dismissively, as the 'biomedical model'. Rather than being seen as honest attempts to reduce biases (including one's own), iron out noise, and facilitate valid causal inferences, techniques such as randomised controlled trials and systematic reviews are seen as emanating from a powerful and dominant clinical medicine oligarchy who are unsympathetic to qualitative research, participative democracy, or the views of patients. As Ann Oakley and others have pointed out, however, the approach of applying controlled experimental approaches in the real social world did not initially stem from clinical medicine (Oakley, 1998; 2000) (indeed clinical medicine has been slow and reluctant to take on such techniques, preferring to rely in many cases on clinical experience, anecdote or received wisdom, rather than on approaches which attempt to reduce observer bias). The fact that some medics will dismiss claims from health promotion researchers or activists unless based on randomised controlled trials does not necessarily mean that the principles of randomised controlled trials are not valid, or that they cannot be applied to social interventions.

Fifthly, another characteristic of health promotion and public health researchers in the UK is that they are often antipathetic to the evaluation of *outcomes* (as compared to inputs or processes). In a recent review of public health intervention research, the Health Development Agency found that of published or funded public health research in the UK, only 4% dealt with interventions rather than descriptions of the problem. Only around 10% of these, i.e. 0.4% of the total, focused on the outcomes of interventions rather than processes. The review also found that in specific topic areas the evidence about inequalities, and tools for capturing social differences, were not very robust, and that very few systematic reviews of interventions have focused on the effect of interventions on *inequalities in health*, rather than on *aggregate health outcomes* (Milward *et al.*, 2001).

The antipathy to outcome evaluation seems to arise from several sources. One is that projects or programmes may be set up with particular goals, but these goals in themselves may shift, and therefore examining the original objectives may be seen as inappropriate. Related to this 'mission drift' is 'evaluation drift'. For example, if one asks whether the healthy cities programme has made anyone healthier, or whether a teenage pregnancy reduction programme has reduced teenage pregnancies, one can be told that 'that's not the right question'. Often activists and health promoters are committed to particular approaches and therefore believe it to be obvious that this approach will work (in this regard it may well be the case that they are not the best people to evaluate the outcomes of their programmes, in the same way that advocates of particular surgical procedures or drug therapies are not the best people to assess the efficacy or cost effectiveness of their innovations). Proponents of particular programmes may be worried that an outcome evaluation will not show their programmes to be cost-effective, and may therefore prefer to rely on an analysis of processes or capturing the views of participants. Unlike in surgery or pharmacology, there is also a reluctance to believe that well-intentioned programmes may do harm as well as good.

The problem is that process evaluation may give a different picture to an outcome evaluation, and the fact that participants like a programme does not necessarily mean that it meets its original goals. A well-known example is that of the Scared Straight programme in the United States. In this programme, at risk or delinquent children were brought into prison to meet prisoners who try to deter them from a life of crime. Inmates, juvenile participants, parents, corrections personnel, teachers, and the general public were positive about this programme and thought the programme was doing good. However, of seven randomised controlled trials identified in a recent review, all found that the programme increased the proportion of the treatment group compared to the no treatment group committing new offences (Petrosino *et al*., 2000). In relation to inequalities in health, well-intentioned interventions may increase inequalities, and overall improvements in aggregate health behaviours or health may mask increasing differentials between socio-economic groups. However, as the health impact assessment movement has tended to define health impact assessment as trying to anticipate possible harms and benefits of interventions, rather than empirically examining whether these harms or benefits do occur, we know little of the effects of a range of policies or programmes on inequalities in health (Lock, 2000).

What can we do about the lack of clear evidence about the effectiveness and cost-effectiveness of interventions to reduce inequalities in health? Firstly, lack of clear evidence should not be a reason for not trying to act to minimise inequalities in health, using the most plausible mechanisms; however, it is important to examine in as robust a way as possible (and in ways that try to minimise the biases of enthusiasts for the particular policy) whether any such policies do achieve the desired outcomes, whether they also have adverse effects, and what the costs, including opportunity costs, are. Secondly, we should accept that ‘did it work? (and at what cost?)’ is a legitimate question to ask of all policies and programmes whether these be keyhole surgery, hormone replacement therapy, closed-circuit television as a crime prevention strategy[1], or Health Action Zones. Thirdly, we need to demand better data for monitoring trends in inequalities in health in the UK. Although there are difficulties in assigning occupational social class to mothers, the fact that in Scotland the collection of social class data on pregnant women was abandoned in 1995 means that we can no longer examine trends in the social class distribution of perinatal mortality or birthweight. We need better data and we need to call the bluff of governments by saying that if they wish to reduce inequalities in health they have to provide the tools for the robust measurement of inequalities in health. Finally, we should try to take existing studies which examine the effectiveness of a range of policies and programmes in influencing population health, and reanalyse them to study their effects on inequalities in health.

References

Department of Health and Social Security (1980) Inequalities in health. Report of a Working Group chaired by Sir Douglas Black. London, DHSS.

Department of Health (1999) Reducing health inequalities: an action report. London, Department of Health.

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[1] About which there is considerable dispute concerning the reliability of the evidence base, although the Home Office, Welsh Office and many police forces claim it to be highly effective (OST, 2002; Privacy International, 2002).

Heart Protection Study Collaborative Group (2002) MRC/BHF protection study of antioxidant vitamin supplementation in 20536 high-risk individuals: a randomised placebo-controlled trial. The Lancet 360: 23-33.

Lock K (2000) Health impact assessment. British Medical Journal 320: 1395-1398.

Macintyre S (1997) The Black Report and beyond: what are the issues? Social Science & Medicine 44: 723-745.

Macintyre S (1999) Reducing health inequalities: an action report. Critical Public Health 9: 347-350.

Macintyre S, Chalmers I, Horton R, Smith R. (2001) Using evidence to inform health policy: case study. British Medical Journal 322: 222-225.

Mackenbach J, Bakker M (2002) Reducing inequalities in health: a European perspective. London, Routledge.

Macintyre S. Before and after the Black Report: four fallacies. Contemporary British History: Contemporary British History 16: 198-219.

Mackenbach J, Bakker M (2002) Reducing inequalities in health: a European perspective. London, Routledge.

Milward, Kelly, Nutbeam (2001). Public health intervention research: the evidence. London, HDA.

Oakley A (1998) Pubic policy experimentation: lessons from America. Policy Studies 19: 93-114.

Oakley A (2000) A historical perspective on the use of randomised trials in social science settings. Crime and Delinquency 46: 315-329.

OST (2002) http://www.parliament.uk/post/pn175.pdf

Petrosino A, Turpin-Petrosino C, Finchkenauer J (2000) Well-meaning programs can have harmful effects! Lessons from experiments of programs such as scared straight. Crime & Delinquency 46: 354-379.

Privacy International (2002) http://www.privacyinternational.org/issues/ cctv/cctv_faq.html

Scottish Office Department of Health (1999) Towards a healthier Scotland: a White Paper on health. Edinburgh, The Stationery Office.

PRACTICAL ISSUES IN TRANSLATING EVIDENCE INTO POLICY AND PRACTICE

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1. Introduction

This paper examines the practical issues involved in translating evidence on tackling health inequalities into policy and practice using the real life example of Merseyside Health Action Zone (MHAZ). It discusses the tensions between a top down government initiative and local bottom up implementation and the practical implications of working within a "turbulent institutional and policy environment" (Bauld and Judge, 2002). It also questions the relevance of traditional forms of evidence to the evaluation of a complex initiative. It argues for the use of creative, participatory methods to generate and validate evidence from the lived experience of people involved with more innovative interventions where existing evidence may not be available (Springett and Young, 2002) but where 'upstream' action on inequalities is urgently required (Wanless, 2001).

This paper is the result of partnership working on Merseyside, in particular the joint funding of MPhil students working alongside the MHAZ coordination team to evaluate the effectiveness of the MHAZ change process.

2. Practical issues

Health Action Zones (HAZs) come from the tradition of health promotion as defined in the Ottawa Charter (Ottawa Charter, 1986), with an emphasis on a holistic approach to health improvement through strategic, multisectoral partnerships and community participation to modernise services and reduce health inequalities (HAZnet, 2001). HAZs are part of the English public health strategy set out in *Saving Lives: Our Healthier Nation* (DoH, 1999a). They were established to facilitate innovation in tackling the underlying determinants of health, with a focus on the local needs of some of the poorest areas of the country (HAZnet, 2001).

HAZs are a government ‘area based initiative’ (NRU, 2002), the only one accountable to the Department of Health. Twenty-six areas were chosen with a 5-7 year lifespan (HAZnet, 2001). Although the purpose of HAZs was to tackle inequalities and modernise and improve services it also allowed government to inject additional funding into areas of deprivation in acknowledgement of need, until such time as a revised formula for the allocation of NHS health care resources could be developed.

However, HAZs were expected to be more than a source of additional funding. Frank Dobson saw HAZs as a means to generate “systematic change and improvement” in health outcomes (DoH, 1999b, p.1), Powell and Moon (2001) suggest that HAZs were established mainly “to find new ways of organisational working in order to disseminate innovative practice to the national level” (Powell and Moon, 2001, p.48). This immediately suggests a tension not only between the expectations in the purpose of the HAZs, but also in how one might assess the achievements, or otherwise, of their work. Systematic change in health outcomes suggests improvements that can be measured quantitatively, whereas changes in ways of working are more readily assessed through qualitative methods.

This is just one of the many tensions that have characterised the experience of HAZs. Original guidance to areas applying to become a Health Action Zone was attractive. They were ‘trailblazers’ for new ways of working to address longstanding problems (Bauld and Judge, 2002). There were promises of substantial funding, flexibility in how it could be used and permission to take risks and experiment, in order to find out “what works and why” (DoH, 1997). Each HAZ application identified its own local priorities with the Department of Health: consequently there is a wide range in the size of HAZs and the content of their programmes (Bauld and Judge, 2002). However, with a change of minister, the focus became more on NHS priorities and health services. This caused conflict with the earlier bottom up approach, and performance management from the centre focussed on the HAZs contribution to NHS priorities when HAZ programmes had the potential to contribute across government departments.

Merseyside was awarded HAZ status in 1999. As the largest HAZ, with the most complex partnership, it had an ambitious, integrated programme including action on employment, social inclusion, and quality of life, and high ideals for improving health for its most deprived communities (www.mhaz.org.uk, 2002). Health Action Zones have clear underpinning principles – equity; community and staff involvement; whole system, person centred; evidence based approaches; and partnership. The approach on Merseyside has been to embed these principles into the HAZ programme and the work of mainstream partner organisations by raising awareness, facilitation and modelling good practice (Springett and Young, 2002). This has resulted in a strong partnership across 4 health and 5 local authorities (Mackinnon, 2001).

The pragmatic view of the MHAZ partnership has been to scan the political horizon and respond positively to government imperatives whilst continuing to invest in the less high profile, more long term, local priorities such as quality of life for older people. ‘Early wins’ expected by ministers were used as demonstration projects to promote the broad HAZ concept of health and raise awareness of inequalities issues and the role of partner organisations in, for example, transport, community safety and discrimination. This was necessary because government recognition of the links between equity and health was relatively recent, and understanding, particularly within the NHS, was sparse. Locally, high level political support has been maintained through regular progress reports and ongoing involvement.

The effect of the change to NHS priorities in Merseyside was a shift in emphasis. As a second wave HAZ it was easier to predict, and, as cancer, coronary heart disease and mental health were all relevant issues for Merseyside, they had been included in the original programme (Mackinnon, 2002). Champions were identified in the mainstream who took on the role of ‘MHAZ Convenor’, making the best use of MHAZ investment to improve services and achieve national targets whilst ensuring HAZ principles, innovation and added value. This approach was taken with each national service framework policy as it emerged.

One stakeholder respondent to the MHAZ evaluation described the MHAZ experience as a ‘rollercoaster’ (Mackinnon, 2002). There was a need to respond to changes in national imperatives, often within short timescales, whilst making every effort to remain true to the ethos of the local partnership and HAZ principles and maintain a commitment to long term change, in order to make genuine improvements to the health of people on Merseyside.

In addition to policy changes, MHAZ has had to maintain its partnership vision through institutional reorganisation with the formation of Local Strategic Partnerships and the demise of Health Authorities as a result of *Shifting the Balance of Power* (DoH, 2001). Long term planning has also been affected by uncertainty about the continued funding of HAZs. There were indications that funding would cease as early as the end of 2001/02; it was then confirmed very late and for only another year. At the time of writing there is uncertainty about the remaining 3 years of HAZ funding, although the ‘success’ of HAZs in making progress towards their various objectives has been well documented (HAZnet, 2002).

3. Evidence

The debate about what constitutes evidence of effectiveness within the HAZs is one of the issues identified by the National Evaluation of Health Action Zones. The National Evaluation reports to date (Barnes *et al.*, 2001; Bauld *et al.*, 2000; Lawson *et al.*, 2002; Mackinnon *et al.*, 2001; Mackinnon *et al.*, 2002; Bauld and Judge, 2002) have consistently highlighted the frustration felt within HAZs at the heavily centrally driven nature of the programme. Such top-down pressures on the bottom-up processes of HAZs make the assessment of HAZ success problematic. The performance management by the Department of Health has been burdensome, and it is felt this does not accurately reflect the impact that HAZs have had (Lawson *et al.*, 2002). It is perhaps more important to understand the processes involved within HAZs and to use these to influence further policy development (Lawson *et al.*, 2002).

Raphael (2000) uses the categorisations of investigative (quantitative), interactive (qualitative) and critical (reflective) knowledge to argue for differing types of evidence. Investigative knowledge is dominant within the 'evidence-based' paradigm and, he suggests, this is what is traditionally accepted as evidence. However, as health promotion programmes, like HAZ, are as much about processes over time as they are about outcomes (WHO, 1998), a focus mainly on experimental evidence misses some of the complexity and richness of the processes involved (Judge and Bauld, 2001; Labonte, 2001; Raphael, 2000; WHO, 1998; Bauld and Judge, 2002). Investigative methods, such as randomised controlled trials, aim to isolate the effects of an intervention from other compounding factors. With health promotion, this is not usually possible as, over time, there are many policies and programmes that will affect the conditions the programme is aimed at changing (WHO, 1998). For these reasons, it is argued that multiple methods should be used to evaluate health promotion programmes; methods that take into account both the outcomes and processes of an intervention (Bauld *et al.*, 2001; Raphael, 2000; WHO, 1998).

In addition, the innovative nature of HAZ interventions to address inequality has meant that in many cases evidence is sparse or non-existent. HAZs have encouraged 'learning by doing' (Dabbs, 2002) in order to generate evidence from practice through ongoing evaluation (Mackinnon, 2002; Bauld and Judge, 2002).

Evaluation underpins the programme and processes within Merseyside HAZ and includes the co-ordination of various elements. The aim is to ensure that the evaluation generates knowledge for use locally as well as at national policy level, and contributes to sustainable learning systems (Springett and Young, 2002). MHAZ is an integrated case-study site for the national evaluation which aims to gain an understanding of the process of change at a strategic level, including a focus on visions and goals, and measuring progress (Bauld and Judge, 2002). The quantitative elements of the MHAZ goals and outcomes have been measured through a joint Merseyside Public Health Annual Report. The Department of Health performance management framework has been integrated into local monitoring of the 350 plus MHAZ interventions to record progress with respect to milestones and performance against a variety of national and local indicators and targets depending on the nature of the intervention. This is supplemented by qualitative information (Cropper, 2001). In order to facilitate people delivering the MHAZ programme in articulating and recording the learning from their intervention, an evaluation training programme is in place at all levels of the MHAZ from strategic level to community level. This uses a theory of change model used in the national evaluation of HAZs (Bauld and Judge, 2002) adapted for use as a tool within a participatory evaluation process (Springett and Young, 2002). MHAZ uses creative approaches to engage the diverse elements of its partnership, including communities and socially excluded groups. It encourages the use of multiple media including stories, pictures, video, diaries and celebration events to overcome barriers to participation and the recording of data. This has proved to be effective in demystifying and promoting evaluation as an everyday tool for project management. It has also helped to create a learning environment spanning a wide range of organisations.

Despite the challenges they have faced, HAZs have continued to be at the forefront of attempts to modernise health services and to reduce health inequalities (Bauld and Judge, 2002). From the point of view of Department of Health performance management, most have achieved 'green light' status. Although it is too early to show long term changes in improving health, the evidence of HAZ 'success' in mobilising partners to address inequality is not in question.

4. Conclusion

The question, then, is not only what constitutes evidence, but what evidence is acceptable to the policy makers (who also make funding decisions). This depends on the ideological position of the policy makers, and from where the evidence originates (Bryant, 2002). Although investigative knowledge is preferred, interactive and critical knowledge may be well received as evidence, as long as it does not challenge dominant ideology (Bryant, 2002; North, 2000). Evidence from 'deprived' areas may not be acceptable to policy makers (Bryant, 2002), and yet the experiences and values of such communities may differ from the expectations of researchers and policy makers (Dockery *et al.*, 2001; North, 2000; Richardson and Le Grand, 2002).

There is also a question about whether an initiative like HAZ is in a position to reverse health inequalities. Much of the edited volume, *Promoting Health: Politics and Practice* (Adams *et al.*, 2002), argues that structural factors, such as local, national and international fiscal policies that exacerbate poverty and inequality, have the greatest impact on health. Area and community based programmes may make small changes in those areas, but there also needs to be action at the national and international level to address the structural determinants of health (Duggan, 2002; Russell, 2002).

If national HAZ funding ceases and continued action on health inequality falls to the emerging Primary Care Trusts, the learning from HAZs will become their legacy. Some argue that the success of action to improve the health of excluded populations lies with sympathetic individuals within statutory organisations (Dockery *et al.*, 2001; Adams and Cunning, 2002; Bryant, 2002). If this is the case, the Merseyside HAZ legacy will include not only practical evaluated examples of action on inequalities, but a complex network of individuals who have a raised awareness of inequality and have links with other like-minded individuals who are in positions of power and responsibility.

References

Adams L, Amos M, Munro J (2002) Promoting health: politics and practice. London, Sage Publications.

Adams L, Cunning F (2002) Promoting social and community development in Sheffield: a reflection of ten years work. In: Adams L, Amos M, Munro J (2002) Promoting health: politics and practice. London, Sage Publications.

Barnes M, Sullivan H, Matka E (2001) Building capacity for collaboration: the national evaluation of health action zones context, strategy and capacity. Initial findings from the strategic level analysis. HAZ strategic overview report. The National Evaluation of Health Action Zones. Birmingham, University of Birmingham.

Bauld L, Judge K (2002) Learning from health action zones. Aeneas.

Bauld L, Judge K, Lawson L, Mackenzie M, Mackinnon J, Truman J (2000) Health action zones in transition: progress in 2000. The national evaluation of health action zones. Glasgow, University of Glasgow.

Bauld L, Mackinnon J, Judge K (2001) Community health initiatives: recent policy developments and the emerging evidence base. Report submitted to the Department of Transport, Local Government and the Regions. Glasgow, Health Promotion Policy Unit, University of Glasgow.

Bryant T (2002) Role of knowledge in public health and health promotion policy change. Health Promotion International 17: 89-98.

Dabbs C (2002) Taking the risk to blossom: the Salford social entrepreneurs programme. In: Bauld L, Judge K (2002) Learning from health action zones. Aeneas.

Dockery G, Barry L, Hedley E (2001) Community participation in health: how does it work? In: Martineau T, Price J, Cole R (2001) Health by the people: a celebration of the life of Ken Newell. Proceedings of a colloquium held on 23rd and 24th March 2000. Liverpool, Liverpool School of Tropical Medicine, pp.79-86.

DoH (1997) Health action zones: invitation to bid. EC (97) 65, 30th October, Leeds.

DoH (1999a) Saving lives: our healthier nation. London, Department of Health. Available at: http://www.doh.gov.uk/ohn.htm

DoH (1999b) Health action zones must bring change. Press release 1999/0182. London, Department of Health. Available at: http://tap.ukwebhost.eds.com/doh/Intpress.nsf/page/1999-0182?OpenDocument

DoH (2001) Shifting the balance of power. London, Department of Health.

Duggan M (2002) Social exclusion, discrimination and the promotion of health. In: Adams L, Amos M, Munro J (2002) Promoting health: politics and practice. London, Sage Publications.

HAZnet (2001) Background. Available at: http://www.haznet.org.uk/hazs/background/background.asp.

Judge K, Bauld L (2001) Strong theory, flexible methods: evaluating complex community-based initiatives. Critical Public Health 11: 19-38.

Labonte R (2001) Health promotion in the 21st Century: celebrating the ordinary. Health Promotion Journal of Australia 12. Available at: http://vhpax.vichealth.vic.gov.au/hpja/previous/2001_2/03.html

Lawson L, Mackenzie M, Mackinnon J, Meth F, Truman J (2002) Health action zones: integrated case studies – preliminary findings from fieldwork in Spring 2001. Glasgow, Health Promotion Policy Unit, University of Glasgow.

Mackinnon J, Bauld L, Judge K, Lawson L (2001) Monitoring interviews: Autumn 2001. Summary report. National evaluation of health action zones. Glasgow, Health Promotion Policy Unit, University of Glasgow.

Mackinnon J (2002) National evaluation of health action zones. Merseyside HAZ: a case study. Glasgow, Health Promotion Policy Unit, University of Glasgow.

Neighbourhood Renewal Unit (NRU) (2002) Collaboration and coordination in area based initiatives.

North P (2000) Is there space for organisation from below within the UK government's action zones? A test of 'collaborative planning. Urban Studies 37: 1261-1278.

Ottawa Charter (1986) The Ottawa charter for health promotion. First international conference on health promotion. Ottawa, Canada, 17-21 November, 1986. Available at: http://www.who.int/hpr/archive/docs/ottawa.html

Powell M, Moon G (2001) Health action zones: the 'third way' of a new area-based policy? Health and Social Care in the Community 9: 43-50.

Raphael D (2000) The question of evidence in health promotion. Health Promotion International 15: 355-367.

Richardson L, Le Grand J (2002) Outside and insider expertise: the response of residents of deprived neighbourhoods to an academic definition of social exclusion. CASE paper 57. London, Centre for Analysis of Social Exclusion, London School of Economics.

Russell H (2002) Regeneration and health. In: Adams L, Amos M, Munro J (2002) Promoting health: politics and practice. London, Sage Publications.

Springett J, Young A. (2002) Evaluating community-level projects: comparing theories of change and participatory approaches. In: Bauld L, Judge K (2002) Learning from health action zones. Aeneas.

Wanless D (2002) Securing our future health: taking a long-term view: Final report. London, H.M. Treasury.

WHO (1998) Health promotion evaluation: recommendations to policymakers. Report of the WHO European working group on health promotion evaluation. Copenhagen, Denmark, WHO Europe.

IMPLEMENTING POLICIES TO TACKLE HEALTH INEQUALITIES AT LOCAL LEVEL

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1. Introduction

In England, the government has asked primary care trusts (PCTs) to take lead responsibility at a local level for tackling inequalities in health. PCTs, however, are new and immature organisations with a range of responsibilities for commissioning secondary health care and developing primary care. Within PCTs, responsibility for leading on inequalities usually rests with directors of public health and their teams, most of which are newly appointed and face a challenging and wide agenda, ranging from neighbourhood renewal to emergency planning for major incidents. There is national and local recognition that tackling health inequalities is a long-term agenda which will require joined up policy at the centre and effective local multi-agency partnerships. This paper describes one PCT's approach to tackling health inequalities. It is not claimed to be a model of good practice; rather it is offered as a reality check, a case study to examine the strengths and weaknesses of national policy and local implementation.

2. Identifying health inequalities at local level

Bristol North is a PCT of c. 230,000 population covering the northern and eastern half of the city of Bristol. Overall, Bristol is a prosperous city, with a successful local economy characterised by a skilled workforce and low unemployment. Most indicators show health in Bristol North to be similar to that of the nation as a whole. Mortality rates from the major killers such as coronary heart disease and cancer, for example, are about average for England. Within this overall picture, however, there are significant inequalities both in wealth and health. The DETR indices of deprivation show that Bristol North includes some of the wealthiest as well as some of the poorest wards in the country. Westbury-on-Tryme and Henleaze are prosperous and pleasant areas with very low scores on the DETR indices. In Henleaze for example, only 3.7% of children live in families which claim means tested benefits. By contrast, there are inner city wards such as Ashley, Easton and Lawrence Hill and areas of outlying estates like Kingsweston where over half of all children live in families claiming means tested benefits. A range of health indictors show a similar gap in health between the more affluent and poorer wards. There are marked inequalities in health related behaviours (e.g. smoking, breastfeeding, fruit and vegetable consumption), self-assessed health and health outcomes (e.g. low birth weight, premature deaths). There is a gap in male life expectancy of almost five years between the most prosperous quintile of the population (77.8 years) and the most deprived quintile (73.2 years).

3. The national policy context

Since 1997 the PCT and its predecessor organisations have sought to respond to and implement government policies to tackle inequalities in health. From a PCT perspective, these policies can usefully be divided into those which offer specific guidance to the health sector, and those which convey broader government policy on tackling inequality and social exclusion. The more health specific policies are included in:

- *Independent Inquiry into Inequalities in Health* (Acheson Report) (Stationary Office, 1998);
- *Saving Lives: Our Healthier Nation* (Secretary of State for Health, 1999);
- *The NHS Plan* (Department of Health, 2000);
- *Shifting the Balance of Power* (Department of Health, 2001);
- *Tackling Health Inequalities: Consultation on a Plan for Delivery* (Department of Health, 2001).

Wider government policy on inequality and social exclusion implemented locally in Bristol North include:

- Local strategic partnership;
- Neighbourhood renewal (eight priority areas);
- Sure Start (two in Bristol North);
- Education action zone;
- New Deal for Communities (Barton Hill).

4. Local implementation

The local implementation of policy on tackling health inequalities was profoundly influenced by the NHS organisational change following publication of *Shifting the Balance of Power* in 2001. Bristol North PCT came into being on 1 April 2002; during the year 2001-

2002 the predecessor health authority worked to disaggregate a number of functions, including public health, which had formal responsibility for leading on tackling health inequalities. A public health specialist was seconded to the then Bristol North primary care group (PCG) and led the development of a *Strategy for Reducing Inequalities in Bristol North*, published in November 2001. The strategy was structured around the Acheson report recommendations; it recognised that most of the determinants of health lie outside the direct influence of the NHS and that effectively tackling health inequalities requires broad partnership working. At the same time, the strategy also emphasises the need to change ways of working within the PCT.

In terms of partnership working on inequalities, 2001-02 was also a transitional year in the establishment of a new local strategic partnership for Bristol. During this year the new Bristol Partnership worked to establish itself and rationalise the wide range of existing partnerships and partnership initiatives, which include:

- Bristol Partnership (the local strategic partnership responsible for producing the community strategy);
- Bristol Regeneration Partnership (pre-existing partnership responsible for managing regeneration funding);
- Bristol Neighbourhood Renewal Strategy (with 10 priority areas, 8 in Bristol North);
- Bristol Community Safety Partnership (crime and disorder);
- Bristol Health and Social Care Partnership (responsible for the Health Improvement and Modernisation Plan);
- Bristol Drug Action Team;
- Avonsafe Injury Prevention Alliance.

In practical terms the PCT and its staff contributed to this wide ranging partnership agenda at both a strategic and operational level. For example, the PCT both contributed senior officer time to the Bristol Partnership and the various community strategy working groups, and its community health development staff worked at grassroots levels with communities and local workers. Often this continued work in areas of deprivation where health promotion staff had been active for years, but which had only recently been labelled neighbourhood renewal areas and so attracted additional funding.

Within the PCT, the strategy for reducing inequalities proposed a number of new structures which were agreed by the Board. These included:

- Health equalities strategy group;
- Directorate of Community Development and Public Health;
- Inequalities ‘filter’ on all Board papers and strategies;
- Inequalities audit of PCT programmes;

- Development of local inequality targets;
- Community development secondments;
- Inequalities budget.

A number of specific (but small scale) initiatives on health inequalities were funded either from the PCTs ring fenced inequalities budget or from neighbourhood renewal funds. These include:

- Black residents access project;
- Breastfeeding initiative;
- Clean air for kids (tackling environment tobacco smoke);
- Criminal justice workers – drug services;
- Specialist health visitor – infant mental health;
- Lifeskills training for year 6 children;
- Welfare advice in primary care.

5. Barriers to implementation

Despite commitment and support for action on inequalities at Board level and within the senior management team, a number of barriers to local implementation of policy on health inequalities have been encountered. An important contextual factor has been the large and recurring financial deficit inherited by the PCT from its predecessor health authority. This has highlighted the priority given to achieving financial balance and access (e.g. waiting time) targets within NHS performance management. The centre has made it clear that these are NHS 'must do's' while other policy objectives including tackling health inequalities are effectively lower priority. This relative de-prioritisation of tackling health inequalities was illustrated in the recent Service and Financial Framework (SaFF) process for the Bristol area health community, where proposals relating to tackling inequalities were not funded while access initiatives were. Moreover, despite the government's clear intention to engage in 'joined up' policy making to tackle inequality and social exclusion across the public sector (e.g. Sure Start, neighbourhood renewal), there are still many examples of centrally driven policies which discouraged effective partnership working on health inequalities at a local level. The drive for improved educational attainment in schools, for example, has understandably focused the Local Education Authority and schools on academic performance, but has not encouraged them to engage in local partnerships to tackle the wider determinants of inequality and social exclusion. The local strategic partnership is the obvious forum to address such issues locally, but it is still in an early developmental stage. To date the Bristol Partnership has led to additional strategic groups and meetings rather than a rationalisation of the plethora of existing partnership structures.

Although the PCT welcomed the setting of national targets on reducing inequalities in health, there is some difficulty in using them operationally. The evidence base is still not clear on what local interventions are most likely to help us to achieve the targets, and we are still awaiting the national basket of indicators to help us monitor progress on the targets. Infant mortality is fortunately rather rare, so at a local level it is not a sensitive indicator of progress. We particularly lack models of good practice in 'bending mainstream services', a key element in government thinking on tackling inequality. If Sure Start is, as it appears, an effective evidence-based approached to multi-agency action to tackle inequality by giving children in deprived communities a good start in life, then we need to roll it out across our communities not just in our two tightly bounded Bristol North Sure Start areas. But there appear to be many barriers to doing this, including the challenging financial context and local workforce shortages in key agencies. Similarly, neighbourhood renewal funding is intended to be used to bend mainstream services, but the evidence to date suggests that this is difficult to achieve in practice. Finally, within the PCT, action on inequalities has been hampered by the degree of disruption to the public health function by organisational change over the last year, and a reduction in the public health workforce.

6. Next steps

There are a number of things the PCT can do to further develop and implement its strategy to reduce health inequalities. We need to continue to work with partners to make the national targets meaningful locally, and set achievable local objectives and milestones. Our community health development team has a long record of engaging with local communities but we now need to ensure that the whole organisation involves the community in action on inequalities. Thus we need to develop the skills and involve our wider pubic health workforce in inequalities work, particularly our community practitioners. We need to ensure that tackling inequalities is fully included in our performance management framework and that we actively monitor and manage performance in this area. We need to contribute to making the Bristol Partnership a vibrant and action orientated forum for partnership work on tackling inequalities, and rationalise the many existing local partnership structures. Finally, we need to improve our knowledge management support so that practitioners have the skills to access the evidence-base on inequalities and that the evidence is available in accessible forms.

7. The role of the centre

Although there is much we can and will do locally, further progress on tackling health inequalities will be highly dependent on how well the centre responds to needs which we and others have expressed in the consultation on the national plan for delivery. We need more joined up thinking at the centre. If the government is serious about tackling inequalities in health, then it needs to send this message through the NHS resource allocation and performance management systems, as well as through the drivers in other public sectors. The centre needs to provide more leadership in the development of the wider public health workforce, and to develop and disseminate the evidence-base on effective local interventions. Finally, and most fundamentally, we must recognise that despite our best efforts locally, the biggest impact on local inequalities in health will come from broader central macro-economic policy. As George Davey Smith and colleagues (1999) have said 'ending poverty is the key to ending inequalities in health.' Tackling inequalities in health will remain a priority in Bristol North, and we will try to do more and work more effectively, but effective central government action on poverty remains the key action to make the most difference locally.

References

Davey Smith G, Dorling D, Gordon D, Shaw M (1999) The widening health gap: what are the solutions? Critical Public Health 9: 151-170.

Department of Health (2000) The NHS Plan: A plan for investment, a plan for Reform. London, The Stationary Office.

Department of Health (2001) Tackling health inequalities: consultation on a plan for delivery. London, Department of Health.

Department of Health (2001) Shifting the balance of power. London, Department of Health.

Secretary of State for Health (1999) Saving lives: our healthier nation. Cm 4386. London, The Stationery Office.

The Stationery Office (1998) Independent inquiry into inequalities in health. London, The Stationery Office.

TACKLING HEALTH INEQUALITIES IN THE UK: WHAT IS THE GOVERNMENT DOING?

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1. Background and policy context

Soon after being elected in 1997 the Blair Government commissioned an Independent Inquiry into Inequalities in Health, chaired by the former Chief Medical Officer, Sir Donald Acheson. The Report of this inquiry was published in 1998 (http://www. official-documents.co.uk/document/doh/ih/contents.htm).

The Acheson Inquiry examined the determinants of health using the 'layers of influence' model first proposed by Dahlgren and Whitehead (1991). *The Report* made 39 recommendations and provided policy directions to tackle health inequalities. It recognised that tackling health inequalities would require actions to address all of the 'layers of influence', as well as ensuring that access and utilisation of health services improves among those who had previously been under-served. Two key policy papers have framed the government's response to these challenges.

The Saving Lives – Our Healthier Nation White Paper (DoH, 1999) was published in 1999 and set out a programme to save lives, promote healthier living and reduce inequality in health. It advocated co-operative effort across government to tackle the determinants of health inequalities, and recognised that sustainable action will come from government working in partnerships with local communities and individuals.

The NHS Plan (DoH, 2000) was published in 2000 and provides a blueprint for the reform of the NHS. *The Plan* emphasised the importance of tackling health inequalities in a context of considerable extra public investment directed towards improving and modernising the

National Health Service (NHS). It gives particular emphasis to reducing inequalities in access to NHS services, especially primary care, as well as emphasising the need to improve child health, and on a population basis, to improve nutrition and reduce smoking. Although primarily focussed on the NHS, *The Plan* overtly recognised the need for the NHS to work in partnership with other public services and agencies to tackle the underlying causes of ill-health and inequalities.

2. Targets to reduce health inequalities

The Government gave a commitment in *The NHS Plan* to establish national health inequalities targets which would narrow the gap in health status in childhood and throughout life, between socio-economic groups, and between different areas in the country. These were originally announced in February 2001, and are now included as part of the 2002 Spending Review Public Service Agreement (PSA) for the Department of Health in the following form:

By 2010 reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth.[1]

International comparisons indicate that there is substantial scope for improvement on both life expectancy and infant mortality. Both targets aim to narrow the gap between those with poor health status and the population as a whole, a gap that is generally widening. Achievement of the targets is not only about saving lives overall, but is about ensuring that a higher proportion of the gains are made by those in poorer circumstances. It focuses attention on the *distribution of health benefit*, rather than simply on overall health outcomes from the provision of programmes and services.

Improvements in life expectancy will be achieved through a very wide range of actions. The *Saving Lives* White Paper emphasised the need for action to tackle some of the well-established risks for the ‘big killers’ – cancer and coronary heart disease (CHD). This includes reducing smoking, improved diet and weight control, better detection and management of hypertension, effective screening services, and improved access to high quality treatment, alongside action directed at the determinants of health highlighted in the *Acheson Report*. Death rates for CHD and cancer in the UK remain unacceptably high overall and reflect substantial geographical, social class and ethnic group differences.

The purpose of the infant mortality target is to galvanise a wide range of actions to improve the health of mothers and their children. These include reducing teenage pregnancies, improving access to high quality ante-natal care, efforts to reduce smoking and improve nutrition during pregnancy and early childhood years, and effective early childhood support.

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1. These targets being in detail:
   A. Starting with children under one year, by 2010 to reduce by at least 10 per cent the gap in mortality between routine and manual groups and the population as a whole.
   B. Starting with local authorities, by 2010 to reduce by at least 10 per cent the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole.

3. Action across government to reduce health inequalities

The ambitious targets set by the UK Government will only be met if all parts of government act in a coherent way to address the underlying determinants of health and health inequalities. Significant actions have already been taken across government in the past five years. These include:

- **Tackling poverty and low income:** for example, by increasing the national minimum wage and by reforming tax credit and welfare payments. This has led to a redistribution of wealth that has raised the income of poorest families (Myck, 2001).
- **Improving educational and employment opportunities:** for example, by substantial public investment in New Deal programmes to assist people into work (especially young people and the long-term unemployed), in school education, and in extending opportunities for lifelong learning.
- **Rebuilding local communities:** for example, through the Strategy for Neighbourhood Renewal (http://www.cabinet-office.gov.uk/seu/published.htm, http://www.neighbouhood.dtlr.gov.uk), and the promotion of local strategic partnerships between local government, non-government organisations and the NHS.
- **Supporting vulnerable individuals and families:** for example, by improving the coverage of Sure Start programmes (http://www.surestart.gov.uk), introducing a Fuel Poverty Strategy (http://dti.gov.uk/energy/fuelpoverty/index.htm), and programmes to support the socially excluded.

To better co-ordinate and further support action across the different government departments, the government established a Cross-Cutting Spending Review focussed on health inequalities. This presented a unique opportunity to provide coherence and direction to the range of government services and programmes that have the potential to reduce health inequalities. As the name implies, the review examined government spending across departments to consider the distribution of benefit to health of a range of government programmes in education, welfare, criminal justice, environment, transport and local government.

The report from this review was used by these departments to inform their spending plans for the 2003-6 period, and will lead to binding commitments to take action as a part of a cross-government delivery plan to reduce health inequalities, due to be published late-Autumn 2002. The report grouped the findings of the review into five themes as follows:

- **Breaking the cycle of health inequalities** – addressing poverty, especially in families with children, supporting a healthy pregnancy, and early childhood development (Sure Start), and educational interventions to close the attainment gap.
- **Tackling the major killers** – addressing the social gradient in modifiable behavioural and physiological risks, and in treatment service provision.
- **Improving access to public services and facilities** – addressing the inverse care and provision ‘law’, especially in relation to primary care, and public transport.

- **Strengthening disadvantaged communities** – working ‘with the grain’ of neighbourhood renewal, and regeneration strategies – improving housing, creating a safe environment, engaging public services in employment and education.
- **Reaching vulnerable groups** – working ‘with the grain’ of social exclusion strategies to address the needs of the ‘fuel poor’, the mentally ill, rough sleepers, and prisoners and their families.

4. Consultation on a plan for delivery

A further commitment from the NHS Plan was to consult on the wide range of actions that might be taken by government, communities and individuals to address the causes of health inequalities. In parallel with the cross-cutting review, the Department of Health conducted a public consultation through the document *Tackling Health Inequalities* (DoH, 2001). This focused on identifying working examples of successful programmes to tackle the causes and effects of health inequalities – to improve our understanding of *how* to take practical action in local communities to address the determinants of health and inequalities. The results of this consultation have recently been published (DoH, 2002).

5. Setting in place a system for delivery

A major focus for subsequent work is on developing systems and structures that will protect and support existing good practice, extend the reach and impact on health inequalities of existing programmes and services, and oversee the implementation of the future commitments that emerge from the cross-government delivery plan.

The delivery plan will be structured around the long-term targets (above) to reduce the gap in health status between social groups and geographical areas and will be published in late Autumn 2002. The Plan will be underpinned by short to medium term ‘milestones’ drawn from a cross-government ‘basket of indicators’. These milestones and indicators will be used to monitor progress, and will inform the future allocation of funding and assessment/management of performance in both the NHS, and in local government through Local Public Service Agreements (LPSAs).

6. Concluding remarks

Much progress has been made in getting the policies right, and aligned in a way that will produce a powerful cross-government effort to address health inequalities.

The *Acheson Report*, the *Saving Lives* White Paper and *The NHS Plan* provide a substantial analysis of the problem, and provide the policy context for the response. The consultation on a plan for delivery provided information on front-line practitioner experience to add to this existing evidence. The cross-government spending review has sought to bring comprehensiveness and coherence – backed by resource commitments. The current finalisation of the delivery plan will specify what needs to be achieved, and who will be responsible for delivery.

Success is most likely with strategies that connect health care reforms with the wider set of UK public sector reforms and in doing so address the underlying determinants of health inequalities. Great attention will need to be given to sustaining current interest and commitment as we build capacity for effective action at the local level.

References

Dahlgren G, Whitehead M (1991) Policies and strategies to promote social equity in health. Stockholm, Institute of Futures Studies.

Department of Health (1999) Saving lives – our healthier nation. London, Department of Health. Available at: http://www.doh.gov.uk/ohn.htm

Department of Health (2000) The NHS Plan. London, Department of Health. Available at: http://www.dohdoh.gov.uk/nhsplan

Department of Health (2001) Tackling health inequalities: consultation on a plan for delivery. London, Department of Health. Available at: http://www.doh.gov.uk/healthinequalities

Department of Health (2002) Tackling health inequalities: the results of the consultation exercise. London, Department of Health. Available at: http://www.doh.gov.uk/healthinequalities

Myck M (2001) Briefing notes: fiscal reforms since May 1997. London, Institute for Fiscal Studies. Available at: http://www.ifs.org.uk/taxben/fiscalreform

JOINING UP THE 'BIG WINDOWS AND LITTLE WINDOWS' OF IMPLEMENTATION

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1. Introduction

There has been much debate in implementation research between the 'top-down' and 'bottom-up' perspectives. Many traditional implementation studies assume a 'top-down' perspective, where orders are transmitted down a hierarchy (see, for example, Parsons, 1995). One of the main criticisms of those who prefer the bottom-up approach was that central policy makers did not tend to set clear and explicit goals. With its pledge cards, manifesto commitments, Annual Reports, Public Service Agreements, and Performance Assessment Frameworks, New Labour has no shortage of central goals, and in this way, the 'top-down' perspective might be very relevant for the current government. However, in another way, it is too simplistic as it tends to focus on the vertical link or 'silo' between one central department and a peripheral agency. With the current emphasis on the horizontal dimension of partnership and joined-up government (Glendinning *et al*., 2002), implementing policies to solve 'wicked problems' is more complex.

This paper attempts to examine the implementation of health inequalities policy in the context of a model of policy streams (Powell and Exworthy, 2001). It argues that successful implementation is more likely to occur when the three policy streams are aligned across the three dimensions of the (traditional) vertical national-local dimension, and the horizontal dimensions of both central-central (joined-up government at the centre) and local-local (joined-up governance at the periphery). The model is illustrated with data drawn from a project that uses questionnaire and interview data (Exworthy *et al*., 2000).

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2. Equity and partnership in health policy

Commentators on Labour's health policy are generally agreed that equity or fairness is seen as an important goal (e.g. Paton, 1999; Acheson, 1998; Shaw *et al.*, 1999; Bull and Hamer, 2001), and there is an emphasis on mechanisms of partnership and co-operation as an essential ingredient in 'joined-up government' (Paton, 1999; Hudson, 1999; Exworthy *et al.*, 1999). In other words, equity is an important end, and partnership is an important means of New Labour's health policy.

2.1. Health inequalities agenda

One aim of the 'new NHS' (DoH, 1997) was to renew the NHS as a genuinely national or 'one nation' service characterised by 'fair access' to services, replacing the unfairness, 'unacceptable variations' and 'two-tierism' of the internal market. The Green and White Papers on public health (DoH, 1998a; 1999) sought to improve the health of the population as a whole *and* also to improve the health of the worst off in society thereby narrowing the health gap. The NHS Plan (2000) points again to unacceptable variations and a lack of national standards. It argues that "no injustice is greater than the inequalities in health which scar our nation" and that a national inequalities target will be set "for the first time ever." The two national health inequalities targets address health outcomes in terms of infant mortality and life expectancy (DoH, 20001b). "Action on health inequalities was a feature of the first term and is a key priority of the second term of the Government" (DoH, 2001a: p.16).

2.2. Partnership agenda

The White Paper, *A New NHS* (DoH, 1997) regarded the third way as a "system based on partnership". The Green and White Papers on public health (DoH, 1998a, 1999) stated that "complex problems require joined up solutions" and that "the goals of this health strategy will be achieved only by a joint effort." The NHS Plan (2000) argued that an inability to forge effective partnerships has inhibited the NHS' ability to prevent ill health and tackle health inequalities. "Partnerships and joined-up working with a range of players nationally and locally will be crucial in achieving the health inequalities agenda and achieving the new targets" (DoH, 2001a: p.30). Another document in the same year (DoH, 2001b: p.21) also stressed the necessity of "joining forces to make things happen." In short, the twin themes of equity as an end and joint action as a means are clearly stated: "Action to improve health and to reduce health inequalities requires joined up working across Government and across sectors at national, regional and local levels" (DoH, 2001a: p.17).

3. Big windows and little windows

This section presents a heuristic policy streams model (Powell and Exworthy, 2001). The policy stream is concerned with goals and objectives. The process stream includes issues such as causal, technical and political feasibility. The resource stream deals with

– unsurprisingly – resource adequacy, but not simply financial resources. Human resources including staff time, power, reputation and ownership play crucial roles in organisations and may hamper implementation. In other words, a successful policy is likely to have clear objectives, mechanisms that achieve those objectives, and resources to fund them.

3.1. The vertical dimension

The vertical dimension, linking the centre with local agencies, is the traditional focus of interest of implementation studies. The policy stream focuses on whether objectives are clearly stated, and whether they are successfully transmitted to local levels. As shown above, Labour's policy documents revealed two objectives: 'fair access' within the NHS and reducing the health gap. However, the precise operationalisation of each remains unclear. Moreover, as with other organisations, the goals that the NHS pursues are invariably multiple and often conflict. Policy documents often give no clear indications of opportunity costs and trade-offs between objectives.

The government recognises some of the problems associated with the process stream. Regarding causal and technical feasibility, it has been claimed that "Because the causation is complex and many factors inter-react, it is not possible to set realistic quantified targets for greater health equality at this stage" (DoH, 1998a). Problems of political feasibility are many and manifest. Large scale fiscal redistribution ('tax and spend') from rich to poor is unlikely to feature on policy agendas. Moreover, this potential solution is 'owned' by central rather than local levels.

Turning to the resource stream, resources are not generally ring-fenced within general budgets. In other words, there is no separate vertical 'pipe' carrying resources to local levels. As many agencies have generally static (real) budgets or are in deficit, there exists little organisational slack for policies. It is difficult to transfer money from established interests; in the NHS, treating patients now generally takes priority over the long-term and diffuse benefits of reducing health inequalities.

3.2. Horizontal dimension (i): joined-up government at the centre

Although reducing health inequalities is an issue across all government departments (DoH, 2001a), the notion of 'departmental-itis' at the centre remains an issue. This makes 'joined-up government' and a shared vision at the centre problematic. Central departments with different Performance Assessment Frameworks (PAFs) and Public Service Agreements (PSAs) may issue different orders down vertical 'silos'. However, there has been some progress towards joint PSAs, and the Treasury has assumed greater responsibility for policy co-ordination through the introduction of Cross-Cutting Reviews to inform the Comprehensive Spending Review.

However, interviewees pointed to the 'overwhelming' number of priorities that they were required to tackle (see Exworthy *et al.*, 2002). All priorities were important, but some were seen as more important than others. Interviews were carried out before the introduction of the national health inequalities targets, but informants differentiated between 'hard' and 'soft' targets (cf. Goddard *et al*., 1999; 2000). Health inequalities targets will be long-term and shared between agencies. It is unlikely that these will focus the mind as clearly as waiting lists and financial balance that were regarded as important and immediate. Joint PSAs with their blurred lines of accountability might indicate the possibility blame-shifting.

While the introduction of these targets may have clarified the policy stream somewhat, there are still problems with the process stream. Although some advances have been made (Bull and Hamer, 2001), the evidence base to reduce health inequalities is unclear, with the result that there is little knowledge of which policy levers to pull. There is also the difficulty of attributing changes in health inequalities to specific policies and also the length of time before policy impacts may be observed. Joint PSAs may highlight the task, but the DoH has no direct lever over, for example, the DfES or the DTLR, when attempting to meet their targets.

Centre-centre relations also showed disjunctures in the resource stream. In particular, the lack of coordination between funding cycles hampered efforts to focus on the longer-term agenda which was seen as necessary in tackling health inequalities. Whereas interviewees wanted to establish local initiatives to tackle ingrained problems, their funding was on an annual or sometimes three year cycle, despite the shift of central government policy, to some extent, towards longer term perspectives in recent years.

3.3. Horizontal dimension (ii): joined-up governance at the periphery

There is an extensive literature on the factors that lead to successful partnerships at the local level (e.g. Glendinning *et al*., 2002). Local partners – with different cultures, policy styles, finance structures and modes of accountability – may find it difficult to agree on common goals or a 'shared vision'. At the horizontal level, the government claims that it is important to clarify the common purpose of the partnership (DoH, 1999a; cf. DoH, 1998b). However, it can be argued that this common purpose has been enforced vertically rather than developed horizontally.

The questionnaire survey of local practitioners highlighted a lack of consensus (shared vision) and some systematic differences between local organisations on policy priorities. This was manifest in terms of the desirability and feasibility of objectives. Equal access for equal need and equality of outcome were seen as the most desirable objectives of health inequalities policies, with equal input and equal use as the least desirable. In general equity (responding to need) was seen as more desirable than equality. However, equal input was seen as the most feasible, with equality of outcome seen as one of the least feasible. There was some shared vision regarding equal access for equal need. This is the government's 'gold standard' and it is regarded as both desirable and feasible. However, the government's other stated objective of equal outcomes is regarded as desirable but not feasible.

Conflicts may arise over policy mechanisms such as joint finance and pooled budgets. This may generate problems of accountability. Policy entrepreneurs (Kingdon, 1984) were clearly evident in each case-study area. However, to varying extents, these entrepreneurs became identified with the policy to the extent that others deferred responsibility for health inequalities to them. In short, health inequalities were not seen as a 'core activity' or 'everyone's business' across organisational departments.

Finally, despite pooled budgets local agencies still had incentives to try to shift costs to their local 'partners'. In other words, the resource stream still tended to flow into separate pools. Common pools were small in comparison to mainstream budgets. Human resources in the form of policy entrepreneurs tended to flow towards other posts. For example, on revisiting our three case study sites about a year after the fieldwork had ended, two of the three main policy entrepreneurs had moved on.

4. Conclusions

This paper argues in favour of an analysis of implementation that incorporates two key perspectives. First, there is a need to address the composition and confluence of streams relating to policies, processes and resources. In short, implementation requires clear policy objectives, feasible mechanisms and processes to meet these objectives, and adequate resources to finance them. Second, there is a need to address the spatial levels of implementation. Successful implementation requires a similar confluence of streams at the centre-centre, local-local and central-local (inter-governmental) levels. Together, the streams and spatial levels can be seen as a series of windows. 'Successful' implementation requires the coincidence of 'big' and 'little' windows of streams operating at three spatial levels.

This leads to a rather pessimistic conclusion concerning current health inequalities policy. Although there are some promising signs at central and local levels, the limited confluence of the streams at the centre, at the periphery and in the silos between the centre and the periphery is unlikely to lead to a sea-change in the level of health inequalities.

References

Acheson D (chair) (1998) Independent inquiry into inequalities in health. London, The Stationery Office.

Bull J, Hamer L (2001) Closing the gap: setting targets to reduce health inequalities. London, Health Development Agency.

Department of Health (1997) The new NHS. London, The Stationery Office.

Department of Health (1998a) Our healthier nation. London, Stationery Office.

Department of Health (1998b) Partnership in action. London, Department of Health.

Department of Health (1999) Saving lives. London, The Stationery Office.

Department of Health (2000) The NHS plan. London, The Stationery Office.

Department of Health (2001a) Tackling health inequalities. Consultation on a plan for delivery. London, Department for Health.

Department of Health (2001b) From vision to reality. London, Department of Health.

Exworthy M *et al*. (1999) The NHS: quasi-market, quasi-hierarchy and quasi-network? Public Money and Management 19: 15-22.

Exworthy M, Powell M, Berney L, Hallam E (2000) Understanding health variations and policy variations. End of grant report to the ESRC.

Exworthy M, Berney L, Powell M (2002) How great expectations in Westminster are being dashed locally: the local implementation of national policy on health inequalities. Policy and Politics 30: 79-96.

Glendinning C *et al*. (2002) Partnerships, New Labour and the governance of welfare. Bristol, Policy Press.

Goddard M, Mannion R, Smith P (1999) Assessing the performance of NHS trusts: the role of 'hard' and 'soft' information. Health Policy 48: 119-134.

Hudson B (1999) Dismantling the Berlin Wall: developments at the health-social care interface. In Dean H, Woods R (1999) Social policy review 11. Luton, SPA.

Kingdon J (1984) Agendas, alternatives and public policies. Boston, Little, Brown & Co.

Parsons DW (1995) Public policy. Cheltenham, Edward Elgar.

Paton C (1999) New Labour's health policy. In: Powell M (1999) New Labour, new welfare state? Bristol, Policy Press.

Powell M, Exworthy M (2001) Joined-up solutions to address health inequalities: analysing policy, process and resource streams. Public Money and Management 21: 21-27.

Shaw M, Dorling D, Gordon D, Davey Smith G (1999) The widening gap. Bristol, Policy Press.

Wolman H (1981) The determinants of program success and failure. Journal of Public Policy 1: 433-464.

COMMENTARY: MAKING POLICY IN A FOG

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Only one clear conclusion can be drawn from the various papers discussed at the conference whose proceedings are reported in this volume. This is that policy making about health inequalities takes place in a fog of disagreement about goals, controversy about causes and uncertainty compounded by ignorance about means. The challenge therefore is how best to make sensible decisions in the absence of both consensus about what ought to be done and evidence about how best to set about achieving whatever policy aim we choose to set for ourselves. In what follows I draw on the conference papers – not always in ways that their authors might approve – in order to explore this issue.

First, disagreement about policy goals. Conferences about inequalities tend to attract congregations of the like-minded. It is taken as an article of faith that it should be the overriding aim of public policy to narrow, if not eliminate, health inequalities. The proposition is not self-evident. What if this aim conflicts with another goal of public policy, which is to improve the health of the population as a whole? Does reducing inequalities trump improving the population's health? If so, engineering a deterioration in the health of the best-off – for example, by encouraging them to smoke – would do the trick even if the health of the worst-off did not improve.

But even if we agree (as I do) that reducing health inequalities is desirable, this leaves open the question of how much priority we should give to this aim of policy relative to other, possibly equally desirable, policy goals. Inescapably, there are opportunity costs. And it is the failure to acknowledge this which explains the failure of both the Black and the Acheson reports to make instant converts of policy makers in government. Missionaries may not count costs; Treasury ministers and officials must do so, irrespective of the party in power. Had the Black report been submitted to the Labour Government which commissioned it, Ministers would have been just as embarrassed and unsympathetic as the Conservative Ministers who received it. In proposing large increases in child benefits the Black committee were indulging, rather irresponsibly, in fantasy at a time when the Labour Government was striving to cut public expenditure in the face of a major economic crisis.

Second, controversy about causes. Arguments about the causes of health inequalities continues, as the academic industry churns out ever more papers. There are bitter skirmishes on the methodological battle field. There is disagreement about how to measure inequalities: different approaches yield different results. Are health inequalities simply a function of socio-economic inequalities or do they reflect people's place in workplace hierarchies irrespective of income? Are they determined by conditions at birth or by later circumstances? Is education or income the decisive factor? To the extent that there is a common theme, it seems to be that the causes of health inequalities are multi-factorial – while disagreement continues about the weight that should be given to individual factors.

Third, uncertainty about means. This flows, of course, from controversy about causes. If we can only be sure of one thing – that the causes of health inequalities are a complex bundle of factors (which interact in ways we do not fully understand) – then it is difficult to know how best to intervene. If we have a simple faith that socio-economic differences are all, then it follows that we must demand a massive redistribution of income: a recipe for chronic frustration and indignation among the proponents of this view. If we take a more nuanced view, and argue for more specific micro-strategies of social engineering, we encounter a difficulty of another kind: ignorance. We know very little about what works. This did not prevent the Acheson report from making a profligacy of recommendations, ignoring the reservations of its own expert advisers about the lack of solid evidences bearing on the effectiveness (let alone cost-effectiveness) of the proposed interventions and expenditures. But it may prevent the Acheson recommendations being treated as seriously as their authors hoped. Like the members of the Black committee, the Acheson collective will carry a large degree of responsibility for their own, likely, eventual disappointment. The decision not to include an economist in the group, on the grounds that this would only delay the production of the report, strikes even a non-economist like myself as bizarre: the result was that, like Black, the Acheson report ended up spending monopoly money.

Nevertheless the Department of Health has been set some targets for reducing health inequalities. So, for example, one target is to reduce by at least 10 per cent the gap "between the quintile of areas with the lowest life expectancy at birth and the population as a whole" by 2010. Another is to reduce the inequality in the under 18 conception rate "between the worst fifth of wards and the average by at least a quarter" by the same target date. And there are specific officials whose head is on the block for achieving those targets (always assuming that they will still be around in 2010).

But there is an obvious difficulty about all this. Assume that the targets are indeed met by 2010. Will this necessarily have anything to do with the policies pursued by the Department of Health or the National Health Service? The worst off areas and wards are the site of a whole range of governmental initiatives: Sure Start and Neighbourhood Renewal, to name only two. At the same time the Chancellor of the Exchequer, Gordon Brown, is pursuing a strategy of redistribution designed to favour the least well-off. So if health inequalities do indeed decline, who deserves the credit? Should success be attributed to Mr. Brown or to the Department of Health or to the government's pursuit of a variety of cross-cutting initiatives? And conversely, assuming that the government targets are not met, who takes the blame? Nor is this just a problem of accountability, important though that is. If we cannot be sure about what has or has not worked in the past, where do we place our bets for the future?

All this would seem to lead to a rather pessimistic conclusion. If we don't know what works, maybe we should simply do nothing about health inequalities and accept that these are the product of ill-understood, complex factors which reflect changes in social and family structure and in the economy of work that may be largely immune to government policy. But there is a rather different, more radical conclusion that can be drawn. This is that governments should indeed pursue policies of social reform, but that these policies should be justified in their own right rather than as a means of reducing health inequalities. So I would regard bringing about a greater equality of incomes as desirable in its own right. Similarly, I would regard policies designed to improve the quality of education and housing in deprived areas as desirable in their own right. Strong arguments for all these and many other policies can be deployed without mentioning the word 'health'. If such policies help to reduce health inequalities, that should be seen as a bonus rather than being used as a dubious argument for pursuing them in the first place.