findings

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Tackling health inequalities since the Acheson Inquiry

Commissioning the Independent Inquiry into Inequalities in Health (also known as the Acheson Inquiry) was one of the first decisions of the incoming Labour Government in 1997. This indicated the extent to which tackling health inequalities has become a major policy priority in the UK. Mark Exworthy and colleagues at University College London investigated the impact on policy-making of the Inquiry's recommendations, and examined the subsequent development of policies to tackle health inequalities. Key findings were that:

- Across most government departments there has been a significant amount of activity related to tackling health inequalities, including commissioning of the Independent Inquiry into Inequalities in Health.
- These policies have addressed most of the recommendations in the Inquiry's report.
- Policy-making continues to develop across central government. Policies were initially disparate and typified by projects, funding 'challenges' and one-off initiatives which could be detached from mainstream activity. These are now being brought together more systematically and coherently.
- New mechanisms and structures are placing more emphasis on systems and processes that support policies to reduce health inequalities. However, further steps are required to join up and embed these policies more fully into mainstream policy, planning and provision.
- Measuring the progress of policies is difficult, but has been aided by the introduction of performance management mechanisms. Targets and objectives are being monitored by new and existing indicators. Further steps are required to establish meaningful indicators of whether health inequalities are being reduced as a result of policies.
- The researchers suggest that the use of health inequalities impact assessments needs to be widened, including assessments of likely impact as policies are formulated. In addition, research studies need to place more emphasis on interventions to improve outcomes, rather than on demonstrating causation.

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Background

In recent years, tackling health inequalities has become a key political objective in the UK and other countries. However, few studies have examined the formulation and implementation of policies designed to address inequalities in health care or health status.

This study examined the impact of the recommendations proposed in the report of the Independent Inquiry into Inequalities in Health (the 'Acheson Inquiry', chaired by Sir Donald Acheson and published by The Stationery Office, November 1998). The study also looked at the subsequent development of policies across central government in the UK.

Impacts of the Acheson Inquiry

The Inquiry's report and its recommendations were instrumental in fostering widespread recognition that health inequalities need to be addressed, and that tackling their wider determinants is crucial to this process. The report's four major impacts were that it:

- acted as a prompt to new policies;
- engendered a climate of opinion favouring policies to tackle health inequalities;
- introduced a health inequalities dimension to current policies;
- acted as a reference book.

The report also provided the context for the public health strategy in England, *Saving lives: Our healthier nation* (The Stationery Office, 1999). Public health strategies in other parts of the UK have also drawn on the Acheson Inquiry's analysis and recommendations.

Resulting policies have primarily focused on areas (mainly geographical zones) and on individual employment (through welfare-to-work strategies, mainly tax credits), and have involved some income redistribution (through tax and benefit reform). Most of the recommendations in the Acheson Inquiry's report have been addressed by these policies, which have sought to tackle the wider determinants of ill-health and to cover the lifespan. The study found, however, that no progress was evident in areas such as water fluoridation, reform of private medical practice, and reform of the Common Agricultural Policy.

Wider policy developments across government

The Government initially implemented a disparate collection of policies to tackle health inequalities, but these are now being brought together in a more systematic and coherent way. This is evident in the development of systems and processes at national and local levels. It is especially evident in the two national targets for addressing health inequality, new Public Service Agreements (PSAs) arising from the 2002 Spending Review, the Department of Health's *Consultation on a plan for delivery* (2002) and the Treasury's *Cross-cutting spending review on health inequalities* (2002).

Most government departments have recognised the relevance of their existing and new policies for tackling health inequalities, and the contribution that these policies can make.

In addition to these positive developments, however, the study identified scope for further improvements in policy-making across government:

- better use of existing information and evidence;
- identification and rectification of inadequacies in data;
- promotion of more effective 'joined-up' working among and within departments, through central co-ordination (by means of cross-cutting PSAs and task forces), improved interdepartmental co-operation, enhanced scrutiny mechanisms and improved budget flexibility;
- provision of support for officials and ministers who work across departmental boundaries (through improvements in skills and capacity, and incentives for career promotion).

Further possible improvements are indicated below.

Systems and processes supporting policies to tackle health inequalities

Achievement of the sustainable, long-term benefits of reducing health inequalities requires the integration of a comprehensive range of policies into mainstream policy and planning. Hence, appropriate systems and processes are needed to support existing and new policies.

Policies to address health inequalities have often been typified by projects, funding 'challenges' and one-off initiatives. As a result, such policies may remain partial and detached from mainstream activity. There is a clear need to learn from these exercises and extend their coverage to geographical areas and population groups not currently included. In doing so, a health inequalities dimension could be introduced at the policy-making stage.

New mechanisms and processes have recently been introduced to support the formulation and implementation of policies to tackle health inequalities. An extensive range of targets and performance measures (which address health inequalities) has been introduced. Mechanisms and units which cut *horizontally* across departmental boundaries have been established (for example, the Sure Start unit). The experience of these structures and processes could be applied more rigorously in relation to tackling health inequalities. However, at the same time, conflicts with the *vertical* structures and processes of individual departments would also need to be tackled.

A significant new development is the proposal in

the Treasury's *Cross-cutting spending review* that objectives for addressing health inequalities should be incorporated into departments' mainstream programmes. Individually based policies (such as tax credits) need to be continued as well, but could be more 'joined-up' with other relevant processes.

Measuring the progress of policies

Measuring the progress of policies to tackle health inequalities is difficult because:

- the link between policy and (health) outcomes is uncertain;
- it is difficult to attribute observed impacts to a particular policy;
- the suitable balance across and within policy programmes (such as the relative health benefits of policies on tax and benefits versus education) is unknown;
- unintended consequences of policies (such as widening health inequalities) may yet appear.

These difficulties do not constitute a reason for inaction, however, and policy-making has indeed continued nonetheless. Many policies have already been implemented, some are still being formulated, and the implementation of others is still underway.

However, the difficulties cited above serve to underline the need for rigorous monitoring and further research into interventions which improve outcomes. Performance management systems have been introduced at all levels to ensure that objectives and targets are set, and that mechanisms to monitor these targets are introduced.

The Acheson Inquiry recommended health inequalities impact assessments. Assessments have been conducted for some policies, but not as a universal practice. Within and across departments, the application of assessments is patchy. Impact assessments are common, but few take an inequality perspective and fewer still examine the impact of policies on health inequalities. The inclusion of a health inequalities perspective would require further development across government. Such a perspective could include assessments of likely impact as policies are formulated, to minimise the likelihood that policies may inadvertently widen health inequalities.

Indicators of progress are being considered for implementation, following consultation. Better measures of progress will be required, which would:

- incorporate the wider determinants of health;
- support a joined-up approach across government;
- not simply be disease-oriented;
- not be dominated by health care or the NHS;
- combine long-term/outcome and shorter-term/process measures;
- leave scope for local priorities within national policies.

Conclusion

Although much progress has been made in policy-making in response to the Acheson Inquiry, the study identified three main gaps:

- a lack of mechanisms to promote and ensure progress in policies to tackle health inequalities;
- a need for independent, regular evaluation of the progress of policies, in terms of their impact on individuals, intermediate markers of progress and targets;
- a need to conduct and collate research studies on effective interventions and outcomes.

Possible policy solutions

Mechanisms to promote and ensure progress in policies to tackle health inequalities:

- The role of the Inequalities and Public Health Task Force could be revised, to examine and promote ways to embed a health inequalities dimension in mainstream policy, planning and provision, at both central government and local level.
- The terms of reference of the Ministerial Sub-Committee on Social Exclusion could be amended to include tackling health inequalities, with a rolling programme of work (including tax and benefit policies).
- A support unit could be created for the Ministerial Sub-Committee. This unit might consist of officials drawn from relevant departments, or a clearly identified group of officials from those departments. They would work together to exchange information and produce material for the sub-committee.
- This support unit for the Ministerial Sub-Committee could be commissioned to:
  - track progress on tackling health inequalities, as identified during monitoring of the relevant departmental PSAs, targets and the basket of indicators;
  - advise on further action, such as adding new targets and objectives;
  - act as a source of information and advice to departments on the data available to assess the impact of policy proposals on health inequalities, and for health inequalities impact assessments.
- The Ministerial Sub-Committee on Social Exclusion could be required to produce an annual progress report for Parliament on tackling health inequalities.
- A special cross-departmental select committee could be formed (perhaps initially on an experimental basis), drawn from relevant departmental select committees. This cross-departmental select committee would receive the annual progress report on health inequalities (see previous suggestion) and question ministers on it.
- To aid policy, planning and provision, departments could be required to share relevant data on (a)

inequalities in access to services, and (b) progress in meeting targets relevant to health inequalities.
- A review of relevant data collection could be commissioned, to ensure that existing sources cover all groups and aspects which need to be monitored in relation to health inequalities (notably social class, birth registrations by lone parents, and ethnic minorities).
- As a result of such a review, action could be taken to address limitations in data collection – either by changes to routine collection or by commissioning studies (perhaps on a periodic basis) to provide the necessary information.
- A range of interim indicators could be devised to track progress in establishing structure and process, along with longer-term indicators to appraise outcomes. Many existing PSAs and targets are relevant to tackling health inequalities. Progress on these could be regularly collated and monitored to assess their overall impact on health inequalities and the wider determinants.
- There could be greater and/or more sensitive application of health inequalities impact assessment (especially across central government). This could be achieved through developing methodology, improving skills and capacity, refining data collection, conducting assessments prior to implementation, and changing the scope of performance management systems.

Evaluation of the progress of policies:
- A mechanism could be created (possibly under the auspices of select committees or the Audit Commission) to scrutinise and independently evaluate the annual progress report on health inequalities; this evaluation mechanism would report to Parliament (see earlier suggestion for a cross-departmental select committee).
- Mechanisms could be introduced to enable local authority scrutiny committees to include health inequalities within their remit.

Co-ordination of research:
- Agencies which fund research could commission studies to fill gaps in evidence concerning the effectiveness of policies to reduce health inequalities (including studies on social interventions and outcomes).
- A centre of expertise could be created to conduct and collate studies that describe and explain effective interventions to tackle health inequalities.
- A forum of funding agencies involved in health inequalities research could be convened, in order to co-ordinate research programmes focused on outcomes (rather than on causation, research on which is relatively well established).

About the project

The research took 19 months (February 2001 to August 2002) and comprised two phases. The first phase entailed analysing the aims, targets and resources associated with policies for each of the 74 recommendations made by the Acheson Inquiry. The second phase looked at three case studies of policy formulation and implementation. These case studies were: tax and benefit reform; performance management in health and education departments; and transport. For both phases, documentation such as reports, plans and strategies was analysed, and over 30 interviews were carried out with policy-makers across central government.

An advisory group of academics, policy-makers and practitioners supported the project team.

How to get further information

The full report, **Tackling health inequalities since the Acheson Inquiry** by Mark Exworthy, Marian Stuart, David Blane and Michael Marmot, is published for the Foundation by The Policy Press (ISBN 1 86134 504 6, price £14.95).

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