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**Reflections on the Development of Health
Inequalities Policy in the United Kingdom**

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Contents

Abstract	4
1. Introduction	5
2. A brief history	7
3. The policy response	15
4. Some policy proposals	19
4.1 <i>Non-financial competitive incentives</i>	21
4.2 <i>Financial incentives</i>	23
4.3 <i>Libertarian paternalism</i>	24
5. Conclusion	26
References	28

Abstract

Abstracts are written to summarise documents and to whet the reader's interest. Alas, many readers just use them as a substitute for reading the whole paper, which given the brevity of abstracts can give a somewhat distorted impression. I hope that having read this abstract, you will read on. If you do, you will find that I offer a little personal history and a little impersonal history on the development of interest in the issue of health inequalities in the United Kingdom. I then summarise the policy response of recent Labour governments, briefly detail the effects of this response, and finally offer my own three-pronged policy attack on our thus far really quite stubborn inequalities in health.

“Perhaps a short sketch of the wanderings of a raw but well-intentioned mind, in its researches after moral truth, may, on this occasion be not unuseful: for the history of one mind is the history of many.”

Jeremy Bentham, *Fragment on Government*

1. Introduction

In health policy circles, as indicated by an ongoing public consultation exercise (House of Commons Health Committee, 2008), the discourse on socioeconomic inequalities in health remains fashionable, and yet most people in the United Kingdom (UK), from a historical perspective and compared to most other nations on earth, enjoy a really very high standard of living. True, in recent years much of this may have been based on an over-inflated credit bubble, and true, pockets of poverty remain, but if Harold Macmillan were alive today he would probably say that we’ve never had it so good. In terms of health as well as more material items, this may be the case, but for some it appears that the relative increase in this particular ‘good’ continues to outpace that experienced by others.

From a personal perspective, for as long as I can remember I have been interested in matters of social justice generally, and, later on, health inequalities in particular. I am not quite sure from where this interest originates. Probably some of it stemmed from what I had been told about my own family’s history. For example, my paternal great grandmother had no legs and no husband, apparently, which led to my grandmother being brought up in a Victorian workhouse at the end of the nineteenth century, in conditions that she felt were so bad that towards the end of her life no-one dared tell her she was being sent back to the same building, after it had long since been turned into a nursing home. Also, when I was a child my father had to retire early due to ill health that was probably caused by his addiction to cigars and by the fact that he had worked for more than twenty-five years in a foundry, where, on visiting on a couple of Saturdays, I remember the air being thick with something that was clearly not ideal for human health.

Although I didn't quite realise it as I was living through those years, his ill health and inability to work probably had a profound effect on my own character, for better or for worse.

A couple of years prior to the onset of my father's illness, Margaret Thatcher won her first general election. Thatcher of course didn't care too much about health inequalities. In fact, her Government barely acknowledged their existence, but with the election of Tony Blair's first government in 1997, the policy rhetoric leant itself towards taking the reduction of health inequalities seriously. Indeed, one of the new government's first acts was to commission an independent inquiry into health inequalities, which became famously known as the *Acheson Report* (Department of Health, 1998), on which more will be written later. Incidentally, soon after the publication of the independent inquiry, Richard Cookson and I met with Sir Donald Acheson to talk about the possibility of establishing a UK Health Equity Network (HEN). Sir Donald was encouraging, Richard and I established HEN, and, with about 700 members, it remains in good health, although when following the discussions on its listserve I sometimes reflect that the biggest obstacle to left-leaning people is other left-leaning people. A lesson that I have learned from that meeting with Sir Donald, and from various other people over the years, is that, for the most part, if you have an idea that you genuinely think is worth pursuing, you should only ever listen to people who offer encouragement.

Having divulged perhaps a little too much personal history, the rest of this paper will be broadly structured as follows. I will start with a brief history of how the issue of health inequality got onto the research agenda in the UK, and how it was successively embraced and ignored by different UK governments, depending of course on whether a more progressive or more conservative government held power. Recent government responses to reducing health inequalities will then be outlined, and an attempt will be made to summarise the success or otherwise of these policy initiatives. Based on the work of others, I will propose a three-pronged policy approach to reducing health inequalities, which will centre on non-financial competitive incentives for health professionals,

financial incentives to improve personal health, and libertarian paternalism. At the end I will offer some concluding thoughts.

2. A brief history

Concern with health inequalities, or rather the health conditions of the relatively poor, has a long tradition in the UK, possibly best epitomised in the work of the utilitarian social reformer Edwin Chadwick in the middle of the nineteenth century, a few decades before my grandmother's experiences in the workhouse. In the 1830s, in response to an influenza and typhoid epidemic in Whitechapel, London, Chadwick was invited by the then government to undertake an independent inquiry on sanitation. In 1842, about 7,000 copies of his report, *The Sanitary Conditions of the Labouring Population of Great Britain*, were published at his own expense, with the main conclusion being that disease within the poorer sectors of society was in large part caused by damp, filth and overcrowded living conditions. He further concluded that the deaths of males resultant on these factors generally occurred before the age of 45 years, 13 years below the life expectancy of the population of Sweden, and that the loss of productive working years numbered between eight and ten on average. Furthermore, he argued that the health of young people, bred under 'noxious physical agencies', was seriously harmed, and insisted that these circumstances produced adults who were short-lived, improvident, reckless, intemperate, and with a habit for sensual gratifications.

Perhaps obviously given the above, Chadwick advocated improvements in drainage, ventilation and water supply, calling for a water closet in every house. This, he argued, would reduce sickness and premature mortality, and would ensure a period of extended life commensurate with that observed in Sweden, for the whole of the labouring classes. Interestingly, I think, Chadwick strongly believed that his proposed reforms would save money, and this, together with him being a committed utilitarian, and having, the reader will have noticed, a highly moralizing character that made him extremely unpopular, qualifies him, in broad terms, to being the world's first health economist.

When Chadwick presented his report, a Conservative Government, led by Sir Robert Peel, proved unwilling to support his recommendations, but with the election of a Whig (or Liberal) administration in 1847, led by Bertrand Russell's grandfather and sympathizer of the poor, Lord John Russell, Parliament passed the 1848 Public Health Act. The Act encompassed many of Chadwick's concerns, legislating for street cleaning, refuse collection, and establishing and improving water supplies and sewage systems.

Great strides were therefore taken in public health at the end of the nineteenth century, but in terms of the provision of health care, the poor had to wait until the middle of the next century before they escaped the lottery of the voluntary and charitable sector. In 1948, the UK introduced its National Health Service (NHS), supported strongly by the influential Minister of Health, Aneurin Bevan, providing for the first time universal health care, free at the point of use, from each according to their means to each according to their needs, which for some these days is a romantic socialist slogan that, due to the legacy of Thatcherism, one is almost made to feel embarrassed to write.

The opportunity to introduce the NHS relied on a very unusual conjunction of circumstances. For example, during the Second World War the nation had been united for several years in a struggle against a common enemy, and the medical profession had been successfully mobilized which demonstrated doctors' capacity to work together. In 1945, Winston Churchill's coalition government had been annihilated in a general election by the most socialist government in British history, which had secured a strong mandate to introduce major social and industrial reform.¹ Moreover, there were few strong financial interests, such as a powerful pharmaceutical sector, opposing the introduction of universal health care insurance, and the majority of the population was eager to receive comprehensive health care coverage, which for many was the first time in their lives that they had been offered such security. The introduction of the UK NHS was – and is – one of the great pieces of social reform in the history of mankind, and for two to three

¹ As an aside, despite these days often being polled as the greatest ever Englishman, Churchill never won a majority of the popular vote at any general election, and my mother remembers him being roundly and soundly jeered whenever he appeared on the news at the local picture house towards the end of the war years.

decades the issue of health inequality was largely – although not completely – absent from the health policy discourse (Webster, 2002). It was simply assumed by many that the NHS would resolve any health inequality that remained.

By the early 1970s, however, the issue of health-related inequalities had begun to re-rear its ugly head prominently in academic and, eventually, health policy circles. In 1971, Tudor Hart published his famous inverse care law, in which he claimed that the use of and need for health care were inversely related, implying that the relatively poor were facing disproportionate barriers to NHS access. Then, in the mid 1970s a young student, who later became the social epidemiologist Richard Wilkinson, wrote an open letter to the magazine, *New Society*, addressed to the Secretary of State for Social Services, David Ennals, stating that the inequalities in death rates by social class were then at their largest since accurate records had been collected. Wilkinson assumed Ennals would want to address this situation and urged him to commission an inquiry to examine health inequalities and recommend remedial action. Ennals read the letter but was not at first convinced that there was a need for an urgent inquiry and, in truth, Wilkinson's letter probably had little direct effect. Ennals later changed his mind, however, primarily due to the influence of his advisor, the LSE economist and social policy analyst, Brian Abel-Smith, who had long been worried about health inequalities, even in the era of the 1950s and 1960s when they were not a key policy concern. In March 1977 Ennals, in a speech to the Socialist Medical Association – written by Abel-Smith who had incidentally also persuaded civil service colleagues of the importance of the issue – pointed out that socioeconomic differentials in health had widened since the introduction of the welfare state, and announced that he was setting up an independent inquiry into the issue, chaired by Sir Douglas Black, then Chief Scientist at the Department of Health and Social Security. Abel-Smith was also the key player in recommending Ennals to appoint to the committee figures such as the sociologist Peter Townsend and the epidemiologist Jerry Morris, colleagues who had shared his longstanding concern with inequalities in health.

The *Black Report* was eventually released three years later, in 1980 (Department of Health and Social Security, 1980). It focused on evidence of the decades preceding the

mid 1970s, and showed that the poorer health experience of lower occupational groups was apparent at all stages of life, and that the gap between the lower and higher occupational groups was widening. The widening gap was attributed to social class disparities in, for example, incomes, working conditions, unemployment rates, standards and levels of education, housing conditions, transport facilities, smoking, diet and alcohol consumption. That is to say, disparities in pretty much everything, although the *Black Report* emphasized that the health service itself played only a marginal role in causing the inequalities in health.² Thus, the *Black Report* made a large number of recommendations to improve the material circumstances of the worst off, including increases in child benefits, maternity grants, infant care allowances, disabled benefit allowances, sheltered housing and home improvement grants, and also called for more emphasis to be placed on preventive and primary health care.

Unfortunately for the authors, by the time they offered their recommendations there had been a change in government, with Margaret Thatcher coming to power the year before. In a case of history repeating itself vis-à-vis Chadwick's *The Sanitary Conditions of the Labouring Population*, the serving Conservative Government were not only not interested in implementing the findings of the *Black Report*, but attempted to suppress their dissemination, a strategy that subsequently backfired. In this context, one ought to remember that in the summer of 1980 Thatcher's Government was highly unpopular and was being attacked in particular for economic policies that were to cause increases in unemployment on a scale that hadn't been seen since the Great Depression. Thus, the government may well have felt that highlighting the plight of the poor would have been politically inconvenient and somewhat hypocritical. Probably as a consequence, the release of the *Report* was scheduled for the August Bank Holiday, with only 260 copies

² Related to this, but moving away from a strict focus on health inequalities for one moment, it has become somewhat fashionable to claim that the health service impacts on population health only fractionally, and that most of our 'health-related' efforts should be geared towards the broader determinants of health. One ought to be careful with this line of argument. Irrespective of how much effort we put into preventive activities, people will always get sick and will want to be treated when that happens. Maybe my father's ill health would have been prevented had his foundry been cleaner and had he never smoked. Maybe not. But what is clear is that the NHS has saved his life on numerous occasions over the past three decades, and that he's still here to tell (and tell, and tell) his tale. Had he lived in another time and/or place, he would have died decades ago.

being made available, which, it was probably hoped, would minimise interest in the findings.

The authors were not best pleased and decided to stage their own press conference. Media interest was thus sparked, and the medical press in particular kept the issue of health inequalities alive, at least as a research agenda, for the next decade and more. At the level of policy, the Labour Party, which at that time could still seriously lay claim to being ‘socialist’, passed a resolution that its next government would give priority to implementing the recommendations. Somewhat ironically, therefore, the manner in which the *Black Report* was dealt with by the then sitting government probably stimulated a growth in health inequalities research undertaken by those who were ideologically opposed to Thatcher, and perhaps in turn served to shape, at least to some small extent, the policy agenda of the Labour governments that have held power over the last decade.

As will now be clear, however, the direct policy impact of the *Report* at the time it was released was non-existent. Patrick Jenkins, the then Secretary of State for Social Services concluded that due to their cost, the implementation of the recommendations would not be possible in current or foreseeable future economic circumstances. Given the economic circumstances of the time, Jenkins did perhaps have a point, although when faced with such justifications for inaction some may nonetheless question why public finances can often be found to wage wars, with the 1982 Falklands War, which ultimately helped to secure Thatcher’s enormous electoral victory in 1983, being a case in point. On balance, purely in terms of their anticipated cost, one can understand why the recommendations were not accepted in their entirety, but that does not seem to offer grounds for them being dismissed wholesale. Had the Labour Party still been in power, it is probable that at least some of the recommendations would have been enacted.

The above then begs the question of why it had taken so long to publish the *Report*, by which time the political window of opportunity, at least in the immediate term, had been slammed shut. Some may point to the fact that two of the authors, Peter Townsend and Jerry Morris, found it difficult to agree on one particular aspect of the *Report*; Townsend

wanted to propose a small cut in hospital expenditures to pay for the recommendations, and Morris thought this opposed his principles as a medically trained academic, preferring instead to maintain real incomes for hospitals but committing relatively more of any future expenditure growth to community health (Berridge, 2003). On this point, they were both perhaps in some sense right. Given the economic circumstances, it was perhaps wise to offer an indication of where the resources to finance the recommendations might come from, but the public and media fall-out from cutting hospital expenditures may have made such action politically reckless. In truth, however, this dispute was rather minor, and the main reasons for the delay in releasing the *Report* were civil service obstruction, coupled with Townsend's and Morris' joint decision that a draft prepared for them in mid 1978 was not sufficiently substantive for public release.

Putting to one side the issue of civil service obstruction, one can conclude from the history of the *Black Report* that in order to have an immediate policy impact, it may often be more apt to offer some 'quick and dirty' recommendations rather than delay to reach some kind of 'ideal', a fact that is anathema to many academics, including me.³ The reason for this is that political windows of opportunity open usually for only brief moments, and then close tight again for many years, perhaps for decades.⁴ This proved to be the case for health inequalities policy in the UK – the Labour Party did indeed honour its resolution to engage in the issue of health inequalities on its return to government, but its opposition to the ruling Conservative Party lasted seventeen years. As noted in the introduction, one of the first acts of the new New Labour Government was to commission a new independent inquiry into inequalities in health, chaired by the former Chief Medical Officer, Sir Donald Acheson.

³ In a personal note to me, Peter Townsend offered the entirely plausible argument that radical change depends on both authoritative evidence and recommendations, and the ability to persuade professional scientific and political opinion of the validity of one's recommendations. All of this, he suggested, inevitably takes time, and the earlier, in his words derisory, draft, presented to the authors in 1978 would have had no political impact. He also emphasized the point, alluded to earlier, that the way in which the *Report* was dealt with by the Government may in fact have increased its long term impact by igniting an interest in health inequalities among many analysts and, subsequently, policy makers that lasts to this day.

⁴ Political windows are, however, easy to identify in retrospect. Therefore, one ought to be a little guarded about being too smug in suggesting what others should and should not have done.

A few years after the publication of the *Acheson Report*, I wrote a monograph in which, from the perspective of a health economist, I was quite critical of the content of the *Report* and the process by which it had been written. To quote:

[A] criticism that can be aimed at the Acheson Report is that its recommendations were not prioritised according to their cost-effectiveness. Resources are always limited and it is a duty of government to ensure that they are utilized in the best possible way ... Prioritising policies for reducing health inequalities according to their cost-effectiveness is an important way of taking the health inequality debate forward (Oliver, 2001, p.49).

I was also a little perplexed at the time that the inquiry team didn't include a health economist, particularly because the government, on inviting Acheson to undertake his inquiry, specifically requested evidence on the cost-effectiveness of any forthcoming recommendations.

As I write this paper in September 2008, however, I know I was too quick to criticize the authors of the *Acheson Report*. Given the large number of recommendations they made – thirty-nine in general, and many more specific recommendations – I still believe that they should have better highlighted which ones they felt were most pressing and given at least some ball-park estimates of costs, but I now think that the reductive nature of standard formal cost-effectiveness analysis – i.e. the recommendation simply to maximize health from a given unit of health care resource – is an appropriate decision rule in only a limited range of circumstances, and that it is sometimes unnecessary and self-defeating to wait for concrete evidence to support policies that are clearly 'good' in and of themselves. I believe that some of my other criticisms of the *Report* – for example, that many of the recommendations focused upon general health maximization rather than the reduction of health inequalities *per se* – were legitimate, not least because measures to improve population health can widen health inequalities if the relatively well off are best able to take advantage of those measures, a point that was acknowledged by the Acheson team

but was not reflected too well in their recommendations. But at the time, the tone of my criticisms, in both the document cited and other writings and presentations, indicates that I was perhaps suffering from what the cancer and aids specialist, Jerome Groopman, has termed, the arrogance of inexperience.⁵

The *Acheson Report* was much less polished than the *Black Report*, but this was probably the consequence of the Acheson team having learned a lesson of their own. They had perhaps learned from Black that the warm breeze from open political windows can be fleeting, and they perhaps felt that a ‘quick and dirty’ yet possibly more immediately effectual list of recommendations was better than a perfectly presented and fully justified – yet delayed – list of priorities that had no immediate policy effect at all. Moreover, they were helped, or hindered, by being given only one year in which to complete their work, and therefore perhaps the government too had learned the lessons of Black. This, I suspect, is the main reason why a health economist was not on the team. Indeed, anecdotally, I was told by members of the team that they feared that involving a health economist would have slowed down the production of the *Report*, which was not an illegitimate concern given the almost intractable disagreements that I have personally observed between health economists and public health specialists, particularly those of the older generation.

In terms of the evidence, by focusing on the 1970s to 1990s period, the *Acheson Report* started from where the *Black Report* left off, and in many ways the former was an updated if less dense version of the latter. The *Acheson Report* concluded that socio-economic inequalities in health remained significant and had indeed become increasingly marked over time, and offered forth a great many recommendations that extended far beyond the NHS. The *Report* also transcended health inequalities by social class and income by looking at those across groups defined by, for example, level of education,

⁵ Groopman (2000) describes how this ailment can cause deaths if one is a medical doctor; fortunately, the arrogance of inexperience in health economists can cause at most, I hope, unrestrained annoyance. It can also be something of a chronic condition – the reader may be surprised to learn that arrogance in even experienced health economists is not uncommon, but is of course not a condition specific to the health economics community. Related to all this, another lesson that I have learned over the past decade is that one should never be ashamed of changing one’s mind. Indeed, Bertrand Russell thought that this was a sign of wisdom.

gender and race. Overall, three recommendations were highlighted as crucial. First, that all policies that are likely to have an impact on health should be evaluated in terms of their impact on health inequalities. Second, that a high priority should be given to the health of families with children, on the understanding that health in childhood can have a profound impact on all stages of the life course. Also, including children in any policy recommendation somewhat neutralises any potential source of opposition, because children are generally perceived to be blameless regarding issues of health. Third, further steps should be taken to reduce income inequalities and improve the living standards of poor households. The main recommendations were therefore clearly rather general. What, then, was the policy response to the *Report* from the government that had commissioned it?

3. The policy response

It is difficult to ascertain the policy initiatives that were specifically informed by the *Acheson Report*, not least because the government would have introduced some policy initiatives that are consistent with the *Report* even if it had never been written. Thus, in some cases, the *Report* served to provide added justification for existing and impending policy initiatives. Nonetheless, one cannot deny that the *Acheson Report* had an influence; addressing health inequalities became a central part of the government's health policy rhetoric, and the *Report* and its three crucial recommendations were cited in several official policy documents. Moreover, the then Head of Public Health at the Department of Health, Donald Nutbeam, wrote that the government placed an emphasis on tackling the 'big killers' of cancer and coronary heart disease, which particularly affect those on relatively low incomes, and also recognized explicitly that in order to reduce health inequalities, one needs to focus on the distribution of – and not just overall improvements in – health, resonating with one of my own criticisms of the *Acheson Report* (Nutbeam, 2003).

In February 2001, the then Secretary of State for Health, Alan Milburn, announced a pair of health inequalities targets, the first time that targets in this policy domain had ever been set in the UK (Milburn, 2001). The targets are as follows:

(1) By 2010 to reduce by at least 10% the gap in infant mortality between those engaged in manual work and the population as a whole. The hope was that this target would, for example, galvanize efforts to reduce teenage pregnancy, improve access to good ante-natal care, and improve nutrition during pregnancy. It was also hoped that progress towards meeting this first target would help towards achieving the second target.

(2) By 2010 to reduce by at least 10% the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole. The hope was that this target would be achieved through tackling the major killers, by, for example, reducing smoking prevalence, improving diets and lifestyle, through better detection and management of hypertension, and effective screening practices (Nutbeam, 2003).

In addition to those alluded to above, the government implemented a plethora of policies that it believed were consistent with narrowing the health divide. These included the minimum wage, the 'New Deal' to assist the young and long-term unemployed into work, a 'Strategy for Neighbourhood Renewal' of rundown areas, 'Sure Start' to provide early learning opportunities for children living in poverty, a fuel poverty energy strategy to help people, particularly pensioners, afford adequate heating, and a cross-government delivery plan to facilitate a co-ordinated health inequality reduction effort across the different government departments. With so many concurrent policies, there is inevitably an attribution problem, in that it is probably impossible to separate the effect that each policy initiative has had on inequalities in health. Moreover, the cross-government delivery direction, sometimes termed 'joined-up' government, is perhaps always likely to shine brighter in words than deeds, principally because government departments tend to work in silos, each with their own pressing agendas. On inviting Alistair Darling, then Secretary of State for Social Security, to the first meeting of the Health Equity Network, for instance, I received the reply, probably from one of his secretaries, that I had surely

made a mistake and that I should write to the Secretary of State for Health instead. Nonetheless, to sum up, the first Blair government was active indeed.

More recent attempts to address health inequalities have acquired more focus. Specifically, in relation to target (2) above, the government has identified the fifth of local authority areas that it considers to have the poorest health indicators, and has categorised these authorities as the ‘spearhead group’. To be a member of the spearhead group, which comprises 28% of the population of England, a local authority has to be in the bottom fifth nationally on three of the following five measures:

- (a) Male life expectancy at birth.
- (b) Female life expectancy at birth.
- (c) The cancer mortality rate for those aged under seventy-five years.
- (d) The cardiovascular mortality rate for those aged under seventy-five years.
- (e) An index of multiple deprivation.

In order to help the spearhead group improve their populations’ life expectancies, and thus to facilitate progress toward target (2), the Department of Health, in collaboration with the London Health Observatory, has developed an interactive online resource called the ‘health inequalities intervention tool’.⁶ The tool, for example, shows the current life expectancy in each spearhead authority, the life expectancy gap between each spearhead and the England and spearhead averages, and a breakdown of the prevalence of each major illness category in each spearhead. The intention, I think, is to indicate the illnesses that each particular spearhead may most fruitfully concentrate on by demonstrating, for instance, the death rates from the various causes of illness in each spearhead compared to, say, the spearhead average.

So much for the health inequalities policy initiatives introduced over the past decade. What has been the overall effect? In terms of target (1), infant mortality for all groups is at an all time low, and in 2004-06 stood at 5.6 per 1,000 live births for the ‘manual

⁶ http://www.lho.org.uk/HEALTH_INEQUALITIES/Health_Inequalities_Tool.aspx

labour' group versus 4.8 per 1,000 live births for England and Wales as a whole (the comparable figures were 6.3 and 5.6, respectively, in 1997-99). However, the gap between the manual labour group and the population average has not narrowed over the period since the target baseline (i.e. since 1997-99). In fact, the gap widened slightly, from a 13% difference in 1997-99 to a 17% difference in 2004-06 (Department of Health, 2007).

Similarly, with respect to target (2), although life expectancy increased for all groups, it increased at a slightly slower rate in the spearhead group, and thus the gap continued to widen. Table 1 summarises the changes in English and spearhead average life expectancy changes by gender, between 1995-97 – which, in this target, is the baseline – and 2004-06.

Table 1: Average life expectancies

Men	England	Spearhead	Difference
1995-97	74.6	72.7	2.57%
2004-06	77.3	75.3	2.63%
Women	England	Spearhead	Difference
1995-97	79.7	78.3	1.77%
2004-06	81.6	80.0	1.96%

Source: Department of Health, 2007

It thus seems unlikely that the government targets to reduce by 10% the gap in infant mortality and life expectancy by 2010 will be met. However, one should take a little care in reaching conclusions that the government's health inequalities initiatives have therefore failed entirely, because, if persevered with, they may well prove to have a lagged effect, reaping fruit many years down the line.

One slightly confusing aspect of the government's health inequalities policy direction, however, concerns their choice of metric in their targets. More specifically, one wonders why they chose the national average health indicators against which to compare the

performance of their spearhead groups. Quite apart from the fact that many really quite advantaged people live in the spearhead local authorities,⁷ which somewhat blurs the picture of health inequality, using national averages as the comparators weakens the overall message considerably. For instance, infant mortality rates, as noted above, are at historically low levels for all groups, and the difference in life expectancy between the spearheads and the national average is only two years for men, and less than two years for women. This leaves one wondering whether these inequalities are really that significant and whether the resources and effort required to reduce them might be better spent elsewhere. Perhaps the government focussed on these comparisons because they felt that they would offer the best chance for them actually to meet their targets by 2010, but had they focussed on reducing by some percentage the inequality between the ends of health divide when constructing their targets – for example, at birth life expectancy is about ten years longer for men and women in Kensington and Chelsea than it is in Liverpool and Manchester (Department of Health, 2007) – then there might be a little more public urgency in supporting measures to meet them.

Nonetheless, if one remains convinced that health inequalities are a problem that warrant attention, then notwithstanding the lagged effect argument, the 2010 targets are unlikely to be met. Thus, some supporting policy initiatives may well be required. Make way, then, for my own three-pronged policy attack on this seemingly perennial sticky issue.

4. Some policy proposals

Before offering a little detail on my proposals, I should offer a short disclaimer. In what follows I am in no way suggesting that factors that are often extrinsic to an individual's own actions, such as income levels and distribution, working conditions, education, housing and all other socioeconomic determinants of health, are not major contributors to health and health inequalities. Indeed, tackling the distribution of the broader socioeconomic determinants of health was of course the principal overarching recommendation of the *Black Report*, and would no doubt have far more impact on

⁷ I live in one myself – Lewisham, which, at least for men, is on track to meet the life expectancy target, maybe because I moved there recently.

narrowing health inequalities than anything I propose here. Thus, I am in no way implying that the health care system is the main sector on which policy makers ought to focus to tackle the issue at hand, and neither am I offering an exhaustive list of health care-specific policy proposals. Offering financial incentives to health care providers in an attempt to narrow the socioeconomic distribution of health may, for example, prove highly effective, but I do not reflect on this possible policy direction in this paper. There are a plethora of policies that could feasibly tackle health inequalities – *Black* and *Acheson* proposed many of them long ago – but I wish to limit my scope to three initiatives. My three-pronged attack mainly focuses on health care funders and providers and ways in which to encourage people to adopt healthier lifestyles, although the basic ideas underlying some of my suggestions could no doubt be applied to other sectors. My proposals are therefore limited, to be sure, but do, I think, offer some food for thought for how policy makers might attempt to narrow health inequalities at the margin. Moreover, by protecting individual autonomy (at least at face value) all of my proposals perhaps comply quite neatly with the prevailing political ‘climate’, which is important if one wants one’s proposals to be considered seriously by government.

I have lived and worked among people from many walks of life in several countries (namely, the UK, the Netherlands, Japan and the USA), and one thing that most people seem to have in common is that they don’t like to be told what to do. This is perhaps especially the case if people are told to stop what they often consider to be the few pleasures that they have in life, such as cigarettes, alcohol, chips, the couch and the remote control. Thus, we need to find ways of encouraging people to alter their behaviours under their own steam, assuming of course that changes to their behaviours are warranted, rather than telling them or ordering them to do, or not do, things. My proposals fall under this encouragement rubric, I hope, and can be labelled as non-financial competitive incentives for health professionals, financial incentives to improve personal health, and libertarian paternalism.

4.1 Non-financial competitive incentives

It is possible to improve the performance of professionals across perhaps every conceivable sector by playing to their natural competitive instincts. Moreover, this can be achieved without the need to reward people in direct financial terms. In their recent book, *Nudge*, Richard Thaler and Cass Sunstein (2008), distinguished professors of behavioural science and jurisprudence, respectively, discuss several initiatives outside the health care sector that have successfully applied non-financial incentives. For instance, the United States (US) has a statutory Toxic Release Inventory, whereby firms have to report to the government the volume of toxic chemicals they release into the environment, and must disclose information about potential harms to health. The consequence, unexpected by the government, has been that the disclosure requirements have led to large reductions in toxic emissions. According to Thaler and Sunstein, the reason for this is that the main offenders have been targeted by the government and placed on an environmental blacklist, which can lead to bad publicity for the firm in question. Thus, firms will make efforts to reduce their emissions to get off and stay off the blacklist, because no-one wants to be perceived as a poor performer. In essence, the disclosure requirements have created a form of league table competition among firms that is good for the environment, and good for population health. Thaler and Sunstein cite similar findings in other sectors. For example, Los Angeles County requires restaurants to display hygiene quality grade cards in their windows. Since their introduction in 1998, restaurant health inspection scores have improved, customer sensitivity to restaurant hygiene has increased, and hospitalizations from food-borne illnesses have decreased (Zhe Jin and Leslie, 2003).

Disclosure of information among ‘competitors’, and the league table competition this generates, can thus drive up performance at minimal financial cost to government, and there are in fact a few health care examples where this has already been tried and tested. For instance, the Veterans Health Administration, the publicly financed and provided health care system for veterans of the US armed forces, was traditionally a poor performer, but on introducing open disclosure of hospital performance on a range of process quality indicators in the mid 1990s, went to being, in the space of five years, arguably the best performing sector of US health care (Oliver, 2007). Again, the ‘driver’

was simple: nobody wants to be perceived as a poor performer. The hospital star rating system, introduced in 2001, is a precedent for this type of initiative in the NHS. The rating system, which awarded hospitals between zero and three stars depending on their performance, involved an annual assessment on a number of indicators, including targets around waiting times, cleanliness, treatment-specific data and financial management, and there is some evidence that ambulance response times and inpatient waiting times improved as a consequence (Bevan and Robinson, 2005).

So how does this relate to narrowing health inequalities? Although one ought to take care against de-motivating people with blacklists and other forms of ‘criticism’, the health inequalities intervention tool could have a big role to play here, by disclosing particular performance indicators within, and hence encouraging competition across, the various spearhead authorities. The tool could be used a little more imaginatively, and somewhat more specifically, than it is at present. There are, for instance, a number of health care process quality indicators that are quite inexpensive to adhere to and yet have a demonstrable link to health outcomes and therefore should be routinely followed by health care providers; for example, prescribing patients an aspirin immediately after they present with myocardial infarction. The Veterans Health Administration, mentioned above, showed enormous improvements in standard health care procedures after it exposed the process quality performance of its hospitals to widespread scrutiny, and it may well prove to be the case that similarly reporting the performance of the hospitals that are situated within each spearhead authority on criteria such as cervical screening rates and the prevalence of smoking cessation advice will have similar effects. If the spearhead authorities and the providers located within each authority are sufficiently motivated to improve against specific, tangible quality indicators that are seemingly quite easy to respond to, one might expect an eventual narrowing of the gap in nationwide inequalities in health.

4.2 Financial incentives

The idea of paying people to alter their behaviours is currently a highly topical area of investigation in efforts to improve population health internationally, and is being tried or mooted to incentivise people to, for example, eat more healthily, stop smoking and taking drugs, and engage in regular exercise. In order to address health inequalities, these incentives will have to be targeted towards those who are in relatively poor health – namely, the relatively poor – an approach that is currently being considered by the UK Department of Health. This raises a whole series of ethical dilemmas that warrant further investigation, and indeed will be analysed in a new Centre for the Study of Incentives in Health, co-directed by me, the health psychologist Theresa Marteau and the bioethicist Richard Ashcroft. For example, are financial incentives coercive, encouraging people to do things that they don't really want to do, a potential problem that carries added force when one is focusing on the poor, and should we be paying people to do things that most taxpayers might believe they ought to be doing anyway?

Aside from the ethical concerns, are these incentives likely to have an effect? On the basis of existing evidence, the answer seems to be, 'it depends' – on such factors as the size of the incentive, and its source (e.g. government, charities) (Jochelson, 2007). In Dundee in Scotland, the local health authority has recently introduced a pilot programme that pays people to stop smoking (BBC, 2008). Smoking is a leading cause of ill health, and smokers in the poorest parts of Dundee, over a twelve week programme, are being offered £12.50 per week to spend on groceries on the condition that they give up smoking, with a simple carbon monoxide breath test offering proof of their behaviour. However, a Cochrane review of the effects of financial incentives on smoking behaviour concluded that although financial rewards can have some short term effects, these effects dissipate when the rewards are no longer offered (Hey and Perera, 2008). A review of the use of financial incentives to reduce obesity reached a similar conclusion, finding that such incentives generally had no effect at 12 and 18 months, although there was a slight though still non-significant effect if the reward was more than 1.2% of disposable income (Paul-Ebhohimhen and Avenell, 2007).

It seems, therefore, that if these forms of incentives are to show a substantive effect, then we need to find a way of sustaining rewards that people value. Therefore, assuming that we can identify initiatives that are not subject to paralysing ethical objections, some creativity around the choice of rewards might prove useful. For example, perhaps employers could offer an extra half day holiday entitlement to those who remain ‘smoke free’ at the end of each month, although this would of course only be relevant to those in employment, which may dampen somewhat its effects on reducing health inequalities. It may prove to be the case that in some contexts encouragement and positive reinforcement is a more effective reward than small financial payments. A Japanese proverb states that by using flattery you can even get a pig to climb a tree. Thus, flattery may indeed get you everywhere. With this in mind, one possible way forward would be instigate a brief periodic health check up undertaken by a nurse visitor in poor communities, for those who wish to receive the service. The nurse could, for example, test for changes in weight and smoking prevalence, providing a performance chart for patients, and offering strong positive reinforcement for movements in the ‘right’ direction. Overall, the jury is still of course out on the benefits, appropriateness and affordability of financial (and non-financial) incentives to improve personal health, but a detailed investigation in this area may be a fruitful avenue of exploration in attempts to address inequalities in health.

4.3 Libertarian paternalism

Thaler and Sunstein (2008) are perhaps most associated with the concept that is topically known as libertarian paternalism. The basic idea is that, for various reasons, human beings often make genuine errors of judgment that they would ideally want to avoid, and could avoid if given a little help. Thus, if policy makers are aware of these errors and biases, they could still allow people the freedom to choose (the libertarian aspect of libertarian paternalism), but could help them to make ‘better’ decisions (the paternalistic aspect). This could be done in a variety of ways. For instance, one could change the ‘default option’, which can have profound implications. There is a far higher ‘expressed’ willingness to donate organs, for example, in countries where people have to ‘opt out’ of donating, compared to those where people have to ‘opt in’. Framing effects, or differences in the ways that options and outcomes are described, can also impact heavily on people’s choices. Informing smokers of the negative effects of continuing smoking,

for instance, may make them take more notice than informing them of the positive effects of smoking cessation, because people tend to pay more attention to losses than gains of the same magnitude; e.g. a possible loss of, for example, five years from 75 years to 70 years may affect people more than a possible gain of five years from 70 to 75 years. Moreover, when people are faced with an array of options, conditions could readily be created – by, for example, providing simple web-based decision tools – that would make it easier for them to make better choices, a classic example being Medicare Part D in the US, whereby those over the age of 65 years are required to choose a pharmaceutical insurance plan from a bewildering range of options. The nurse visitors proposed for the UK context in the previous section could I believe be effectively trained in human psychology so as to enable them to present options to patients that would be more likely to produce outcomes that the patients themselves desire.

The British economist and social policy analyst, Julian Le Grand, has also embraced libertarian paternalism (Le Grand, forthcoming). One of his proposals is that smokers, most of whom state that they want to quit smoking, ought to be required to obtain a licence in order to purchase cigarettes. Le Grand argues that the time and inconvenience of acquiring the licence would serve as the disincentive required for many smokers to give up their habit, although his proposal of course allows smokers to continue smoking if they wish to do so. For me, this measure falls too far towards the paternalistic end of libertarian paternalism, and it is unclear whether the measure could really be enforced, or even effectively monitored, in the face of resistance to government interference into personal lifestyle behaviours, but the merit or otherwise of measures of this type warrant consideration and discussion.

Libertarian paternalism can inspire further measures that could possibly be used to address health inequalities. For example, the nurse visitors mentioned above could present data to people living in relatively poor areas that shows that their lifestyle choices, for instance with respect to smoking and diet, are relatively poor compared to the national average, which may inspire them to ‘do better’, a measure synonymous with the non-financial competitive incentives for health professionals presented earlier. Moreover, it

has been shown that if people are asked their intentions, they are more likely to act according to those intentions, so, for example, if they say they are going to consume fewer fatty foods in the next week, they do indeed consume fewer fatty foods in the next week. The nurse visitors might do well to ask people their intentions, assuming, of course, that those intentions are health enhancing.

5. Conclusion

There is a long history behind the issue of health inequalities in the UK. Governments have been concerned with health inequalities, not been concerned with them, been concerned with them, not been concerned, been concerned, not been concerned, and been concerned again, depending on who is in power at any point in time. Despite all the concern with health inequalities and the recent attempts to address them, they still appear to be widening, and to reduce them, in the absence of a major redistribution of the broader socioeconomic determinants of health, perhaps requires a little imagination.

If we allow people to live the lives that they want to live, and given the existence of, for example, congenital health problems, some health inequalities are of course inevitable. It is just a matter of how wide they are allowed to be between particular groups before they become unacceptable. If one of the main determinants of health – income – were perfectly equitable, man would still find things to cause him envy. The classic studies of British civil servants conducted by Sir Michael Marmot and his colleagues, where people who are comfortable in material terms suffer differential levels of an important determinant of ill health – i.e. stress – depending on their position in their workplace hierarchy, seems to provide support for this conjecture (Marmot et al., 1991). It is worth remembering that human beings are merely higher level beasts, and that power lust, envy, jealousy and other less than admirable instincts are in our nature.

My friend and co-founder of the Health Equity Network, Richard Cookson thinks, I think, that my concern with health inequalities has waned, and recently asked me if I still think they are a problem. I do. As I said in the introduction, I don't know why. Maybe I was socialised that way. Maybe those of us who care about social justice have altruistic genes,

or memes. Maybe, consciously or subconsciously, we just want to look good in the eyes of others, or maybe to care for what is happening to people who are less fortunate than ourselves is our defence against feeling utterly alone. But one ought to put the health inequalities that exist in the UK today into context. The London School of Economics and Political Science was founded in 1895, at a time when my grandmother was languishing in her workhouse. In those days, LSE academics, the things they talked about, the circles they moved in, the houses they lived in and the food they ate, would, to my grandmother, have probably made them seem like creatures from another planet. And yet, although having been born into the same social class as my grandmother, I have been working as an academic at the LSE for the best part of the last decade. Only a few decades before the LSE was founded, at around the time that Chadwick was looking at the sanitary conditions of the labouring classes, the life expectancy of a factory worker in Manchester was 17 (Johnson, 2008), and it was not uncommon for children to die while sweeping chimneys. There has been so much social improvement in the UK over the last 150 years, perhaps more than over the rest of the country's history combined. That, I think, is progress.

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