Addressing health inequalities in the United Kingdom: a case study*
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Summary
Health inequalities research has a long history in the United Kingdom, and the development of government policies that are intended to explicitly address the existing health inequalities has been gathering pace since the Labour Party returned to power in 1997. In this paper, using the influential Acheson Report as a reference point, one of us (D.N.) describes how health inequalities policies have been developed, and the other (A.O.) assesses how, ideally, such policies ought to be developed. Although progress in the development of health inequalities policies has been made, the policies, and the evidence that has informed them, have been less than ideal.

Keywords: United Kingdom, health inequalities policy, equity, Acheson Report

Introduction
Research into health inequalities in the United Kingdom has a substantial history, but government attention probably dates from the commissioning of an independent inquiry into health inequalities in 1977, chaired by Sir Douglas Black and later published as the Black Report.1 The Black Report was commissioned by the then Labour Government as a reflection of concern that despite the existence of a comprehensive National Health Service (NHS) that was largely free at the point of use, significant disparities in health across the social classes persisted. The Report broadly concluded that health inequalities across the social classes were wide and increasing, and argued that the causes of this problem were to a large degree attributable to differential income levels, working conditions, unemployment rates, standards of education, housing conditions, transport facilities and lifestyle factors (i.e. non-health service factors). The Report recommended an improvement in the material conditions of the most vulnerable members of society.

The Black Report was completed in 1980, but by this time there had been a change in the political climate. A new Conservative Government had been elected to office in 1979, and the conventional wisdom is that the new Government was less inclined to respond to the Report’s recommendations than the previous administration might have been. The reality, however, is more complex. The policies recommended by the Black Report, although desirable in themselves, would have entailed substantial financial and opportunity costs at a time when the UK Government was only just emerging from a major economic crisis. Klein has argued that the failure of the authors of the Black Report to explicitly recognize these costs undermined its credibility amongst policy makers, and that had the Report been submitted to the Labour Government that commissioned it, its influence (if not the manner in which it was received) would have been essentially the same.2

Nevertheless, the manner in which the Black Report was dismissed by the new Conservative administration bordered on attempted suppression, which, paradoxically, served the Report well, at least in terms of publicity.3 The summary dismissal of the Report’s recommendations provoked an angry response in The Lancet and the British Medical Journal, with many writers expressing concern that the recommendations were being excluded prematurely from the public policy debate. Relieved of the responsibilities of power, the Labour Party passed a resolution that the next Labour Government would give priority to the implementation of the recommendations.

The next Labour Government was a long time in coming, and although the measurement of health inequalities was a vibrant field of academic research, the issue was not a serious policy concern during most of the 18 year life-span of successive Conservative Governments. The 1992–1997 Conservative administration did eventually set up a departmental committee on health disparities,4 but for most of those engaged in the area it was too little too late.

True to its word in opposition, the issue of health inequalities was enthusiastically embraced by the Labour Party on its return to power in 1997. Translating this political interest and commitment into policies that will support sustainable change for both...
disadvantaged areas and disadvantaged populations has been a major challenge for the New Labour Government in the years since its election to office. Soon after being elected, the New Labour Government commissioned a further independent inquiry into inequalities in health, which became something of an update of (and reached very similar conclusions to) the Black Report. The new independent inquiry was chaired by Sir Donald Acheson, and the resulting publication became known as the Acheson Report.5

In this paper, one of us (D.N.) will chart the influence of the Acheson Report by detailing the health inequalities policies developed by recent Labour administrations. The other (A.O.) will provide a more critical assessment of the Report, giving reasons to question its recommendations as a means for influencing policy. But first, we will state very briefly the circumstances that are required for evidence-based reports (e.g. the Black and Acheson reports) to influence policy.

Requirements for evidence to influence policy

Policy making is rarely an ‘event’, or an explicit set of decisions derived from an appraisal of evidence and following a pre-planned course. Policy tends to evolve through an iterative process, subject to continuous review and incremental change. It is an inherently ‘political’ process – the art of the possible – and is generally derived from an appraisal of:

1. what is scientifically plausible (evidence-based);
2. what is politically acceptable (fits with vision);
3. what is practical for implementation.

In this context, policy is most likely to be evidence-based if the available evidence fits (or can be made to fit) with the political vision, and is practical to implement.6 Practical considerations will include the powers and resources available, the systems, structures and capacity for action (which will in turn be influenced by the views of important stakeholder groups), and the feasibility of implementation.

The development of UK health inequalities policy: the reality (D.N.)

Developing the science

The Acheson Report was published in 1998 and reviewed a similar range of evidence to that considered in the Black Report.5 It found that the available evidence was of highly variable quality and limited in scope. Although there is a large volume of research that describes the problem of health inequalities in the United Kingdom, there is relatively little research on policy interventions that helps to identify practical solutions. Compounding this evidence deficit, there is an inverse relationship between the volume and quality of research and the potential effectiveness of different interventions. For example, although there is a considerable amount of evidence concerning risk factor modification, there is little evidence on interventions to tackle some of the wider social, economic and environmental determinants of health. Moreover, there is very little evidence of any kind that examines the relative costs and benefits of different policy options. This is a real problem when considering alternative options for public sector investment. Governments will invest where there is good evidence to support investment,7 but are taking a risk with public money when making investments where the evidence is deficient.

The Acheson Report was published 5 years ago and remains a fundamental source document for UK government thinking on the causes of health inequalities and how to tackle them. Commentators at the time of its publication, and subsequently, have highlighted deficiencies in the evidence, and the real difficulty in reconciling differing views or interpretations of the available evidence. That there is a gap in health between the rich and the poor is not debatable. Why there is a gap is hotly contested, but is a crucial piece of information in order to understand how to frame a policy response.

Notwithstanding these challenges in obtaining the raw material for the review, the Acheson Report examined the determinants of health using the ‘layers of influence’ model first proposed by Dahlgren and Whitehead,8 and thus recognized that tackling health inequalities would require actions to address all of the layers of influence on health (e.g. social, environmental, economic, etc.), as well as ensuring that access to and use of health care services improves among those who have previously been underserved. Using a variety of indicators, the Acheson Report highlighted that the continuous improvement previously been underserved. Using a variety of indicators, the Acheson Report highlighted that the continuous improvement in particular measures of health – such as life expectancy – had masked a widening gap between the rich and poor (and between other groups in society, such as those defined by educational attainment, gender, race, etc.). The Report made 39 main recommendations through which, it purported, the extant health disparities would be narrowed. The inquiry team considered the following three recommendations to be crucial:

1. All policies likely to have an impact on health should be evaluated in terms of their impact on health inequalities. This recommendation was based on the scope of the evidence considered by the inquiry team, reflecting the broad range of determinants of inequalities indicated by the ‘layers of influence’ model.
2. A high priority should be given to the health of families with children. This recommendation reflected the evidence demonstrating the crucial influence of early life on subsequent mental and physical health and development.
3. Further steps should be taken to reduce income inequalities and improve the living standards of poor households. This recommendation reflected the evidence showing a consistent and linear relationship between family income and health status.
Two further statements in the Acheson Report are also worth noting:

1. Major gains will be derived from those health problems that occur most frequently. This reflects the simple fact (often overlooked) that the majority of premature deaths among poorer populations are from the most common causes of death—coronary heart disease, cancer and injury.

2. Policies that improve average health may have no effect on inequalities. This statement was based on an analysis of the distribution of benefit from policy change (e.g. in health, transport, education), which recognized that policies need to be consciously directed towards those who have traditionally been underserved, or have under-utilized existing services.

The remaining recommendations cover a broad canvas of issues ranging from tax reform to reform of the Common Agricultural Policy, but the recommendations and statements noted above are those that have been most influential in framing the Government’s response to the Acheson Report.

**Fitting the science into the political vision**

Health inequalities were not discovered in 1997 with the change of government and the Acheson Report. What was different in 1997 was that the issue of health inequalities resonated with the political vision of the incoming Labour Government. The evidence had not changed substantially, but the belief system in government did at least appear to have changed. Unlike the Black Report, the timing and structure of the Acheson Report were compatible with government policy.

Two key policy papers have framed the UK Government’s response to the challenges set by the Acheson Report. The government White Paper, *Our healthier nation*, published soon after the release of the Acheson Report, set out a programme to save lives, promote healthier living and reduce health inequalities. It advocated co-operation across government to tackle the determinants of health inequalities, and recognized that sustainable action will come from government working in partnerships with local communities and individuals.9

The NHS Plan provided a blueprint for the reform of the NHS.10 The Plan emphasized the importance of tackling health inequalities in a context of considerable extra public investment for the NHS. It gave particular emphasis to reducing inequalities in access to NHS services (especially primary care), and also emphasized the need to improve child health. On a population basis, it targeted the ‘major killers’ (i.e. heart disease and cancer) through a programme of improved prevention (e.g. through improving nutrition and reducing the prevalence of smoking) and treatment. Although primarily focused on the NHS, the Plan overtly recognized the need for the NHS to work in partnership with other public services and agencies to tackle the underlying causes of ill-health and health inequalities.

In the NHS Plan, the Government committed itself to establishing national health inequalities targets aimed at narrowing the gap in health status in childhood and throughout life between socio-economic groups, and between different areas of 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 to reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth.’

In detail, these targets are:

1. Starting with children under 1 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.

2. 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.

Alongside the health system policy development that was informed by the Acheson Report, the Government undertook a series of policy actions in pursuit of its core political aims of promoting opportunity and economic regeneration, and reducing social exclusion (see the Labour Party manifestos of 1997 and 2001 at http://www.labour.org.uk/manifesto). These included the following.

1. Tackling poverty and low income – for example, by introducing and increasing the national minimum wage and by reforming tax credit and welfare payments. This has led to a redistribution of wealth and has raised the income of the poorest families.12

2. 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. Britain has its lowest unemployment in decades, and participation rates in education are improving.13,14

3. Rebuilding local communities – for example, through the ‘Strategy for Neighbourhood Renewal’ (http://www.neighbourhood.dtlr.gov.uk), and the promotion of local strategic partnerships between local government, non-government organizations and the NHS.

4. Supporting vulnerable individuals and families – for example, by improving the coverage of ‘Sure Start’ programmes (which may improve the early learning opportunities for children in disadvantaged groups, http://www.surestart.gov.uk), introducing a ‘Fuel Poverty Strategy’ (http://www.dti.gov.uk/energy/fuelpoverty/index.htm), and programmes to support the socially excluded.

**Achieving policy alignment and coherence**

To better co-ordinate and further support action across Departments, the Government established a ‘cross-cutting spending review’ focused upon health inequalities. The review examined government spending across Departments to consider the
distribution of health benefit from a range of programmes in education, welfare, criminal justice, environment, transport and local government. This review follows the recommendation in the Acheson Report that all policies likely to have an impact on health should be evaluated.

The report from this review is to be used by Departments to inform their spending plans for the 2003–2006 period, and will lead to binding commitments to take action as part of a cross-government delivery plan to reduce health inequalities. The findings of the review (http://www.doh.gov.uk/healthinequalities/ccsrssummaryreport.htm) can be grouped into the following five themes.

(1) Breaking the cycle of health inequalities. Addressing poverty (especially in families with children), supporting healthy pregnancies, early childhood development (through the Sure Start programmes), and educational interventions to close the attainment gap.

(2) Tackling the major killers. Addressing the social gradient in modifiable behavioural and physiological risks, and in treatment service provision.

(3) Improving access to public services and facilities. Addressing the inverse care and provision law (i.e. that those most in need of services often use those services the least), especially in relation to primary care and public transport.

(4) Strengthening disadvantaged communities. Working ‘with the grain’ of neighbourhood renewal and regeneration strategies, by improving housing, creating a safe environment, and engaging public services in employment and education.

(5) 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.

Fitting the political vision into practical delivery

A further commitment in 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 spending review, the Department of Health conducted a public consultation through the document Tackling health inequalities. This focused on identifying working examples of successful programmes to tackle the causes and effects of health inequalities. The aim was to improve our understanding of how to take practical action in local communities to address the determinants of health and health inequalities. The results of this consultation have recently been published.

A major focus for current and 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 have emerged from the cross-government delivery plan. At the national level, a cross-Department group of senior officials will oversee this programme. It will be chaired by the Treasury, and will be accountable to a Cabinet sub-committee (chaired by the Deputy Prime Minister).

The delivery plan, published in July 2003 (http://www.doh.gov.uk/healthinequalities/programmeforaction/index.htm), is structured around long-term targets to reduce the gap in health status between social groups and geographical areas. The plan is underpinned by short- to medium-term ‘milestones’ drawn from a cross-government ‘basket of indicators’, which will be utilized in the future allocation of funding and assessment/management of performance in both the NHS and in local government.

The development of UK health inequalities policy: the ideal (A.O.)

Weiss has suggested that the relationship between evidence and policy is a complex business that entails an interactive, political and tactical process. This line of reasoning describes what the relationship is (and, in countries with democratically accountable governments, the relationship, at least to some extent, will always take this form). However, the reasoning does not describe what the relationship between research and policy, in an ideal world, should be. In ideal circumstances, we would perhaps choose to have a more ‘rational’ relationship between research and policy (assuming that the evidence is unbiased and of good quality, and appropriately addresses the policy question to which it is being applied); in the real world, however, this is politically very difficult to achieve. There is therefore a tension between the ‘rational’ evidence-based approach and the interactive/political/tactical approach; the latter is forced upon us because the former, in its most pure form, is not achievable. Nevertheless, policy makers ought to strive – as far as possible – towards making the most rational use of evidence that is relevant to pre-defined, socially beneficial objectives.

The Acheson Report to some extent underlies the Government’s health inequalities policy initiatives. However, the Report contains some fundamental flaws. Three of the fundamental flaws of the Acheson Report are outlined in this section:

(1) its failure to provide a coherent ethical framework;
(2) its failure to focus entirely upon its remit (i.e. policies to address the distribution of health);
(3) its failure to indicate the relative value for money of any of its recommendations.

A coherent ethical framework?

There is an underlying presumption in the Acheson Report that all health inequality is necessarily inequitable. The two concepts are, however, very different. Health inequality is an empirical measurement issue (and some degree of health inequality is inevitable in all societies); health (in)equity is a value-laden ethical issue. Depending on one’s ethics, not all health inequalities are likely to be deemed unfair. As has been argued elsewhere, the process by which an inequality is generated strongly influences the extent to which most people view that inequality as...
inequitable. For example, if health differentials arise because particular groups suffer from poor health as a result of factors beyond their immediate control – factors such as genetically transmitted diseases, illnesses caused by environmental health risks, or socially constructed illnesses that are the consequence of, for example, differential incomes, education, etc. – then we may decide as a society that these health inequalities are inequities that warrant some form of public intervention. If, on the other hand, some health inequalities are the result of certain groups engaging in particular risky activities that they to some extent freely choose to engage in, then some of the extant health differentials may be considered a perfectly just consequence of allowing people the freedom to choose the lives that they wish to lead.

Policy makers should therefore develop a coherent ethical framework to serve as guidance in deciding which health inequalities are unjust. This is, of course, a far from easy task, not least because there will be competing moral claims in formulating the most acceptable concept of equity. Therefore, a broadly acceptable ethical framework will inevitably serve as a very general prescriptive tool. The Swedish Government has, for example, based its targets for addressing health inequalities upon general ethical principles proposed by Sen and Rawls; namely, Sen’s notion that health is a basic requirement in allowing people to flourish as human beings, and Rawls’ theory that inequalities in ‘primary goods’ are just if they do not require sacrifices from the worst off. The Swedish case of referring to the work of Sen and Rawls is given only as an example; it is of course plausible that many alternative general ethical frameworks could be developed, and ultimately, it is the responsibility of the Government to promote a working (and broadly acceptable) definition of what should be regarded as a health inequity. But, ideally, some form of ethical framework is required so that the Government can introduce health inequalities policies that are comprehensible, acceptable, consistently applied and measurable. A clear ethical framework has thus far been lacking from the UK Government’s health inequality policy initiatives.

The impact on the ‘distribution’ of health?

The specific objective of the Acheson Report was to review the evidence of health inequalities in the United Kingdom and provide recommendations as to how the inequalities may be alleviated. However, although the Report included a very general statement that policies need to be directed towards those who have traditionally been underserved, its specific recommendations – by often focusing upon improving general population health rather than narrowing the distribution – frequently lose sight of the remit of the inquiry. Improving general population health levels is undoubtedly a desirable policy goal in its own right, but was not the specific remit of the Acheson Report. As actually acknowledged by the authors of the Report themselves, if everybody’s health improves but the health of those who are already relatively healthy improves the most, improving general population health is in fact perfectly consistent with widening health inequalities.

Consider the following illustrative example, first given by Williams. Women in the United Kingdom have a substantially longer life expectancy and lower morbidity than men. Therefore, with reference to health inequality in this particular dimension, the Acheson Report ought to have provided recommendations to narrow the health gap between men and women (assuming that this inequality represents an inequity). However, the three general recommendations offered by the Report to address health inequality across gender groups were:

1. To reduce excess mortality from accidents and suicide in young men;
2. To reduce psychosocial ill health in young women in disadvantaged circumstances;
3. To reduce disability and ameliorate its consequences in older women.

Therefore, two of the three gender-related recommendations explicitly focus upon the health of women, which, although possibly desirable in itself, does nothing to address – and is in fact likely to widen – the health disparities across men and women.

Although the Government is apparently aware of this flaw in the Acheson Report, the lack of focus upon the distribution of health may have filtered through to some of the Government’s ‘health inequalities’ policy options. For example, in relation to health inequalities, the Government aims to improve access to high-quality antenatal care, reduce smoking and improve nutrition during pregnancy and early childhood years, and provide effective early childhood support. All of these interventions are intuitively attractive with respect to their potential to promote general levels of health, and some are of proven effectiveness (and, in the case of smoking cessation policies, cost-effectiveness), but it is not at all clear how these options would contribute towards meeting the Government’s health inequality targets. Indeed, if the already relatively healthy (and relatively wealthy) benefit most from these policies (and it is feasible that they might), they may in fact widen the existing health disparities.

The possible reason why the Acheson Report and the Government have both recommended or enacted policies that have no direct logical relationship with reducing health inequalities is because (as noted earlier) there is very little evidence of effective health inequalities interventions. However, from the Government’s political perspective, doing nothing is not an option, and the focus on health inequalities that may stem from childhood is seen to have the following important advantages:

1. It appeals to people’s sense of natural justice: that every child should have a fair start in life;
2. It negates attempts at victim-blaming, as the question of young children’s own agency does not arise.

Nevertheless, if targets are set with little knowledge of how they may be effectively met, and policies are enacted that have no logical link with health inequality, then is it politically wise (let
alone socially beneficial) to set those targets in the first place? Ideally, if we collectively decide that the current distribution of health is unjust (which will require the acceptance of a general ethical framework), then far more effort needs to be spent in uncovering policies that effectively alleviate the existing disparities.

Value for money?

Despite being explicitly asked to do so in the invitation to establish their independent inquiry, the authors of the Acheson Report did not prioritize any of their recommendations for their relative value for money. It is a fact that public resources (indeed, all resources) in all societies are limited. The failure of the Acheson Report to prioritize its recommendations according to their value for money reduces the Report to a wish list, providing little guidance to the Government on how to use their (i.e. the public’s – our) resources most effectively. Consequently, we have no way of knowing whether the Government’s health inequality initiatives represent good value for money. Of course, the main reason why the Report could not prioritize according to value for money was because evidence of the effectiveness, let alone the value for money, of health inequalities interventions is simply not available at this time. However, ideally, the Report ought to have acknowledged more forcibly this gap in the knowledge base and recommended its redress, rather than place pressure on the Government to introduce potentially ineffectual, and possibly very costly, policies.

In summary, in addressing the health inequalities issue we ideally ought to: (1) identify inequalities that can be deemed inequitable; (2) identify effective policies for tackling these inequitable inequalities; (3) assess these policies for their relative value for money. All of these three points can realistically be met, but were barely even addressed in the Acheson Report. Although the Government faces pressure to act, which inevitably leads to less than ideal policy implementation when there are such severe gaps in knowledge, in this important area of health policy the Government perhaps needs to assume greater responsibility in (re)directing the thrust of the debate.

Conclusion

The development of public policy is a complex and iterative process. The use of evidence will be a core part of this process if it provides information that is relevant to policy questions (on effectiveness, costs, etc.), if it fits in with the overall political vision, and if it has clear potential for practical implementation (i.e. if it resonates with service providers and other important stakeholder groups).

Current policy on health inequalities in the United Kingdom can be viewed as evidence-informed. Although there are some important deficits in the evidence relating to interventions, this has not stalled the development of a wide range of policies. Because of the political priority given to the issue, doing nothing is not an option in the absence of perfect evidence.

Debate on policy to address health inequalities is alive and well in the United Kingdom. The strength of this debate reflects the complexity of the policy-making process and the less than adequate science that has informed the debate. The intensity of the debate may give the impression that the United Kingdom, in terms of health, is a deeply unequal society. However, with respect to health care, the United Kingdom has one of the most progressive financing structures of any country in the world. In addition, there is evidence that utilization (if not the quality of the utilization) shows neither a pro-rich nor a pro-poor bias. Moreover, even in terms of health outcomes, there is some recent evidence to suggest that inequalities may be narrowing. Therefore, it may be wise for both researchers and policy makers to maintain a sense of perspective with respect to what is, after all, only one of many important health policy objectives.

Acknowledgements

We are grateful for comments received from Professor Walter Holland and Dr Edmund Jessop. The views in this paper are those of the authors, and do not reflect the official views of any government, department, institution, society or network.

References


Accepted on 1 August 2003