Northumbria Research Link

TACKLING HEALTH INEQUALITIES IN POST-DEVOLUTION BRITAIN:

DO TARGETS MATTER?

ABSTRACT

It has been claimed that since devolution in 1998, public policy has diverged between England, Scotland and Wales, including how targets and performance assessment are used in the National Health Service and local government. Health inequality is an example where all three countries have recognised a need to act but approaches to performance assessment have differed. Based on 130 interviews with mainly senior managers, the complexity of health inequality as an object of local intervention is explored and compared. Despite contrasting approaches to targeting, local discourses in all three countries had significant similarities. Health inequality was recognised as a priority but one that was secondary to improving access to acute services and balancing the budget, and health-related behaviours were the main approach to intervention. There was relatively little use of evidence of efficacy and signs that improvements in how health inequalities are measured locally may see a more medically-led approach in future.

INTRODUCTION

The United Kingdom's National Health Service (NHS) is based on universalist principles of providing care free at the point of need funded from general taxation. However, since devolution in Great Britain in 1998, and the restoration of devolved powers in Northern Ireland in 2007, the NHS has been under the separate jurisdictions of the Scottish Government, the Welsh Assembly Government, the Northern Ireland Assembly and, in England, the Department of Health. Although some aspects of health administration in each country were distinctive prior to devolution, each government has adopted approaches that give its NHS and wider public health policies a particular national character (Greer and Rowland 2007). This is especially the case regarding the use of targets and performance assessment, structures for planning and delivering care and improving health, and approaches to charging for prescribed medicines and social care.

A focus that remains common across the UK's national governments is tackling health inequalities, which first moved onto the policy agenda following the Labour Party's general election victory in 1997, and has continued as a priority for the new devolved assemblies (NHS Scotland 2005; NHS Wales 2005; Secretary of State for Health 2006). This has created an opportunity to compare the effects of different national policy and organisational contexts on local action to tackle this issue, which presents particular challenges because of its complexity (Rainham, 2007). [Shouldn't we include reference to the comparative analysis of policy statements which Kat Smith led on? Seems odd not to.] This article compares England, Scotland and Wales, since at the time of our study the Northern Ireland Assembly was suspended. When the fieldwork was undertaken in 2006, Labour Party administrations were in power in all three countries, although following elections a year later the Scottish Nationalist Party took control of the Scottish Government, and in Wales the Labour Party lost majority control and formed a coalition with nationalist Plaid Cymru. All three countries, however, continue to prioritise tackling health inequality as a responsibility of both the NHS and partners in local government.

The relevance of these different national policy and organisational contexts is associated with the nature of health inequality as a 'wicked problem' (Blackman *et al*. 2006). Wicked problems present a challenge for public policy because relationships between cause and effect are complex and often not well understood, and even the definition of the problem may be contested or need revising as new manifestations arise (Rittel and Webber 1973). Health inequality is also a cross-cutting issue, with action needed across several fronts by both health services and other public services. Some of the features of health policy in Scotland and Wales, such as the emphasis on partnerships and integration in Scotland and on local autonomy in Wales, imply a particularly good context for tackling health inequalities, encouraging joined-up working and experimentation (Greer, 2006). In contrast, England's 'command and control' approach to local public services and its strong audit culture of centrally-driven targets and performance assessment may deliver when tackling an issue like reducing waiting times for treatment, but do not seem to fit well with the complexity of health inequalities where there is little knowledge and even less guidance about how to get from 'here to there' (Bevan and Hood 2006a; Propper *et al.* 2007; Smith 2005). National health inequality targets may serve to focus the attention of local actors on the issue, especially if they are held to account for measures of progress, but

may also be ignored or contested if there is not the organisational support or motivation or political will to achieve them (Lindberg and Wilhelmsson, 2007).

We were interested in investigating the concept of health inequalities in terms of the discourses of local actors set in the context of these national differences in local governance, performance management and targets. We might expect, for example, to see more of a discourse of working together in Scotland, of local experimentation in Wales and of working to prescribed targets in England. Senior figures at a local strategic level in the NHS, local government and various local partnerships were interviewed for the study, and the interview transcripts were analysed for key themes. The results discussed in this article are drawn primarily from 130 interviews carried out between June and August 2006. We also gathered and read local plans and reports, and used national policy documents to contextualize interviewees' accounts. Localities for the interviews were selected to be broadly comparable and in each country were a regional city and post-industrial hinterland areas, all with relatively high deprivation. In addition to the local interviews, a small number of contextualising interviews were undertaken with senior civil servants.

The national contexts are summarised in Table 1. In England, Primary Care Trusts (PCTs) are responsible for planning, improving health and commissioning health services from general practitioners (GPs, to whom commissioning is in the process of being devolved), from NHS trusts and, on occasions, from private and voluntary sector providers. All the PCTs in our study included 'Spearhead areas', a Department of Health designation given in 2004 to the 20 per cent of local authority areas with the poorest health and deprivation indicators. Targets for PCTs to reduce gaps in life expectancy and infant mortality by 10 per cent compared to the national average were introduced in 2001, the former based on the gap with what became the Spearhead areas. PCTs have lead responsibility for these targets but are expected to work with local authorities (LAs) and other partners, with coordination through local strategic partnerships (LSPs), which were introduced in 2001 to facilitate strategic collaboration across local organisations.

Table 1 near here

In Scotland, Health Boards (HBs) both plan and provide health care, without England's quasi-market of health care providers, although GPs largely remain independent contractors. This integration was further developed in 2004 with the introduction of community health partnerships (CHPs), bringing together the HBs and LAs to improve the coordination of health and social care services and take the lead role for tackling health inequality. The latter includes targets for the most disadvantaged neighbourhoods in Scotland to increase the rate of improvement across a range of health indicators. Community planning partnerships (CPPs) were also introduced in 2004 as local multi-agency regeneration vehicles that include health improvement in their remit, similar to English LSPs. All the CHPs in which we conducted interviews were pilots in Scotland's *Prevention 2010* initiative aimed at improving access to primary care services for the treatment of risk factors and promoting healthier lifestyles.

Wales retains the split between commissioning health services, which is undertaken by local health boards (LHBs), and the provision of these services by NHS trusts,

3

although without the additional use of private and voluntary sector providers seen in England's quasi-market. Unlike Scotland and England, where some but not all PCTs and HBs were coterminous with LAs at the time of our interviews, in Wales all the LHBs were coterminous with LAs. Although this implies better joint planning, both LHBs and LAs were relatively small compared to most of their equivalents in England and Scotland, with consequences for their ability to commission services strategically. This small scale of governance, which is now under review, reflected the localist paradigm in which devolution in Wales was implemented and within which local government had more influence and autonomy than its English and Scottish counterparts, including less intensive performance assessment from the centre (Blackman *et al.* 2006). NHS trusts were often larger in scale than the LHBs, resulting in claims that hospitals were too powerful and therefore consumed resources that could be spent on public health measures in the community. Partially in response to this, in 2003 the Welsh Assembly Government introduced a duty requiring LHBs and LAs to work together with other local partners to develop and deliver joint Health, Social Care and Well-being Strategies. These became operational from April 2005 for a three year period, so at the time of the interviews we were at the start of their second year. The strategies are expected to address inequalities in health and well-being alongside wider determinants of health, health promotion and improving access to services (NHS Wales 2005).

There are some interesting points to note from these comparisons. England introduced measurable national targets for reducing health inequalities in 2001, constructed on the basis of narrowing gaps between the least healthy areas or socioeconomic groups and the national average. These targets are included in the performance assessment regimes of both PCTs and LSPs (although not LAs or the NHS trusts that provide health care services). Scotland introduced targets a few years later but as improvement targets for the most deprived areas rather than 'gap narrowing' targets. Performance assessment of the Scottish targets includes reviewing how HBs are progressing with improving health indicators, but generally without the emphasis on whether gaps are narrowing that is evident in English assessments. Wales introduced national targets at the same time as Scotland, aiming for a more rapid improvement in health among the most deprived fifth of the country's population, but did not include these targets in local performance assessments of LHBs or LAs. Overall, therefore, with all three governments apparently committed to tackling health inequalities, there was a gradient in the extent of a target culture to tackle these inequalities. England's PCTs and LSPs were formally accountable for their progress with narrowing gaps in mortality and smoking rates and reducing teenage pregnancies; Scotland's health boards were accountable for the rate at which they were reducing smoking, mortality and teenage pregnancies in their most deprived areas; and Wales' local health boards had no formal requirement to account for their progress with tackling health inequalities, despite several national targets.

One of the most important reasons why these differences could matter is the distinction between health improvement and health inequality. As figure 1 illustrates in the case of the progress being made with Scotland's targets, it is possible to improve health – even in the most deprived areas – and see health inequalities widen, because the rate of improvement in more affluent areas is faster than in more deprived areas. However, as figure 1 shows, Scotland also faces a major challenge with improving average health in addition to narrowing health inequalities, given that

average life expectancy trails behind England, Wales and even England's Spearhead areas. This national context is likely to influence local perceptions of whether it is concentrating on differences in health between individuals and groups that matters or whether the challenge is to improve everyone's health. As discussed later in the article, the ostensible commitment to tackling the former in all three countries was interpreted differently at local level depending on local circumstances, and these included some targets other than health inequalities having more perceived importance.

Figure 1 near here

CONCEPTUALIZING HEALTH INEQUALITIES

The interviews started by asking respondents about how health inequality was defined within their organisation. Many different types of health issue were talked about and there was little consistency in the definitions used. Even in England, where prescribed national health inequality targets were something for which PCTs and LSPs accounted to regional agencies [do you mean SHAs – are these regional?], there were many different ways in which our interviewees defined health inequality, so the targets were having little effect on these conceptualizations. Most interviewees focused on the need to improve the health-related lifestyles of people living in deprived areas, although in Wales, for reasons considered below, there was a stronger narrative about improving access to care services and treatment.

Healthier lifestyles were widely described as a challenging objective because deprivation meant that local people were seen as less receptive than in more affluent areas to changing their behaviour. The lifestyles discourse perhaps reflected the emphasis on behaviours in national strategy documents, but there was also a strong local perspective that intervening to improve lifestyles by, for example, supporting giving up smoking, encouraging more exercise and promoting healthier eating, was the right thing to do. Indeed, there was often a view that lifestyle interventions – mainly projects with short-term funding - were not resourced sufficiently because of the priority given by national governments in all three countries to funding health care and treatment, especially spending on hospitals.

There was a surprising lack of scepticism about lifestyle interventions given how limited the evidence is that these interventions can be effective among low income groups, and the time and effort they generally need compared to their mostly modest results (Jain, 2006; Michie *et al.*, 2008). These interventions were believed to be the most effective way of narrowing health inequalities, but none of our respondents explained a plausible relationship between action in these areas and a measurable impact on health inequality. Often this was regarded as impossible to demonstrate because tackling health inequality was widely regarded as a long-term matter, and very few interviewees considered that much progress could be made in the short-term. There was, therefore, scepticism about how performance assessment systems could be useful given their focus on short-term measures. Health indicators were commonly regarded as demonstrating how much needed to be done rather than a means of assessing whether the right things were being done.

Health indicators were not used as a source of meaningful intelligence about what was working in any of the countries, but in England their incorporation into local targets meant that there was a distinctive narrative about whether localities were 'narrowing their gap'. The process was explained by one of the PCT Directors of Public Health as follows:

> 'What we've done is we've looked at our male and female life expectancy compared to the England average, we've done projections to show whether we're likely to meet our national targets or not … Then we put that into a reporting mechanism that goes to the board … We've also taken the same national target for the reduction in the gap in life expectancy between the worst quintile of local authorities and the England average and we've said okay let's take that same challenge and apply it within (the locality).'

This narrative about the gap was also evident in Scotland, although more in terms of narrowing local gaps than reducing national inequality. A Director of Public Health in one of the HBs commented:

> 'Although mortality in the under 75 population from coronary heart disease has been in decline, probably for the last 20 or 30 years, it's declining more rapidly in the more affluent population than it is in the more deprived populations and that gap is not narrowing. We've been set a target by the Scottish Executive through the Prevention 2010 initiative to try and close that gap, to reverse the widening trend'.

In contrast to England, there were no references in the Scottish interviews or policy documents to narrowing the gap with the national average. One of the Scottish civil servants we interviewed explained that aiming for national averages was not good enough because those in Scotland for the main health outcomes were too poor to be targets, while the alternative of measuring health gaps against a UK or English average would not be acceptable to a Scottish government. Tackling health inequalities was therefore operationalized as increasing the rate of health improvement in the most deprived areas, with narrowing the gap between these and the most affluent areas subject to monitoring by the Scottish government but not performance measures. Although the use of such performance measures in England meant that localities were busy measuring their gaps, the effect on the ground was in fact little different to Scotland, with both targeting health improvement measures on deprived areas, mainly to promote healthier lifestyles.

In Wales, there was an awareness of 'gaps' but they were not talked about as targets for intervention. Rather than the narrative of how far or fast the gap was narrowing, interviewees tended to see the issue they faced as one of poor absolute health that was a legacy of past health-damaging heavy industrial employment, which meant that access to care and treatment was a higher priority than prevention. An LHB planning and partnership manager explained:

> 'Well most of our work is looking at the management of long-term conditions, chronic disease management and, you know, the issues surrounding health and the history of deprivation in the area.'

Interviewees in Wales had difficulty talking about health inequality in terms of targets. The issue tended to be conceptualized in qualitative and largely absolute terms as one of widespread chronic illness in these localities. Not only were there no national targets for tackling health inequalities that were passed down to the local NHS, but at the time of our study there was widespread media coverage of the very high rates of both limiting long-term illness and incapacity benefit claims in the Welsh localities, which skewed local narratives towards managing demand on acute services and investing more in community health services. This was reinforced by Welsh Assembly Government policy documents on health, where the priority was to improve access to health care services in the community. This dominant focus was a reflection of the recent political history of Welsh government minister Jane Hutt. In 2005, Hutt had been moved from her role as Minister for Health and Social Services in the Welsh Assembly Government, where she had pursued a strong public health emphasis, following media and political controversy over rising waiting times for NHS treatment, which were often contrasted with them falling in England.

In England and Scotland there was a common perception among our interviewees that doing something about health inequality had moved from being an undercurrent in national policy to an explicit objective. Government adoption of targets, with local accountability for them, was clearly an important part of this perception. In contrast, in Wales interviewees tended to see reducing health inequality as an 'underlying direction', and health policy was regarded as being dominated by tackling pressures on acute care services. At the time of our interviews, the LHBs in Wales were dealing with over-spends while at the same time being under pressure to reduce waiting times for acute services and emergency admissions. The situation was summed up by one LHB chief executive as:

> 'It's almost like an ideological thing in a sense that it is a real drive from the Assembly to look at inequalities. But a lot of the performance management is around the hard stuff and the hard stuff at the moment is the waiting times and chronic disease management'.

A director of public health in another LHB explained that:

> 'You end up having to go for the health care access issue …so you know it's acceptable to talk about rectifying health inequalities through more equal access to health care services, which obviously is a determinant of health (but) you'd have wanted to tackle the health inequalities in lots of other ways'.

In England, all the interviewees in the PCTs regarded health inequality as something on which they needed to focus. This emphasis, however, varied from some describing it as a 'key priority' to others talking of it as a 'responsibility' among several others. The overriding priority was dealing with local NHS deficits and achieving waiting time targets, the former reflecting the high priority the then Secretary of State for Health was placing on tackling deficits at the time of the interviews. Health inequality, therefore, was not an issue that interviewees felt under any great pressure to resolve or in a position to deliver quickly. Thus, one comment by a local councillor was that:

> 'The government is very much public opinion and target-driven and they often want quick wins … you can get quick wins quicker by reducing waiting times than reducing health inequalities. I think the government seem to be setting the agenda and they've certainly put some extra resources in. So if they didn't interfere as much and there was a period of consolidation rather than permanent change, we might be allowed to achieve something!'

Indeed, NHS restructuring was a preoccupation in many of the English interviews. It was mostly seen to have little relevance to tackling health inequality and, instead, was criticised as disruptive and distracting.

The priority given to waiting time and budgetary performance in how NHS interviewees described their work was as evident in Scotland as in England and Wales. An NHS chief executive described the situation as follows:

> 'To some extent chief executives have to make sure that they achieve the things that they are going to get sacked for before they achieve anything else … There are some chief executives who would stop at that and there are others who kind of get that done as their licence to then go and do things that they would want to get done … Some of the priorities are more immediate, more measurable and waiting times and money are more politically sensitive than others.'

We asked specifically about teenage pregnancy rates in the interviews, because of the way national policies differed in framing this issue and its strong link with deprivation (Social Exclusion Unit 2005; see also table 1). In England, teenage pregnancies have been the subject of a national target and strategy since 2000, with all local authorities required to have measures in place to meet local reduction targets. A teenage pregnancy target was also introduced in Scotland in 2000 and was built on as a 15 per cent improvement target for the most deprived areas in 2005, when the target was incorporated into a national sexual health strategy (Scottish Office 1999; Scottish Executive 2005). A target to reduce teenage pregnancies was introduced in Wales in 2000 as part of a national sexual health strategy, although the target appears not to have been quantified until incorporated into the Welsh Assembly Government's child poverty strategy in 2006 (Welsh Assembly Government 2006).

Teenage pregnancy was only talked about as a target by interviewees in England, typically in the following terms as expressed by one of the PCT heads of performance management:

> 'Yeah, teenage pregnancies is one of our key targets, must do targets. All the time, we've got probably 65 or 70 targets that I carry round in my head that we're measuring and they're split up into core standards, existing targets, new targets …'

In Scotland and Wales, teenage pregnancy was constructed as part of a wider sexual health matter that was the subject of programmes focusing on sexually transmitted diseases. A director of public health in Wales commented that although there were no targets:

'… we have some strategies and we have some related projects but I guess the area of actually biggest concern is actually sexual health services … and how non-responsive they are …'

In some of the Scottish and Welsh localities, teenage pregnancies were regarded by interviewees as rare, despite these areas having rates similar to the English localities, where incidence was regarded as high and a specific object for intervention. Although there were national differences in the degree of focus on the issue, the national trends in teenage pregnancy rates from 2000 to 2005 do not reflect this very obviously (see figure 2). It is Wales that has seen the greatest reduction in rates, despite lacking a national target until 2006 and all interviewees in our study saying there were no local targets. England has also seen rates decline, although at a slower rate since a national target was introduced. Scotland has seen its downward trend reverse in recent years. There is no evidence from these comparisons that targets have influenced the trajectory of teenage pregnancy rates.

Figure 2 near here

To sum up at this point, the existence of health inequality targets that were incorporated into local performance assessment regimes clearly had an effect on the perceived importance of the issue in the English and Scottish localities. The absence of these arrangements in Wales meant that the issue was getting relatively little attention as an explicit objective for local planning and intervention. However, this made relatively little difference to what was said to be happening on the ground, which in all three countries was largely about delivering projects in deprived areas to promote healthier lifestyles. There may have been more of these in some places than others, but it was impossible to say whether this made any difference because there was no modelling of expected outcomes and little evaluation. [Presumably, too, the focus on 'pojectitis' meant that when funding ended, the initiative ended even if successful rather than becoming embedded in mainstream provision.] Tracking change in health inequality indicators tended to be described in more sophisticated terms by interviewees in England because there were more reporting requirements, but this monitoring was at a high level and there was little connection with implementation. It is interesting to ask the question why this did not matter, given that it clearly would have done for targets like balancing the budget or reducing waiting times. The answer appears to be that in all the countries there was a hierarchy of priorities in which waiting times and balancing the budget trumped health inequality, so the issue was *a* priority but not *the* priority, and was therefore a question of demonstrating that *something* was being done but without pressure to actually deliver the targets (a finding echoed in Hunter and Marks 2005).

CAUSE AND EFFECT

In England, interviewees were much more likely than in Scotland or Wales to talk about health inequality in terms of targets and performance assessment, and to say that there were advantages that performance assessment could bring to working on health inequalities. The following comment about the teenage pregnancy target is an example:

9

'We started driving teenage pregnancy down and all of a sudden it goes back up and now we're the highest in the region … Well, it's no good reacting sort of oh well let's do something … we have to revisit our strategy and make sure we've got the right plans in place, and that's exactly what we're doing.'

However, as we considered when looking at the teenage pregnancy rate trends, there was little evidence that it is planned actions that drive these trends. Why local trends were going in the direction that they were was essentially a 'black box'. One director of public health commented with regard to the good progress in his locality that was being made with narrowing inequalities between small areas that:

'We don't know why we're doing it right … whether it's due to anything we're doing to the actual incidence of disease or whether it's about accessibility of treatments, we don't know … Our message to the service providers has been to keep on doing what you're doing!'

In Scotland, health inequality was not primarily talked about in terms of targets and instead tended to be considered more generally as an issue of social inclusion and social justice. There was a common view among Scottish interviewees that health inequality measures were hard to define, systematize and use for anything other than long-term monitoring.

In Wales, there were few references to measures or quantified targets. Local analysis was undertaken but its implications were often said to be overshadowed by the powerful position of hospitals, as this LHB chief executive commented:

'We have the general goal of bringing up, you know, the health of the poorest to those who are of the highest level which is actually talking about a ten year gap in life expectancy … So it gets in there as a rational kind of analysis … you know, the biggest killers are cardiovascular disease, therefore we should be doing something about that. What are the determinants of cardiovascular disease …? We go through that process but then at some point I think the linkage is lost and decisions only tend to be made at the margin, so the great edifice which is the hospital sails on and the main decisions are made, though only on the margin'.

Although the long-term nature of change in population health and problems of causal attribution were often mentioned as obstacles to understanding the effectiveness of interventions, there were few references to available evidence in the interviews. Interviewees often said that decision-making was more evidence-based than a few years ago, and it was clear that decisions were expected to be supported by evidence about need or different ways of working, but peer-reviewed, published research rarely figured compared to examples of good practice gleaned from conferences or official publications. Very few interviewees pointed to evidence that their local programmes to tackle health inequalities were having a measurable effect, and although local evaluations were occasionally cited as a source of learning about what works, some interviewees commented on the lost opportunities to learn from local projects. There appeared to be a lack of awareness about evaluations that had been undertaken, usually nationally, with the implication that learning from these had been limited.

There were also said to be imperatives that could override 'evidence', such as local political difficulties about steering resources away from less to more deprived areas, and the political priority given to waiting time targets. The latter was summed up by a performance manager in one of the Welsh LHBs as follows:

> 'They've set targets all about waiting times … that's what you're judged on and if your job depends on it, why are you going to disinvest from that and invest long term with preventative services?'.

The difficulty of measuring local health inequalities, especially short-term measurements, was cited by some interviewees as one reason why the issue lost out compared to waiting times and budgets. If the impact of interventions could not be demonstrated over a reasonably short time period, this seems likely not only to inhibit experimentation but also the ability to make the case for interventions that would divert funding away from other targets like waiting times.

This raises the question of whether the extent to which there was even a receptive context locally for tackling health inequalities varied across the three countries. Interviewees in Scotland regarded their NHS as in a better position than in England to tackle health inequality because it was not going down the English route of using the private sector to increase choice and contestability in health care provision. Scottish interviewees felt this worked against the coordination and joint planning needed to tackle health inequalities. One interviewee remarked, 'We don't have competition, we don't have commissioning, we have planning'. [This is in line with the Kerr report's thinking outlined in *Building a Health Service Fit for the Future*, Scottish Executive, 2005, which sought to chart a different direction for the NHS from that being taken in England. Kerr]

However, there was often a view in Scotland that joined-up planning did not extend to health inequality. On the ground, many interviewees felt that there was little sense of a coherent strategy, with the NHS instead preoccupied with waiting times and service reconfiguration. Although there were innovative projects going on, they were described as too often short-term and sometimes lacking coordination. Comments were also made about local objectives not being focused enough, which resulted in a lack of clarity about who was leading and accountable for what.

These comments essentially related to partnership working, which was generally seen as essential to tackling health inequalities. But although partnership working was rarely questioned as an ideal the reality was more complex given different organisational priorities. For example, in England recent joint appointments of directors of public health (DsPH) between the PCT and the LA were generally regarded very positively, but DsPH themselves could be frustrated by the way health inequality was not a shared priority. They were often positive about working with LAs, but some contrasted this with how difficult it was to keep health inequality on the agenda of the NHS. One commented that, 'It's almost like having a Trojan horse … to see if I can infect people with public health thinking'. Another explained that, 'right now, people's jobs are driven by patient demand and GP demand, custom and practice'. LSPs were regarded as important local planning vehicles for tackling health inequality, for which they had a series of targets, but their role was said to be largely confined to supporting various short-term health improvement projects. These were

often cited as examples of good partnership working 'on the ground' but, as yet, there was little evidence from interviewees' accounts of LSPs having an impact on health inequality at a strategic level, where organisations were said still to be largely focused on their own priorities.

In Scotland, local authority engagement with health inequality varied and although some interviewees saw their authority as having an important role, it was often the CHP that was regarded as the vehicle for tackling the issue. CHPs were viewed as positive developments because they meant that the NHS and local authorities could act together, but their degree of engagement with health inequality also varied, reflecting local histories and experiences.[There's a critical Audit Commission (or whatever the correct title for the Scottish equivalent is) on partnership working in Scotland centring on the lack of clarity from the centre as to what the priorities are. The result is that CHPs and CPPs receive conflicting messages from the centre and may be asked to do too much for which they are not adequately resourced.] As in England, successful examples of partnership working on the ground were sometimes contrasted with the difficulty of working in partnership at a strategic level when organisations had separate budgets and accountabilities. There were signs, though, that strategic partnerships were beginning to work, as explained by this HB chief executive:

> 'For example, we got £1 million and we took that to the local council and said we've got this money to do these things, and they invested £200,000 on top of the £1 million for us to make it that bit more integrated with what they do. In the olden days that would have been "our money, our priority" but because we've got really good partnership structures we're able to go and say you know this is what we're going to try and achieve, how can we add value to it. Often it isn't financial resource, often it's just yes we'll help you do it, yes we'll support it as a priority, yes we'll put it on the agenda of that meeting, yes we'll give you space in that school to do that on a Friday night or whatever it is.'

In Wales, the Health, Social Care and Well-being Strategies were said to be successful in engaging LAs with health improvement, and these strategies were often described as having objectives for tackling health inequality, informed by the health needs assessments required to be undertaken before formulating them. An LHB director of corporate development commented that:

> 'We focused really for the first time on communities in this locality … it's a first opportunity to look directly at the needs of the population, not as before just as a part of some larger regional or countywide entity.'

This LHB view was echoed by the LA's chief executive:

> 'We had an event earlier in the year with all the partners and I've got to be honest two years ago we couldn't have even hoped to have put something on like this. That's how far we've come with partnership working … I've been in local government thirty years and I haven't always been that close with health colleagues before.'

However, there was a view that the Health, Social Care and Well-being Strategies contained too many objectives and were aspirational rather than specific. In reality, interviewees in Wales felt that joint action still tended to be dominated by issues about hospital discharges and transfers of care between the NHS and local authorities.

LA interviewees in all three countries rarely considered how health could be improved through their services except in general terms, such as the general health benefits of improving housing, or by particular project initiatives. The latter included schemes such as 'exercise on prescription' or other lifestyle projects often dependent on short-term funding. There was an assumption that local government services were beneficial to health but little evidence that they were the best option or delivered in the best way to narrow health inequalities. Some interviewees in the LAs, in all three countries, cited the lack of any specific mainstream funding for health improvement or prevention as the reason why they did not engage more with these issues.

CONCLUSIONS

The aphorism that 'what's measured is what matters' (Bevan and Hood 2006b, p. 517) clearly needs qualifying in the case of national policies for tackling health inequalities in Great Britain. All three countries measured health inequalities to some extent, with England in particular embedding this as targets within local performance assessment regimes at commissioning and strategic levels. This certainly sent a signal to local actors that health inequalities were a priority but other priorities mattered more. This meant that health inequalities were measured locally but that there was little motivation or support to model the effect of interventions or to evaluate whether they were the right things to do or being done on a sufficient scale. Extensive evidence of more unhealthy lifestyles in deprived areas meant that interventions to promote healthier behaviours were adopted, but interviewees could give little evidence that they would be effective in narrowing health inequalities or that they were systematically and robustly evaluated.

There was little local pressure for the situation to change. In Scotland and England public consultations about health inequalities and how to tackle them were said to be rare. In Wales, the Health, Social Care and Well-being Strategies had been developed with significant community engagement but local priorities were dominated by access issues and waiting times, and this was said to reflect where the public's concerns really lay. This then became 'political reality'. There was even a questioning of the extent to which there could be bottom-up pressure to reduce health inequality from the people most affected: 'You know, quite often you're dealing with people that don't want to live another ten years. Life's pretty hellish for them, why would they want another ten years of it?'. Another interviewee added: 'People bury their heads in the sand in this locality and don't want to even think about cancer'. These comments reflect other findings that those most negatively affected by health inequalities often do not acknowledge or act on these inequalities as an issue (Blaxter 1997; Popay *et al*. 2003). Public and community opposition was also described as making it difficult to 'bend' spending into the areas with the greatest health needs if, as a consequence, other areas would be seen to lose out.

The 'wicked' nature of health inequalities, however, may mean that it is unrealistic to expect to be able to model the anticipated effect of interventions on health inequalities or evaluate these interventions with any certainty. There may be too many interactions and factors that cannot be adequately controlled to isolate the effects of the intervention. It may simply all be too difficult, [or politically unpalatable/unacceptable – if health inequalities are a reflection of income inequality and the social gradient, action could be taken if there was sufficient political will to do so – perhaps some actions are simply off the agenda which might be seen as an example of the limits to policy-making] undermining motivations to work together strategically and making health inequalities vulnerable to being eclipsed by issues where demonstrable achievements are possible (notably reducing NHS waiting times) while still being seen to be 'doing something' about health inequalities by setting targets and running projects broadly focused on these targets but with relatively little impact.

It was in England that targets and performance assessments systems extended most to health inequalities and this was on balance generally thought to be helpful because of the attention to the issue that it brought.[Yes but given all the latest evidence, eg new health profiles published this week, testifying to health inequalities at least as pronounced now as they were 10 years ago, one is inclined to conclude that targets and performance assessments have largely failed. It's surely not good enough simply to suggest that because targets brought attention to the issue this is an indicator of success.] It is perhaps not surprising, therefore, that it was also in England that there were signs that the short-termism of performance assessment was shifting the focus of local interventions downstream to secondary prevention rather than primary prevention. Reflecting recent Department of Health guidance, some interviewees talked about the 'quick wins' in narrowing health inequalities that could be achieved by targeting deprived areas and groups with significant increases in drug therapies to control risk factors, notably statins, antihypertensives and aids to quit smoking (Department of Health, 2005).

The development of new preventative treatments such as statins illustrates the complex and shifting landscape in which work to tackle health inequalities takes place (Lester and Fitzgerald 2008; Watt and Mackay 2006). The political landscape is also shifting; since we undertook our interviews in 2006 there have been significant changes in political control in the Scottish and Welsh governments, and a change of prime minister in Westminster, that have seen new emphases in health inequality plans and reforms to performance assessment that will affect the context in which local work to tackle health inequality is undertaken (Department of Health, 2008; Scottish Government, 2008; Welsh Assembly Government, 2007). [But these latest offerings really only amount to 'more of the same' so what prospect is there of a step change difference in what happens locally? Possibly the Scottish cross-government report is more ambitious and innovative than the DH effort which seems weak and a re-run of earlier failed efforts but time will tell.]

In recognition of this dynamism, we are returning to our localities in 2008 to re-interview local actors to understand how these changes affect their narratives on health inequality. What is apparent so far is that health inequalities present one of the biggest challenges facing the local public services expected to narrow them, but despite national policy commitments the issue is easily overshadowed locally by

higher political priorities, even with health inequality targets and performance assessment. Local interventions also appear to be dominated by lifestyle approaches of questionable efficacy. However, if the ability to scope and measure health inequalities locally improves – and there was evidence from our interviewees that this was happening - we might begin to see some interesting re-alignments of local priorities, including a possible shift to more medically-led interventions. [Have we answered the question posed in the title? Maybe this needs to be addressed more explicitly at the end as a wrap up.]

ACKNOWLEDGEMENTS

REFERENCES

Bevan, G. and Hood, C. 2006a. 'Have targets improved performance in the English NHS?', *British Medical Journal*, 332, 419-422.

Bevan, G. and Hood, C. 2006b. 'What's measured is what matters: targets and gaming in the English public health care system', *Public Administration*, 84, 3, 517-538.

Blackman, T., Harrington, B., Elliott, E., Greene, A., Hunter, D., Marks, L., McKee, L. and Williams, G. 2006. 'Performance assessment and wicked issues: the case of health inequalities', *Public Policy and Administration*, 21, 2, 66-80.

Blaxter, M. 1997. 'Whose fault is it? People's own conceptions of the reasons for health inequalities', *Social Science & Medicine*, 44, 6, 747-756.

Busse, R. and Wismar, M. 2002. 'Health target programmes and health care services – any link? A conceptual and comparative study (part 1)', *Health Policy*, 59, 209-221.

Department of Health. 2001. *From Vision to Reality*. London: DH.

Department of Health. 2005. *Tackling Health Inequalities: What Works*. Best Practice Guidance. London: DH.

Department of Health. 2006. *Tackling Health Inequalities: Status Report on the Programme for Action – 2006 Update of Headlines Indicators*. London: DH.

Department of Health. 2008. *Health Inequalites: Progress and Next Steps.* London: DH.

Greer, S. 2006. 'The politics of health policy divergence', in J. Adams and K. Schmueker (eds), *Devolution in Practice 2006: Public policy differences within the UK*. Newcastle Upon Tyne: IPPR North.

Greer, S. L. and Rowland, D. 2007 (eds). *Devolving Policy, Diverging Values? The Values of the United Kingdom's National Health Services*. London: The Nuffield Trust.

Hunter, D. J. and Marks, L. 2005. *Managing for Health. What incentives exist for NHS managers to focus on wider health issues?* London: Kings Fund.

Jain, A. 2006. 'Treating obesity in individuals and populations', *British Medical Journal*, 331, 1387-90.

Lester, N. and Fitzgerald, K. 2008. *Coronary heart disease mortality and statin prescribing in Wales*. Cardiff: National Public Health Service for Wales.

Lindberg, M. and Wilhelmsson, S. 2007. 'National public health target awareness of staff at two organisational levels in health care', *Health Policy*, 84, 243-248.

Michie, S., Jochelson, K., Markham, W. A. and Bridle, C. 2008. *Low-income Groups and Behaviour Change Interventions*. London: King's Fund.

NHS Scotland. 2005. *Building a Health Service Fit for the Future*. Edinburgh: Scottish Executive (Kerr Report).

NHS Wales. 2005. *Designed for Life: Creating world class Health and Social Care for Wales in the 21st Century*. Cardiff: Welsh Assembly Government.

Popay, J, Thomas, C. Williams, G. Bennett, S. Gatrell A. & Bostock, L. 2003. 'A proper place to live: health inequalities, agency and the normative dimensions of space', *Social Science & Medicine*, 57, 1, 55-69.

Propper, C, Sutton, M, Witnall, C & Windmeijer, F. 2007. *Did targets and terror reduce waiting times in England for hospital care?* CMPO Working Paper Series no. 07/179.

Rainham, D. 2007. 'Do differences in health make a difference? A review for health policymakers'. *Health Policy*, 84, 123-132.

Rittel, H., and Webber, M. 1973. 'Dilemmas in a General Theory of Planning', *Policy Sciences*, 4, 155-169.

Scottish Executive. 2004. *Building a Better Scotland Spending Proposals 2005-2008: Enterprise, Opportunity, Fairness*. Edinburgh: Scottish Executive.

Scottish Executive. 2005. *Delivering for Health*. Edinburgh: Scottish Executive.

Scottish Government. 2006. *Delivering a Healthy Scotland Meeting the Challenge: Health Improvement in Scotland Annual Report*. Edinburgh: Scottish Government.

Scottish Government. 2008. *Equally Well: Report of the Ministerial Task Force on Health Inequalities*. Edinburgh: Scottish Government.

Scottish Office. 1999. *Towards a Healthier Scotland*. Cm 4269. Edinburgh: The Stationery Office.

Secretary of State for Health. 2006. *Our health, our care, our say: a new direction for community services*. Cm 6737. London: TSO.

Smith, P. C. 2005. 'Performance Measurement in Health Care: History, Challenges and Prospects', *Public Money & Management*, 25, 3, 213-20.

Social Exclusion Unit. 1999. *Teenage Pregnancies*. London: SEU.

Watt, G. and Mackay, D. 2006. *The prescribing of statins in general practices serving the most deprived populations in Scotland and NHS Greater Glasgow*. Report 4. Glasgow: General Practice and Primary Care, University of Glasgow.

Welsh Assembly Government. 2004. *Targeting health improvement for all: Health gain targets – National high-level targets and indicators for Wales*. Cardiff: WAG.

Welsh Assembly Government. 2006. *Eradicating child poverty in Wales – Measuring success*. Cardiff: Welsh Assembly Government.

Welsh Assembly Government. 2007. *One Wales: A progressive agenda for the government of Wales*. Cardiff: Labour Party Wales and Plaid Cymru.

Figure 1. Life expectancy at birth: England, Scotland and Wales, 1996-98 to 2004-06

Source: Office for National Statistics

Legend:
- Females: England average
- Females: England Spearheads
- Females: Wales
- Females: Scotland
- Males: England average
- Males: England Spearheads
- Males: Wales
- Males: Scotland
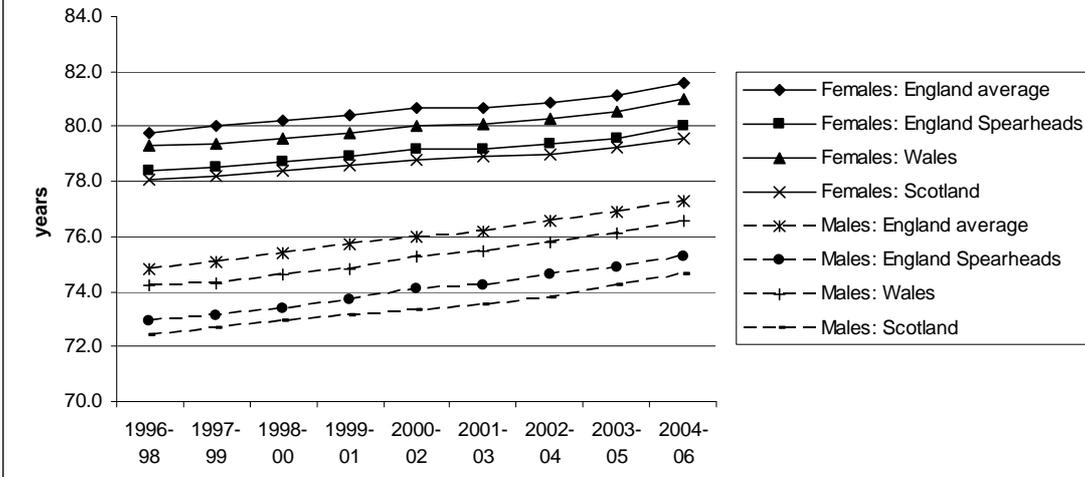
Figure 2. Teenage conception rate: England, Wales and Scotland, 1998 to 2005

rate per 1000 women aged 15-17

Legend:
- England
- Scotland
- Wales

X-axis: 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005

Y-axis: 30, 35, 40, 45, 50, 55, 60

Source: Office for National Statistics

19
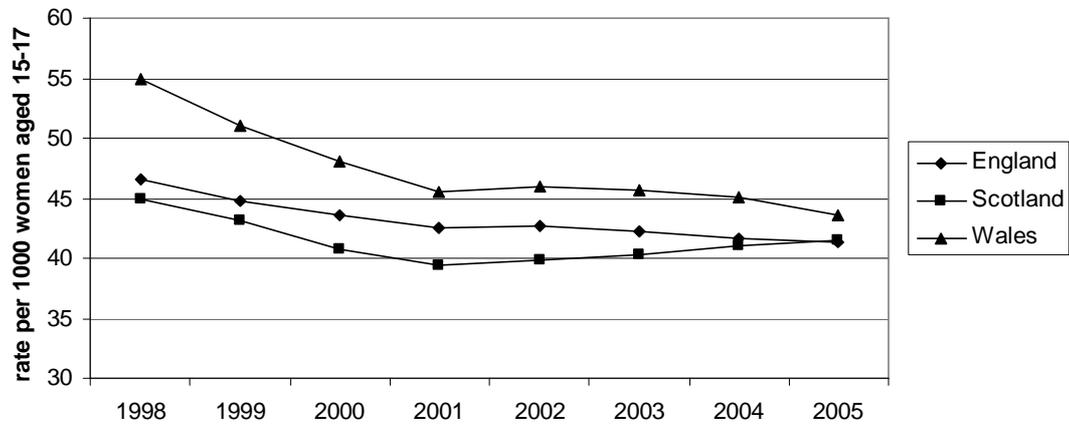
Table 1: Local governance, performance management and targets for health inequalities: England, Scotland and Wales (2006)

	Local governance arrangements	Performance management	Health inequalities targets	Progress as reported at time of interviews (2006)
England	Primary Care Trusts (PCTs) are local NHS organisations that commission health services and are responsible for improving the health of their local populations. They have lead responsibility for health inequalities and are expected to work with their local authorities as well as the private and third sectors. These sectors are represented on Local Strategic Partnerships (LSPs) that facilitate multi-agency collaboration. In 2004, the fifth of local authority areas with the worst health and deprivation indicators were designated as the 'Spearhead group'.	The UK Government adopted national health inequalities targets for England in 2001 for life expectancy, infant mortality and teenage pregnancy. An inequalities element was also added to national targets for cancers, circulatory diseases and smoking. Performance management is focused on the Spearhead group, with PCTs accountable for progress against the targets to regional Strategic Health Authorities and LSPs accountable to regional Government Offices.	Reduce by 10% the relative gap in life expectancy between the Spearhead group and England as a whole (1998 to 2010).	Off target.
			Reduce by 10% the relative gap in infant mortality between the routine and manual occupational group and England as a whole (1998 to 2010).	Off target.
			Reduce by 6% the absolute gap in premature deaths from cancers between the Spearhead group and England as a whole (1996 to 2010).	On target.
			Reduce by 40% the absolute gap in premature deaths from circulatory diseases between the Spearhead group and England as a whole (1996 to 2010).	On target.
			Reduce smoking rate to 21% among all adults and to 26% among the routine and manual occupational group (1998 to 2010).	Off target for routine and manual group; no narrowing of the gap with all adults.
			Reduce the under-18 conception rate by 50% (1998 to 2010).	Off target; no narrowing of the gap between the most deprived fifth of local authority districts and the England average.

Scotland	Local Health Boards are integrated planning and provider NHS organisations. They are represented along with local authorities on Community Health Partnerships (CHPs), which take the lead role for tackling health inequalities, and on Community Planning Partnerships (CPPs), which are similar to LSPs.	The Scottish Executive set targets for tackling health inequalities in 2004. CHPs are accountable to their Health Boards, and the performance of the Health Boards is reviewed through annual assessments chaired by a Scottish Executive minister.	The targets relate to the most deprived fifth of data zone areas in Scotland for the period 2003 to 2008: Reduce smoking during pregnancy by 10.0%.	On target, but because smoking rates in the most affluent areas decreased faster, the inequality gap widened.
			Reduce adult smoking rates by 10.9%.	On target. Inequality gap narrowed.
			Reduce the under 75 cancer mortality rate by 10.1%.	On target. Inequality gap widened and then levelled out.
			Reduce the under 75 coronary heart disease mortality rate by 27.1%.	On target. Inequality gap narrowed.
			Reduce teenage pregnancy rate per 1000 13-15 year olds from 12.6 to 8.4.	Off target. Inequality gap widened.
Wales	Local Health Boards (LHBs) are local NHS organisations that commission health services and are responsible for improving the health of their local populations. LHBs and local	In 2003-04 the Welsh Assembly Government revised its health gain targets to include indicators for monitoring health inequalities. In addition, in 2006 a series of child poverty	Reduce coronary heart disease age-standardised mortality in 65-74 year olds to 400 by 2012 and at the same time aim for a more rapid improvement in the most deprived groups. Reduce cancer age-standardised mortality in those aged below 75 by 20% between 2002 and 2012 and at the same time aim for a more	No reporting has been carried out.

authorities have a duty to work together to deliver joint Health, Social Care and Well-being Strategies that address health improvement and inequalities.	targets were published that included several health inequality targets. LHBs report their performance on various measures and standards to the Welsh Assembly Government, but this does not include health inequality indicators.	rapid improvement in the most deprived groups. Reduce the ratio in the infant mortality rate between the most deprived and affluent fifths of the population from 1.61 in 1998-2002 to 1.3 in 2020. Reduce the ratio in the low birth weight rate between the most deprived and affluent fifths of the population from 1.23 in 1998-2002 to 1.12 in 2020. Reduce the ratio in the under-16 conception rate between the highest local authority area rate and the average for Wales from 1.61 in 1999-2001 to no more than 1.3 in 2020.

Sources: Department of Health, 2006; Scottish Government, 2006; Welsh Assembly Government, 2004; 2006;