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Tackling health inequalities in post-devolution Britain: do targets matter?

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TACKLING HEALTH INEQUALITIES IN POST-DEVOLUTION BRITAIN: DO TARGETS MATTER?

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Abstract

Since devolution in 1998, many aspects of public policy in Great Britain have 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 recognized a need to act but approaches to performance assessment differ. Based on interviews with senior managers, the complexity of health inequality as an object of local intervention is explored and compared. Despite contrasting approaches to targets, local discourses in all three countries had significant similarities. Health inequality had to compete against a preoccupation with improving access to acute services generally and balancing budgets over the short term. There was a bias in the interventions described towards targeting health behaviours, but with limited use of evidence about efficacy, and indications that measuring progress with reducing health inequalities was starting to lead to an emphasis on 'quick wins' from pharmacological interventions.

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 policy regimes 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).

Tackling health inequalities has remained a commitment for the new devolved assemblies but approaches to the issue differ, especially regarding the use of targets (NHS Scotland 2005; NHS Wales 2005; Secretary of State for Health 2005). Health inequality is a 'wicked problem' that presents particular challenges for targets and their use in performance assessment (Blackman *et al*. 2006; Rainham 2007; Smith *et al.*, 2009). Relationships between cause and effect are complex and often not well understood, and even the definition of the problem may be contested (Rittel and Webber 1973). Health inequality is also a cross-cutting issue, with action needed across several fronts by both health and other public services.

Some of the features of health policy in Scotland and Wales, such as the emphasis on integration and partnerships in Scotland, and on local autonomy and joint strategies in Wales, imply a particularly good context for tackling health inequalities, encouraging

joined-up working and experimentation (Greer 2006). In contrast, England has been characterized as having a 'command and control' approach to local public services, with a strong audit culture of centrally driven targets and performance assessment. This may deliver when tackling an issue like reducing waiting times for treatment but does 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' (Smith 2005; Bevan and Hood 2006a; Propper *et al.* 2007). National health inequality targets may focus the attention of local actors on the issue, especially if they are held to account for measures of progress, but may be ignored or contested if there is not the support, motivation or political will to achieve them (Lindberg and Wilhelmsson 2007).

This article reports on a study of health inequality that examines the discourses of local actors in the NHS, local government and multi-agency partnerships in England, Scotland and Wales. These are considered in the context of national differences in local governance, performance assessment and targets. The study excludes Northern Ireland because at the time of the fieldwork its 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.

Senior figures at a local strategic level in the NHS, local government and various local partnerships were interviewed 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,

strategies 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 a regional city and post-industrial hinterland area was part of the selection, all with relatively high deprivation. In addition to the local interviews, a small number of contextualizing interviews were undertaken with senior civil servants.

The policy contexts

Before presenting an analysis of the interviews, this section describes some key features of the three national policy contexts. Policy documents current at the time of the interviews reveal some differences in emphasis regarding policies to tackle health inequality. In England, health inequality targets aimed for faster than average health improvements among the most disadvantaged groups and areas, primarily by encouraging healthier lifestyles:

> Despite overall improvements, there remain big – and in some communities increasing – differences in health between those at the top and bottom ends of the social scale … Our fundamental aim must be to create a society where more people, particularly those in disadvantaged groups or areas, are encouraged and enabled to make healthier choices. In order to close the gap, we must ensure that the most marginalised and excluded groups and areas in society see faster improvements in health … We have included targets to improve people's chances for better health and reduce inequalities in the Public Service Agreement (PSA) framework, which drives forward the

Government's highest priorities . . .. (Secretary of State for Health 2005, pp. 10–11)

In Scotland, the equivalent policy document also emphasises increasing the rate of health improvement among the most disadvantaged groups, but highlights tackling the wider determinants of health inequality rather than individual behaviour change:

There are unacceptable differences in healthy life expectancy in Scotland ... The Executive's approach to closing the opportunity gap by tackling poverty and disadvantage in Scotland will benefit the health of people living in the most deprived communities by addressing aspects of poverty such as improving people's employability, increasing young people's confidence and skills and regenerating the most disadvantaged neighbourhoods ... We have made clear our determination to achieve progress by settings targets to increase the rate of improvement ... for the most disadvantaged communities. (NHS Scotland 2005, pp. 22, 24)

In both England and Scotland, the NHS is also regarded as being able to do more to tackle health inequalities by targeting resources at greatest needs. In Wales, however, there is an overriding emphasis on the NHS itself compared to either encouraging healthier lifestyles or tackling wider determinants. Modernizing services and improving access to care across the population are emphasized in its key policy document of the time, *Designed for Life* (NHS Wales 2005). 'A new vision' for the NHS in Wales includes an aim to 'improve health and reduce, and where possible

eliminate, inequalities in health' (p. 4) but the approach is more tentative than in the other two countries, with the issue primarily one for future action:

> We will assess how much progress we have made in improving the health of Wales and reducing health inequalities. Having completed this, we will publish a revised health inequalities strategy in 2009. This will:

> – build on success;
> – bring renewed impetus to our service improvement agenda;
> – adjust for the growing maturity of our partnerships. It is likely that many of these will have become developed and sophisticated enough to become 'self directive' requiring only a light touch from the centre. (NHS Wales 2005, p. 42)

This last point reveals a more cautious approach in Wales to using performance management from the centre to achieve change locally. *Designed for Life* contains a commitment to strengthening performance management but only in relation to service improvements in the NHS and not health inequalities. In England, targets set at the centre are presented as 'driving forward' health priorities at the local level across the NHS and local government, including targets for health inequalities and local partnerships. Scotland occupies a middle position, with central targets that include health inequalities but none of England's language of 'command and control' and instead an emphasis on monitoring and support for improvement.

Table 1 presents further detail on these national contexts, including local governance arrangements, performance management, targets, and progress at the time of our fieldwork. England's NHS has a commissioner/provider split. Locally, Primary Care Trusts (PCTs) are responsible for commissioning health services from general practitioners, NHS provider trusts and, on occasion, private and voluntary sector providers (some aspects of commissioning are also being devolved to GPs). 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 in England 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; further more detailed targets followed. PCTs have lead responsibility for these targets and are assessed for their performance by regional Strategic Health Authorities. They are expected to work with local authorities (LAs) and other partners with coordination through local strategic partnerships (LSPs). The targets should shape PCTs' decisions about the services they commission. Since 2005/06, the performance of both PCTs and NHS provider trusts against both national targets and a set of public health standards that include health inequalities has been independently assessed annually by the Healthcare Commission.

Table 1 near here

In Scotland, Health Boards (HBs) both plan and provide health care, thus operating without England's commissioner/provider split. GPs largely remain independent contractors. This integration was further developed in 2004 with the introduction of

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community health partnerships (CHPs), which brought together HBs and LAs to improve the coordination of health and social care services and take joint leadership 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 and promoting healthier lifestyles. The progress of HBs and CHPs against their targets is considered in annual performance assessment visits by Scottish government officials, often with the health minister, and with a follow-up letter from the minister setting out conclusions from the visit.

Wales retains the split between commissioning health services, undertaken by local health boards (LHBs), and the provision of these services by NHS trusts, 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. This had consequences for their ability to commission services strategically, especially for health improvement and for tackling health inequality. 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 are often larger in scale than the LHBs, resulting in claims that hospitals are too powerful and therefore consume 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. 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 were included in the performance assessment regimes of both PCTs and LSPs (although not LAs). 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 in narrowing gaps in mortality and smoking rates and reducing teenage pregnancy rates; Scotland's HBs were accountable for the rate at which they were reducing smoking, mortality rates and teenage pregnancies in their most deprived areas; and Wales' LHBs had no formal requirement to account for their progress in tackling health inequalities, despite several national targets.

One of the most important reasons why these differences matter is the distinction between health improvement and health inequality. As table 1 illustrates regarding 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 well behind England and Wales. 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 average health. As discussed later in the article, the ostensible national commitment to tackling the former in all three countries was interpreted differently at the local level, with some targets other than health inequalities being perceived as more important.

Figure 1 near here

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Intervening in health inequalities

This section begins an analysis of the interviews carried out by considering how interviewees conceptualized and operationalized health inequalities for the purpose of intervention. The analysis also sought to discover the priority respondents perceived the issue as having both in national policy and in their local organizations.

Interviewees were asked how health inequality was defined in their organization. Many different types of health issue were talked about and there was little consistency in the definitions used, with national targets having little prominence in their accounts. Most interviewees focused on the need to improve the health-related lifestyles of people living in deprived areas, although in Wales 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 in England perhaps reflected the emphasis on behaviours in national strategy documents, but this discourse was apparent among our interviewees in all three countries. Indeed, there was often a view that lifestyle interventions were not resourced sufficiently because of the priority given by national governments in all three countries to funding health care and treatment, especially the 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). None of our interviewees 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 seen as a long-term matter. There was, therefore, also 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.

In England, the incorporation of indicators of inequality into 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 inequality measured at a national level. A director of public health (DPH) in one of the HBs commented:

Although mortality in the under 75 population from coronary heart disease has been in decline, 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 but not performance management by the Scottish government. Although the use of such performance measures in England meant that localities were measuring their gaps, the effect on the ground was little different to Scotland, with both countries targeting health improvement measures on deprived areas, mainly to promote healthier lifestyles such as stopping smoking and taking more exercise.

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 how 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 found it difficult to talk about health inequality in terms of targets at all. The issue tended to be conceptualized in qualitative and largely absolute terms as one of widespread chronic illness in these localities. No national targets for tackling health inequalities were passed down to the local NHS. In addition, 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 that 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 the falling waiting times 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 DPH 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.

The priority given to waiting times and annual budgetary performance in how NHS interviewees described their work was as evident in Scotland as in England and Wales. An NHS chief executive in Scotland 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.

In our interviews, we asked specifically about teenage pregnancy rates 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, above). In England, teenage pregnancies have been the subject of a national strategy and targets 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).

As a target, teenage pregnancy was only mentioned by interviewees in England, typically in the following terms as expressed by one of the PCT heads of performance management:

> 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 ...

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 DPH 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 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 needing intervention. Although there were national differences in the degree of focus on the issue, the national trends in teenage

pregnancy rates from 2000 to 2006 do not reflect this (see figure 2). Wales has the highest rates but has also seen the greatest reduction, despite lacking a national target until 2006 and despite 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.

Figure 2 near here

Cause and effect

This section considers to what extent having targets for tackling health inequality encouraged local actors to work with cause-and-effect models. Interviewees in England were much more likely than in Scotland or Wales to talk about health inequality in terms of targets and performance assessment. This did seem to encourage a questioning of whether interventions were working. The following comment about the teenage pregnancy target is an example:

> We started driving teenage pregnancy down and all of a sudden it goes back up and now we're the highest in the region ... 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, there was little evidence to show that it was locally planned actions that were driving these trends. Why local trends were going in the direction that they were was essentially a 'black box' issue. One DPH commented with regard to the good

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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 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 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 decisions are made only on the margin.

In Scotland, health inequality was also 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 that health inequality measures were hard to

define, systematize and use for anything other than long-term monitoring, discouraging their use to evaluate whether interventions were working.

In all three countries, 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. Interviewees often said that decision making was now more evidence based, and it was clear that decisions were expected to be supported by evidence either about need or about different ways of working. Peer-reviewed, published research, however, 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?

This perspective also influenced views on partnership working. As an ideal, partnerships were rarely questioned, given the multifactorial causes of health inequality, but the reality was that other priorities could detract from partnership working. For example, in England, 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 organizations were said still to be largely focused on their own priorities.

Scottish interviewees were very positive about their own integrated NHS, contrasting it with England's perceived fragmented and competitive system, but there was little evidence from the interviews that this created a more receptive context for tackling health inequalities. There was often felt to be little coherent planning to address the issue, with the NHS instead preoccupied with waiting times and service reconfiguration. Although there were innovative projects going on in Scotland, they were described as too often short-term and sometimes lacking in coordination.

Comments were also made about local objectives not being focused enough, resulting in a lack of clarity about who was leading and accountable for what. 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 was said to vary, reflecting local histories and experiences. 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 organizations had separate budgets and accountabilities. There were some signs, however, 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

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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. Measurement may occur, even for performance assessment, but have little practical effect. Thus, interviewees in England tended to describe measuring change in health inequality indicators in more sophisticated terms because there were more reporting requirements than pertained in the other countries; this monitoring, however, was at a high level and there was little connection with implementation.

All three countries expressed policies for reducing health inequality in terms of quantified measures. England was notable in embedding measurable targets within local performance assessment regimes at commissioning and strategic levels. Health inequalities were described in key English policy documents as 'not acceptable' and needing a specific focus that included performance management (Secretary of State for Health 2005, p. 11). This sent a signal to local actors that health inequalities were a priority, but our interviewees' accounts revealed that in practice other priorities mattered more. This meant that health inequalities were measured locally and various initiatives were in play, but also that there was little motivation or support to model the effect of these initiatives or to evaluate whether they were the right things to do or

being done on a sufficient scale. This may be one reason why the issue lost ground

compared with waiting times and the issue of short-term financial balance. If impact

could not be demonstrated over a short timescale, it was difficult for DsPH and other

advocates to make the case for large-scale and long-term interventions that might

divert funding away from other targets such as waiting times and balancing the budget

each year. Crucially, while missing waiting time and budgetary targets meant that

senior officers' jobs could be on the line, this was not perceived to be the case for

health inequality targets.

The situation was similar in Scotland, where health inequalities were described in

equivalent policy documents in the same terms: as 'unacceptable' and the focus of

targets for improvement (NHS Scotland 2005, p. 22). The perceived reality, as

apparent from our interviews, was, as in England, that the targets which mattered

most were those that were most politically sensitive relating to access to care and

financial management. There was a hierarchy of priorities in which waiting times and

balancing the budget overshadowed health inequality, so the issue was 'a' priority but

not 'the' priority. It 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).

The policy documents in England and Scotland do not present health inequality

targets as of lesser importance; in these documents, all targets are written about as if

they matter equally, even though in local practice some targets mattered more than

others. It was only in the Welsh policy documents that the secondary importance of

tackling health inequalities is apparent, although this is more implicit than explicit and

reflected in the briefer attention the issue receives compared with modernizing NHS services and improving access (NHS Wales 2005).

Our interviewees felt that 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 interpretations could, of course, be contested but are evidence of the lack of bottom-up as well as top-down pressure that our interviewees felt they were under. 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.

There is a lack of any apparent relationship between the different national policy contexts or our interviewees' accounts and the degree of progress with meeting national targets summarized in table 1, above. However, given the different national targets, measures, and reporting arrangements, it is difficult to make like-with-like comparisons. The focus on inequalities in cancers and circulatory diseases in England

and Scotland may be behind the progress made by 2006, when the interviews were conducted. In England, progress against the life expectancy and infant mortality targets was off-course in 2006, while Scotland had not adopted targets for these indicators. Despite both these countries investing significant resources in supporting people in deprived areas to stop smoking, England's inequality gap (although the gap is measured in different ways) was not narrowing while the gap was narrowing in Scotland. Reflecting the lower priority of health inequality targets in Wales, no data were reported at the time of the study on progress against the Welsh targets. Data on teenage pregnancy rates can be compared across the three countries and are interesting given the different national policy priorities accorded to this issue. As discussed above, the extent of targeting in either policy documents or as described by our interviewees did not show any obvious relationship with trends in rates.

Targets and performance assessment systems extended most to health inequalities in England. There were signs at the time of the study that the lack of progress with the life expectancy target was starting to influence policy and practice: by mirroring, however, the short-termism of performance assessment with 'quick win' interventions. Reflecting recent Department of Health guidance, some interviewees talked about how they were starting to target 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 and affordability of new preventative treatments such as statins illustrates the shifting landscape in which work to tackle health inequalities takes place (Watt and Mackay 2006; Lester and Fitzgerald 2008). The political landscape is

also shifting; since we undertook our interviews in 2006 there have been changes of government in Scotland and Wales and a change of prime minister in the UK government, with a new ministerial leadership in England's Department of Health. These changes have seen reviews of progress and strategies for tackling health inequalities and some interesting shifts in approach, such as more local negotiation about targets in England and an apparent intention to strengthen health inequality targets and their performance assessment in Scotland (Welsh Assembly Government 2007; Department of Health 2008; Scottish Government 2008). In recognition of this dynamism, we are returning to our localities to re-interview local actors to understand how these changes affect their narratives. A lot is likely to depend on whether waiting times and financial balance are sufficiently under control to allow the messages from measuring health inequalities to register on decision making, and whether these decisions make a difference to the inequalities. Especially given the impact of high public debt on government spending following the recent economic crisis, if more progress with narrowing health inequalities is to be made then local actors need much more than targets to focus their resources effectively on inequalities rather than on competing priorities that may have higher public and media profiles.

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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 authorities have a duty to work together to deliver joint Health, Social Care and Well-being Strategies that address health improvement and inequalities. | 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 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. | 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 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. | No reporting has been carried out. |

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

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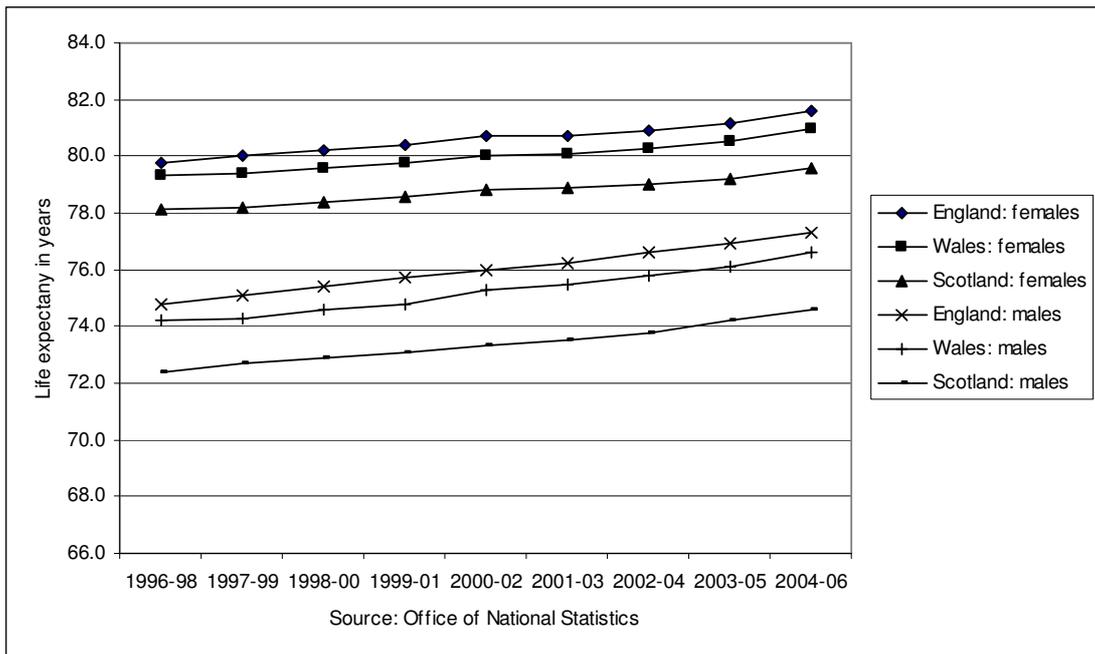

Source: Office of National Statistics

Figure 2. Teenage conception rate: England, Wales and Scotland, 1998 to 2005