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Health Inequalities in England, Scotland, and Wales: stakeholders' accounts and policy compared

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ABSTRACT

Objectives: The election of a Labour government in 1997 brought the issue of health inequalities firmly back onto the policy agenda across the UK. Since then, in the wake of devolution, the need to tackle health inequalities has been highlighted as a policy priority in all three mainland UK countries, albeit with varying degrees of emphasis. This paper reports on a major cross-national, ESRC funded study investigating how NHS bodies, local councils and partnerships make sense of their work on health inequalities, and examining the difference made by the contrasting approaches that have been taken to performance assessment in England, Wales and Scotland.

Study Design: Case-studies, semi-structured interviews and analysis of key policy statements.

Methods: In order to explore how health inequalities have been approached by the three governments (noting that during this time there was a change in governments in Wales and Scotland) key policy statements published between May 1997 and May 2007 were analysed. Concurrently, data from stakeholder interviews carried out in 2006 in case study areas in each country were analysed to determine the extent of alignment between policy and practice at a local level.

Results: This paper suggests that claims about the extent of health policy divergence in post-devolution Britain may have been exaggerated. It finds that, whilst the three countries have taken differing approaches to performance assessment and the setting of targets, policy approaches to health inequalities appear to have been remarkably similar, up until 2007. Furthermore, the first round of interview data suggest that variations in local understandings of, and responses to, health inequalities cannot always be clearly distinguished along national lines.

Conclusions: Based on the policy analysis, devolution in the UK would not appear to have resulted in substantively different national policy approaches to health inequalities. Indeed, the overall analysis suggests that (prior to the 2007 elections in Scotland and Wales) the differences between local areas within countries may be of as much interest as those between countries.

KEYWORDS – health inequality; health policy; devolution; performance assessment; United Kingdom.

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Introduction

The election of a Labour government in 1997 brought the issue of health inequalities firmly back onto the policy agenda across the UK. Since then, in the wake of devolution and with varying degrees of emphasis, the need to tackle health inequalities has been highlighted as a policy priority in all three mainland UK countries. This short paper reports on findings from a major cross-national study[a] investigating what difference devolution makes to how health inequalities are problematised and acted upon at local level in England, Scotland and Wales. A key aspect of the study was a comparison between the different countries which have been seen as taking different paths responding to health inequalities, and diverging in both health policy and performance assessment[1.]

Particular attention was given to the role that contrasting performance assessment regimes might have played in informing variations in national responses to health inequalities. There have been few studies of performance assessment regarding health inequalities. Exworthy et al.[2] explored the implementation gap between policy on health inequalities and local action in England. They identified a number of obstacles to progress, including the dominance of waiting lists in performance management and a lack of engagement by local authorities. Hunter and Marks[3] identified similar problems

[a] Performance assessment and 'wicked issues': the case of health inequalities (ESRC ref. RES-153-25-0079)

with NHS targets and their extension into health improvement and health inequalities. The evaluations of the English Health Action Zones reveal this complexity, with the HAZs taking different approaches to inequalities and their goals and targets varying according to local context [4]. Other studies have drawn attention to how decision making in health takes place in a context of uncertainty and competing priorities[4,5,6,7].

The focus of this paper is on comparing the story that emerged from the analysis of national policy statements with the first round of narrative accounts gathered in 2006 that emerged from interviews with individuals working in the local organisations charged with much of the responsibility for addressing health inequalities.

Methods

In order to explore this issue, key policy statements published between May 1997 and May 2007 were analysed. Concurrently, data from stakeholder interviews in eight case study localities carried out in 2006 were analysed to determine the extent of alignment between policy and practice at a local level in each of the three countries.

Assessments of national policy conceptualisations of health inequalities were garnered through the discourse and thematic analysis[8] of major policy documents published between May 1997 and May 2007 (i.e. those published immediately prior to devolution (1997-1999), when the UK government was responsible for health policy in all three

countries, and those published in the three countries during the first (1999-2003) and second (2003-2007) terms of devolved government in Scotland and Wales).
Owing to the volume of official publications relating to health inequalities in each country, it was decided to include only national policy statements of significant relevance to health inequalities, notably White Papers and related documents and national guidance on how health inequalities should be tackled. Advisory and consultative documents for England and Wales were not included on the assumption that, where aspects of consultative or advisory documents have successfully informed policy decisions, these aspects should be visible in subsequent policy statements. However, as Wales did not have primary legislative making powers during the study period, key consultative documents published here were included, especially those which are referred to in later documents as having set the national agenda. In total 75 documents were included in the analysis (33 from England, 24 from Scotland, and 18 from Wales).

The exploration of local responses to health inequalities was based on interviews with relevant key stakeholders working in the NHS (Primary Care Trusts, Local Health Boards and Health Boards), local government and partnership organisations (Local Strategic Partnerships; Health, Social Care and Well-being strategy groups; Community Health Partnerships) in 8 localities in the three countries (3 in England, 3 in Wales, 2 in Scotland). The Case study localities were chosen because they had contexts that represent a challenge for health improvement and have similar geographical profiles of regional cities and post-industrial areas across the three countries.

The in-depth qualitative interviews were undertaken with key stakeholders (n=130) within the eight case study sites between May and August 2006. The key stakeholders represented a range of positions at strategic and operational level such as Chief Executives, Performance Managers, Directors of Public Health, Finance Directors and Chairs of partnership organisations. Interview data were supplemented with information from Local Delivery Plans, performance assessment reports and statistics relating to health inequalities.

Results

1. The story told by the policy statements

Policies in all three countries have consistently emphasised the need to tackle health inequalities from 1997 onwards (i.e. both before and after devolution) and all three countries have focused on health differences between socio-economic groups and geographical areas (significantly more than, for example, the ethnic and gender based health inequalities which are also acknowledged). However, the three countries have taken quite different approaches to performance assessment of public health issues and to the setting of relevant targets.

England was the first of the three countries to introduce quantifiable national targets for reducing health inequalities, in 2001. Initially there were two separate targets; one which focused on a reduction in the infant mortality gap between manual groups and the rest of the population and another which focused on reducing the life expectancy gap between the fifth of areas with the worst health and deprivation indicators and the

England average (both to be achieved by 2010)[9,10]. These formed Public Service Agreements which the Department of Health is expected to meet, cascaded down to localities and underpinned by secondary targets for circulatory diseases, cancers and smoking[11].

Scotland also introduced quantifiable national targets for reducing health inequalities targets but at a later date, in 2004. However, despite a previous commitment to setting the targets around narrowing a 'health gap'[12], the targets that were eventually introduced were health improvement targets with a specific focus on the most deprived areas[13]. Until 2006 'health gaps' continued to be monitored as part of the Scottish performance assessment framework, but the introduction of a new performance management system based on a core set of key Ministerial targets (Health, Efficiency, Access and Treatment – HEAT - targets) effectively removed performance assessment of narrowing 'health gaps' (although these are still measured) and reinforced a conceptualisation of health inequalities as a problem of 'health disadvantage' needing a health improvement response rather than explicit targeting of health inequality[14].

Wales had not introduced quantifiable national targets for specifically reducing health inequalities in the study period, preferring to opt for aspirational statements that are not quantified but indicate a desired direction of travel. Indeed, much of the language in the documents that were analysed suggests Welsh policymakers were less concerned with targets than their colleagues in England and Scotland. An expert group to advise on measuring health inequalities had been established in 2001 but although it recommended that the Welsh Assembly Government should monitor 'health gaps'

between areas, the Group advised against setting specific, national health inequalities targets. Instead, members suggested that avoiding short or medium term targets would facilitate a longer-term (and more effective) approach to the issue by allowing policymakers to focus on the wider social determinants of health. However, the absence of any quantified objectives makes it impossible to assess the success or failure of Welsh policies to tackle health inequalities by reference to a specific policy commitment.

Whilst different approaches to performance assessment and targets were therefore clearly visible in the three countries, the discourse and thematic analysis of key policy documents suggests that this did not appear to inspire significantly different policy thinking about health inequalities at a national level[15]. Instead, a remarkably similar story emerged from this strand of the research. In each case, as Table 1 illustrates, early statements (pre 2003) emphasise the importance of tackling 'wider' determinants of health and of health inequalities (such as social exclusion, poor housing and inequalities of opportunity) as well as underlining the need to address differential patterns of lifestyle behaviour (the former often being articulated as a key cause of the latter). Documents from this era also frequently refer to the important role of central government in tackling health inequalities, as well as to that of the public sector and individuals. However, around 2003-2005, the statements in all three countries visibly shift, with increasing emphasis being placed on:

- The need to tackle lifestyle-behaviours (smoking, diet, alcohol consumption, etc).
- The responsibility of individuals

- Clinical priorities and the role of the NHS

The post-2003 policy statements in Scotland and England largely continue to emphasise the importance of tackling health inequalities but a shift is noticeable with regard to the emphasis placed on the preferred means of achieving this aim. In Wales, however, where the initial emphasis on tackling the wider determinants of health was perhaps most overt, this shift was more substantive, representing a move away from official interest in tackling social determinants of health and health inequalities to a focus on waiting times and health improvement (this shift is discussed in greater detail elsewhere[15]).

2. Interviews and policies compared

This section present results from the interview data and how these link to the policy findings, addressing the following three questions:

- Did the way in which health inequalities were conceptualised by interviewees reflect conceptualisations in the policy statements?
- Were the different policy approaches to targets and performance management reflected in the way interviewees in local bodies described approaches to the performance management of health inequalities?
- Was the cross-country shift in emphasis that was visible in the policy statements (circa 2003-2005) reflected in the interview data?

Conceptualisation of health inequalities

The interviews in all countries revealed extremely varied definitions of health inequalities, even within the same organisation. For example, definitions included geographical differences in health within localities, geographical differences between localities and the national average, inequalities between different ethnic groups, inequalities in access to services (particularly in relation to rural areas), the unique health concerns of population groups who were considered 'vulnerable' (such as people experiencing mental health problems, those with learning disabilities, and people with drug and alcohol dependencies). Few respondents referred to specific definitions of health inequalities from either local corporate plans or national policy statements, revealing the lack of shared definitions. There was, though, widespread reference to the social model of health and understanding of the impact of wider determinants on health inequalities.

The reduction of health inequalities was seen as a long-term challenge and many health problems were seen as a legacy of past heavy employment, deprivation and job losses: *"So we had a lot of problems… also since then obviously those industries have come and gone but left a legacy in the community. You're then moving into an area where of course we've got deprivation, poor diet etc which of course doesn't really help people to lead healthy lives either. So we've got all those sort of historical problems." CEO Wales*

There were some differences between the countries. In England, the areas in which the interviews were conducted had small BME populations and ethnicity was not seen as a main focus for health inequalities. Ethnicity was an important consideration in Wales

and Scotland, despite our fieldwork areas also mostly having small BME populations, and this was perceived as being driven by the social inclusion policy agenda of the government.

Organisations in all countries were measuring gaps in life expectancy within localities as well as comparing with national figures. However, within areas of high deprivation (within different countries) there was some questioning of the relevance of within locality differences:

> *"All of the wards in Locality 10 are among the most deprived wards in terms of health nationally so I couldn't say that it's particularly necessary for us to have a definition that would allow us to say these three particular wards in Locality 10 are suffering most health inequality, because generally it's a picture that is pretty prevalent across the board." CEO England*

Access to services was seen as an important factor in health inequalities in some of the post-industrial localities in all countries, and in areas with low levels of health services in Wales and England.

As with the policy analysis, the interviews showed few differences in conceptualising health inequalities between countries. There was widespread reference to the wider determinants of health, and measuring gaps in life expectancy within localities as well as nationally. There were slight differences in emphasis (towards social inclusion and health improvement in Scotland and Wales) but a similar focus on the poor health of particular groups rather than social gradients in health.

Performance management

The ways in which health inequalities were being monitored did vary significantly in line with findings from the policy documents. In Wales, there was no systematic monitoring of progress in tackling health inequalities, although the Health Social Care and Well Being Strategies drawn up jointly by the local health boards and local councils included statements about reducing health inequalities. In England there was systematic monitoring and performance management of health inequality targets by the Department of Health through Public Service Agreements. In Scotland health inequalities were being monitored through performance reviews of Health Boards and Community Health Partnerships at the time of the interviews. However, there was explicit rejection of what was often referred to as the 'command and control' strategies or 'market-driven' systems of England:

> *"Well, the politics of Scotland are very different to the politics of England. The NHS in Scotland bears very little resemblance to the NHS in England and that has all happened in the last eight years. And it's quite remarkable how quickly the Scottish ethos has been around collaboration, co-operation, health improvement, narrowing health inequalities." Director of Public Health Scotland*

This emphasis on differences in the 'ethos' between countries recurred frequently in the Scottish interviews.

In all countries organisations regarded themselves as having robust performance management systems. However, there were mixed views about the desirability of

performance management. For example, some respondents regarded it as providing a focus on health inequalities which would not otherwise be there, while others thought that the performance systems were too burdensome and focused on the easily measurable rather than pertinent outcomes. Again these views were not peculiar to any one country even though the policies on health inequalities targets and performance assessment differed between the 3 countries. Penalties for not reducing waiting times and ensuring financial balance made these key priorities for organisations and meant that action to reduce health inequalities was pushed further down the agenda. Although there was a desire to reduce health inequalities, there was little plausible modelling of whether programmes to reduce health inequalities would enable targets to be met. This was even true of England where there was a strong emphasis on performance assessment to achieve targets.

Despite differences in monitoring and some evidence of divergence in response to performance management regimes, the reduction of health inequalities was consistently across countries a lower priority than reducing waiting times and ensuring financial balance and had not resulted in divergence in terms of plausible modelling to achieve targets.

Shifts towards lifestyles, individuals, role of the NHS?

In all countries there was a dominance of clinical and NHS financial priorities. There was little evidence of mainstreaming public health programmes. Many of the programmes were project-based around changing lifestyles (e.g. Five-a-day programmes, healthy eating, exercise on prescription). The wider determinants of

health were acknowledged quite strongly, and some organisations regarded their programmes of benefit take-up campaigns, prioritising home insulation, and regeneration as ones that would contribute to improving health. Nevertheless, when asked about how their organisations were responding to health inequalities, most respondents referred to lifestyle programmes.

There is some evidence from the interviews of a shift in emphasis towards lifestyles and clinical solutions in England with the new focus on “quick wins” by targeting the prescribing of statins, anti-hypertensives and smoking cessation aids. This is a somewhat paradoxical outcome of the specific but relatively short-term targets for reducing geographical health inequalities in England by 2010, encouraging organisations to focus on the "quick wins" achievable through clinical interventions, rather than on tackling the underlying determinants of health inequalities. In Wales local organisations were focusing on health improvement and were also clear that in the post-Jane Hutt [b] era the policy focus had shifted to *clinical* priorities (although this was more acknowledged than particularly welcomed). The focus on chronic illnesses, access to services and a need for more GPs reflected national policy concerns in Wales but meant the emphasis was on NHS services rather than wider determinants of health. In Scottish interviews the importance of the Smoking Ban was frequently emphasised, and although a key public heath initiative, its impact on inequalities remains unclear.

[b] Jane Hutt was Health Minister for the Welsh Assembly Government from 1999 to January 2005 when she was moved following criticism of long hospital waiting lists.

Discussion

It is important to note that this study is multifaceted and this short paper necessarily obscures some of this complexity. It should also be noted that there are inevitable challenges both in comparing policy statements with respondents' accounts and in comparing different countries to each other through reference to case studies within those countries (particularly when these case studies incorporate a range of different organisations and population profiles). It is clearly difficult to capture local nuances and reflect the subtle, qualitative differences in style and values in each locale and thus the analysis has necessarily to be broad brush. However, the research was set up to investigate health inequalities as a 'wicked issue' in the context of differing approaches to performance assessment; what it offers is a reflection of how an array of interviewees in a variety local contexts (both in terms of organisational setting and socio-economic context) have interpreted and put into practice policy guidance. Whilst not unproblematic, and clearly acknowledged as time-bounded, this approach provides an important insight into how the three countries making up post-devolution Britain are responding to the challenges of reducing health inequalities; an area that has so far received relatively little research attention. This paper provides a useful snapshot of the how far and how fast devolution is impacting on policy divergence in this complex arena of health inequalities.

The analysis of policy statements undertaken for this project reveals a visible shift in policy approaches to health inequalities at the national level, which occurred in all three countries around 2003-2005. Whilst wider determinants of health still feature in more recent policy statements, the emphasis on lifestyle behaviours, individual responsibility

for health and clinical interventions all gained greater prominence[15]. The interview data do not significantly challenge this finding, suggesting that, despite widespread awareness of the wider determinants of health, interventions which involved (frequently targeted) attempts to change people's lifestyles and behaviours were more prominent. Furthermore, the interview data from 2006 support the finding from the policy analysis that: (i) in England, there has been a growing interest in the role that NHS and pharmacological interventions can play in tackling health inequalities; and (ii) that policy interest in public health issues in Wales has been pushed aside to some extent by a focus on health service related and clinical concerns. Such a shift was not so detectable in the Scottish interview data, although this may be a reflection of the timing of the interviews, rather than a more concrete difference. In 2007, after the change of government, Scotland did initiate a Ministerial Review on Health Inequalities showing the growing prominence of the issue.

The story which emerged from our analysis of public health policy documents differed substantially from accounts which claim a 'natural experiment' in health policy is occurring within the UK (e.g. Greer[8,16,17,18]). This suggests the differences in approaches to key public health concerns have perhaps been less than the differences in their approaches to health services. For, at least as far as health inequalities are concerned, whilst some differences are perceptible, it is the similarities that invite the most explanation.

A key factor may be the way in which 'health inequalities' have consistently been conceptualised as a problem relating to the poor health of poor people (or people in poor

areas), rather than as an issue which traverses the whole of society. As Table 2 illustrates (drawing on concepts developed by Graham and Kelly[14]), conceptualisations of health inequalities as an issue of 'health disadvantage' are prevalent in policy discourses in all three contexts, whereas references to 'social gradients in health' are rare. As Graham and Kelly[14] outline the former conceptualisation implies that targeted attempts to improve the health of particular groups are a logical response, whereas the latter suggests a broader, societal response is required. Other factors which may account for the similar policy discourses concerning health inequalities, such as political, ideological and institutional similarities between the three countries, are discussed elsewhere[15,19].

Like much policy-orientated research, this project is taking place against a shifting policy backdrop. Performance management systems, organisational structures and national political leadership and governments have all changed during the lifetime of the project and the account presented in this paper may soon be superseded, particularly now the political leadership of all three countries has differentiated. Initial indications from a second round of interviews completed in June 2008 suggest that policy and practice relating to health inequalities are beginning to diverge more significantly. This possibility will be explored in detail in the final report from this study, which is due to be published in February 2009.

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Table 1: Policy emphasis on the wider determinants of health

Policy context	**Illustrative examples**
England	*From Vision to Reality* (Department of Health, 2001a): 'The worst health problems in the country will not be tackled without dealing with their fundamental causes – poverty, lack of education, poor housing, unemployment, discrimination and social exclusion.'
Scotland	*Our National Health* (Scottish Executive, 2000): 'Poverty, poor housing, homelessness and the lack of educational and economic opportunity are the root causes of major inequalities in health in Scotland. We must fight the causes of illness as well as illness itself.'
Wales	*Well Being in Wales* (Public Health Strategy Division, 2002): **'**The mix of social, economic, environmental and cultural factors that affect individuals' lives determines their health and well being. We can only improve well being in the long term by addressing these factors.'

Table 2: 'Health disadvantage', 'Health gaps' and 'social gradients in health' (following Graham and Kelly, 2004)

Policy Context / Concept	England		Scotland		Wales	
	Discourse	Targets	Discourse	Targets	Discourse	Targets
Health Disadvantage	✓	✓	✓	✓	✓	✓
Health gaps	✓	✓	✓	✗	✓ (limited)	✓*
Social gradients in health	✓ (limited)	✗	✗	✗	✗	✗

* Non-quantified