Social Science & Medicine 71 (2010) 1249–1253

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Has the English strategy to reduce health inequalities failed?

Johan P. Mackenbach*

Department of Public Health, Erasmus MC, P.O. Box 2040, 3000 CA Rotterdam, the Netherlands

ARTICLE INFO

Article history:
Available online 3 August 2010

Keywords
Fair Society,
Healthy Lives (The Marmot Review)
Health inequalities
England

Introduction

England, and the United Kingdom as a whole, have a long and frustrating history of engagement with socioeconomic inequalities in health. England and Wales started systematic data collection on social class inequalities in mortality – originally based on the Registrar General's Decennial Supplements on Occupational Mortality – before any other country. England has also lead the world in explanatory research, by investing in birth cohort and other longitudinal studies that have contributed hugely to our understanding of the causes of health inequalities. And yet, attempts to reduce health inequalities by systematic policy action seem to have been in vain so far.

The Black report, commissioned by a Labour government to investigate the causes and possible remedies for Britain's undiminished social class inequalities in mortality, proposed a radical change in social and health care policies and as a result disappeared in a desk drawer after the Conservatives won the 1979 elections (Department of Health and Social Services, 1980). When Labour came back into power almost 20 years later, it again commissioned an expert report – the Independent Inquiry into Inequalities in Health (Department of Health, 1998) – and rushed into action with a series of policy initiatives which were further elaborated upon in subsequent years. The results have recently been reviewed, but suggest that despite more than 10 years of systematic policy action health inequalities have not narrowed (Department of Health, 2010). Has the English strategy to reduce health inequalities failed?

The importance of this question cannot easily be overstated. The explicit and sustained commitment of recent Labour governments to reduce health inequalities was historically and internationally unique (Mackenbach, 2006; Mackenbach, Bakker, & the European Network on Interventions and Policies to Reduce Inequalities in Health, 2003). Their policy initiatives built on decades of public health research, and more often than not were based on empirical evidence which had been collected and summarized by leading public health experts. Labour stayed in power for an exceptional 13 years, and in Western democracies it is difficult to imagine a longer window of opportunity for tackling health inequalities. If this did not work, what will?

The English strategy to reduce health inequalities

The English strategy to reduce health inequalities was shaped in two steps. The first was in 1999, when the Department of Health issued "Reducing health inequalities: an action report" (Department of Health, 1999). This was the government's response to the "Independent Inquiry into Inequalities in Health", which had been published in 1998 and had made 39 recommendations, ranging from higher living standards of households in receipt of social security benefits to improvements in nutrition provided at school, and from improved insulation and heating systems in new and existing housing to a more equitable allocation of resources within the National Health Service (Department of Health, 1998).

The 1999 Action Report adopted a large number of these recommendations. Although most of the policies listed may have had other primary purposes than to reduce health inequalities, it rightly claimed that "[t]his is the most comprehensive programme of work to tackle health inequalities ever undertaken in this country" (Department of Health, 1999, p. 4). It listed a range of new government policies including the introduction of a national minimum wage, higher benefits and pensions, and substantially increased spending on education, housing, urban regeneration, and

* Tel.: +31 10 7038460; fax: +31 10 7038475.
E-mail address: j.mackenbach@erasmusmc.nl.

0277-9536/$ – see front matter
doi:10.1016/j.socscimed.2010.07.014

health care. It also announced a number of specific initiatives including the "Sure Start" program (free child care, early education, and parent support for low income families), "Health Action Zones" (local strategies to improve health in deprived areas), and a series of anti-tobacco policies (including free nicotine replacement therapy for low income smokers) (Department of Health, 1999).

The second step followed in 2003 after the publication of the "Cross-Cutting Review of Health Inequalities", a systematic assessment by government of its progress in tackling health inequalities. This took as its starting point the two national health inequalities targets, announced by the Secretary of State for Health in 2001, to narrow the gap in life expectancy between areas and the difference in infant mortality across social classes by 10% in 2010. The Cross-Cutting Review tried to identify the most significant interventions that would support the delivery of these targets, by quantifying the contribution that the interventions would make to reducing inequalities in specific health outcomes (Department of Health, 2002).

In response to this analysis the Department of Health published a revised strategy in 2003, entitled "Tackling health inequalities: a Program for Action". It had a foreword by the Prime Minister, Tony Blair, and set out the government's plans to achieve the two health inequalities targets by 2010. It reiterated the need to tackle the structural "upstream" determinants of health inequalities, but it had a stronger emphasis on "downstream" policies than the 1999 Action Report. Key interventions expected to contribute to closing the life expectancy gap were reducing smoking in manual social groups, managing other risks for coronary heart disease and cancer (poor diet and obesity, physical inactivity, hypertension), improving housing quality by tackling cold and dampness, and reducing accidents at home and on the road (Department of Health, 2003).

The strategy was structured around the two over-all targets, and underpinned by 12 "headline indicators" (specific targets for intermediate outcomes) and 82 "departmental commitments" (specific actions by various governmental departments) which together were expected to ensure the timely delivery of the targets (Department of Health, 2003). Although there were no explicit and quantified links between departmental commitments, headline indicators and over-all targets, and although many of the departmental commitments may simply have reflected on-going policies, the strategy as a whole was impressive by any standards.

The departmental commitments included further poverty reduction efforts, improved educational outcomes, expansion of the Sure Start scheme, expansion of smoking cessation services, improvement of primary care facilities in inner cities, and improved access to treatment for cancer and cardiovascular disease. Many of the departmental commitments were explicitly targeted towards low income groups or deprived areas, and most were quantified in terms of numbers of people to be reached and budgets to be allocated. Many of these budgets were larger than £100 million per year, and some (such as the commitments towards child poverty reduction, social housing quality improvement, and expansion of the Sure Start scheme) had budgets well in excess of £1 billion per year (Department of Health, 2003).

Reviews of the English strategy to reduce health inequalities

This high level of government commitment to reducing health inequalities was matched by a similar commitment to critically review, revise and then re-review its policies. As a result of these frequent self-reflections it is relatively easy, even for outsiders, to gauge the results of the English strategy to reduce health inequalities.

The 2003 "Program for Action" was followed by a series of "Status Reports" in which the Department of Health regularly reviewed progress against outcome targets, headline indicators and departmental commitments. The 2007 Status Report concluded that while almost all departmental commitments were wholly or substantially achieved, the headline indicators and outcome targets showed a more disappointing picture. Some of the headline indicators showed reduced inequalities (less child poverty and narrowing inequalities in housing quality, educational attainment and uptake of flu vaccinations), but others suggested stable or even increased relative inequalities between socioeconomic groups (heart disease and cancer mortality, child road accidents, teenage pregnancies, smoking). While the infant mortality gap had slightly narrowed, there was little change in the gap in male life expectancy and a widening of the gap in female life expectancy (Department of Health, 2007).

This was followed by an independent evaluation, commissioned by the Department of Health, entitled "Tackling Health Inequalities: 10 Years On". This review, published in 2009, made a detailed analysis of trends in indicators, and pointed at "significant improvements in the health of the population over the last 10 years, an improvement almost wholly shared by disadvantaged groups and areas, as measured by life expectancy and infant mortality". However, "[h]ealth inequalities between different groups and areas and the whole population […] persist" and "[t]he current data […] shows that the gap is no narrower than when the targets were first set". The review then started to draw some policy lessons, pointing at major deficiencies in the implementation of parts of the 2003 Program for Action, particularly at the local level, and the "paradoxical" effect of "other influences, notably the impact of the market and the private sector, […] seen in the widening of income inequalities, which underpin inequality more generally" (Department of Health, 2009, p. 13).

When it became clear that the 10% reduction of the gaps in life expectancy and infant mortality in 2010 would not be achieved, the Health Committee of the House of Commons, the lower house of the parliament of the United Kingdom, decided to conduct its own review of the Labour government's policy to reduce health inequalities. This was published late in 2009, and although it praised the explicit commitment to reduce health inequalities, it presented a devastating analysis of more than a decade of policy making by the Labour government. "It is nearly impossible to know what to do given the scarcity of good evidence and good evaluation of current policy. […] The most damning criticisms of [g]overnment policies we have heard in this inquiry have not been of the policies themselves, but rather of the [g]overnment's approach to designing and introducing new policies which make meaningful evaluation impossible. […] All too often [g]overnments rush in with insufficient thought, do not collect adequate data at the beginning about the health of the population which will be affected by the policies, do not have clear objectives, make numerous changes to the policies and its objectives and do not maintain the policy long enough to know whether it has worked" (House of Commons, 2009, p. 5).

Almost simultaneously, the Secretary of State for Health then asked Professor Sir Michael Marmot, who had been involved in the Independent Inquiry and had chaired a scientific advisory group on health inequalities to the Department of Health since the start of the strategy, to "chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010". Although this review, entitled "Fair Society, Healthy Lives", was mostly forward looking in character, and focused on a revision of the strategy for the imminent post-Labour years, it also contained a chapter with lessons to be learned from the current strategy (Department of Health, 2010).

Briefly summarized, this "Marmot Review" suggested that the current strategy was wrong on three fronts: the policies were partly

wrong, the policies were inadequately delivered, and the targets by which the policies were evaluated were inappropriate. The policies were partly wrong, because they "have not systematically addressed the background causes of ill health and have relied increasingly on tackling more proximal causes (such as smoking)" and because there was a "hunt for quick wins" with "a succession of policy and organisational changes that hampered the partnership working that is essential to addressing the 'wicked issues' of health inequalities". Delivery was inadequate because "more deprived people live outside spearhead areas [i.e., the geographic areas to which many initiatives were targeted] than within them" and local government and other local public sector partners were insufficiently involved. The targets were inappropriate because "the current target does not capture the social gradient in health or the more complex patterning of health associated with other groups (for example, ethnic groups)" and "mortality [does] not reflect health status or other dimensions of well-being through the life course" (Department of Health, 2010, pp. 85–91). The review showed again that inequalities in life expectancy have not clearly narrowed since before Labour came to power in 1997 (Fig. 1).

Nevertheless, in his "Note from the Chair" Marmot stated that "we could go a long way to […] giving more people the life chances currently enjoyed by the few". "I chaired the World Heath Organisation's Commission on Social Determinants of Health. One critic

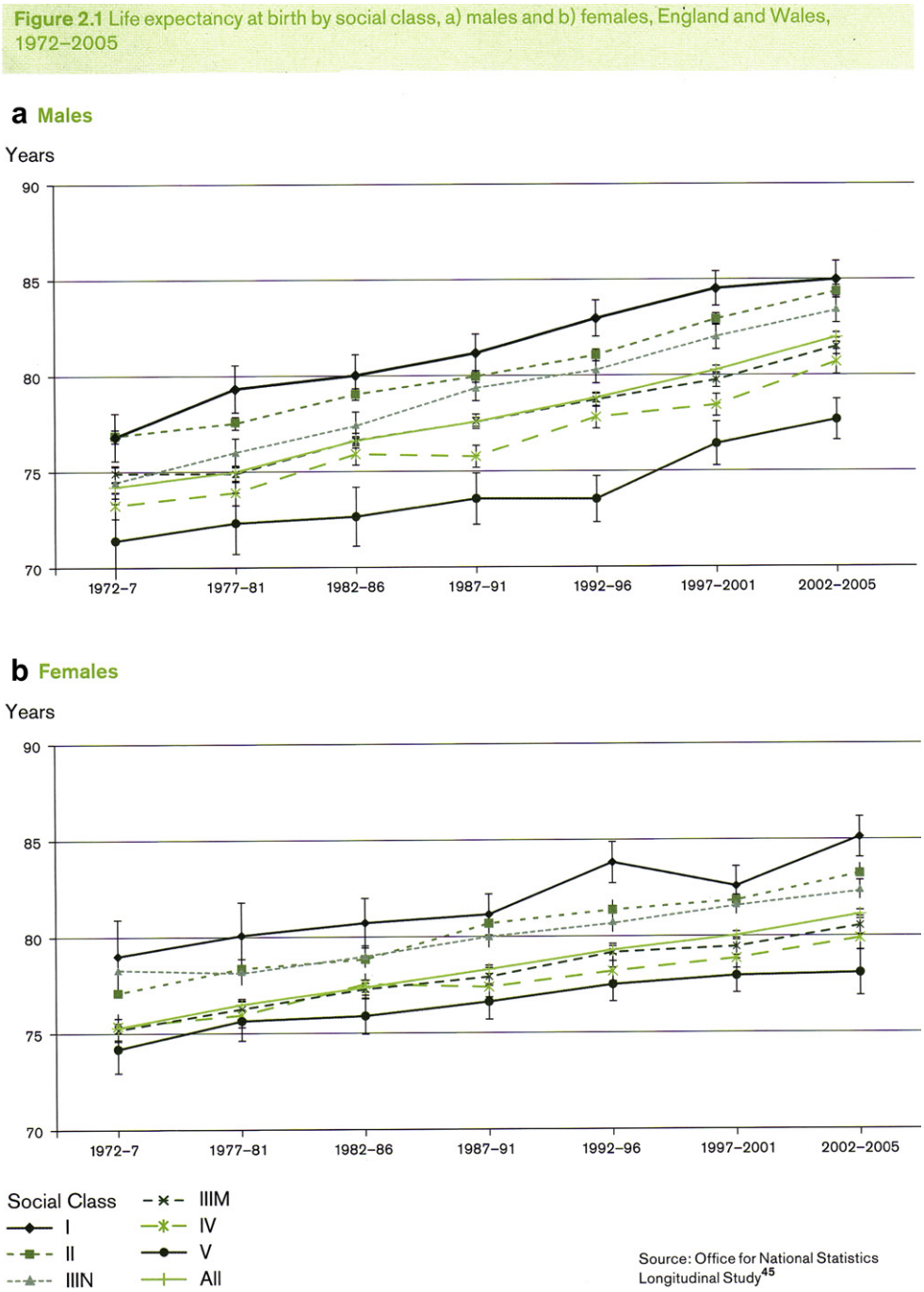

Fig. 1. Life expectancy at birth by social class in **England** and **Wales**, 1972–2005. Source: Department of Health (2010). *Fair Society, Healthy Lives (the Marmot Review)*. London: Department of Health. Also available at: http://www.ucl.ac.uk/gheg/marmotreview

labelled the Commission's report 'ideology with evidence'. The same charge could be levelled at the present Review and we accept it gladly. We do have an ideological position: health inequalities that could be avoided by reasonable means are unfair. Putting them right is a matter of social justice" (Department of Health, 2010, p 3).

Some lessons from the English strategy to reduce health inequalities

This remarkable story, which may well have come to an end with the 2010 parliamentary elections in the United Kingdom, contains a number of important lessons for all those engaged with studying and eventually reducing socioeconomic inequalities in health. The 13-year period started in high spirits, and promised to be a period of harvesting the practical results of decades of research into the determinants of health inequalities. It has become clear, however, that reducing health inequalities is much more difficult than most scientists had foreseen. The English experience shows that there are three great barriers for reducing health inequalities.

The first is that there is no readily available package of policies and interventions with proven effectiveness in reducing health inequalities. This can easily be seen – and has indeed been commented on at the time (MacIntyre, Chalmers, Horton, & Smith, 2001) – in the Independent Inquiry which laid the basis for the English strategy to reduce health inequalities. The latter was a sincere attempt to list all the available evidence which could underpin policy action by the new Labour government, but the whole Inquiry did not list a single evaluation study which showed that the proposed interventions could actually reduce inequalities in health. All the evidence was from observational studies showing plausible entry-points for intervention at most. In this sense, both the 1999 Action Report and the 2003 Program for Action were loosely "evidence-informed" rather than more strictly "evidence-based".

But the strategy might have worked nonetheless. Unfortunately, however, as the House of Commons review noted important opportunities for evaluation have been missed, and as a result the evidence-base for reducing health inequalities has only grown a little over these years (House of Commons, 2009). To the extent that there were evaluation studies these have produced mixed results which are generally insufficient to underpin a new comprehensive post-2010 strategy. Some of the "upstream" policies have certainly been successful in terms of changing the determinants of health. For example, child poverty rates have been effectively reduced (Department of Health, 2009), but it is unknown to what extent this has resulted in better health of children in disadvantaged families. Health Action Zones could loosely be evaluated but the authors concluded that these "made little impact in terms of measurable improvement in health outcomes during their short lifespan" (Judge & Bauld, 2006). The evaluation of the Sure Start program concluded that "there are some signs that Local Sure Start Programs may be effective" but no health outcomes indicative of health inequalities reduction were observed (Melhuish, Belsky, Leyland, Barnes, & the National Evaluation of Sure Start Research Team, 2008). Despite large-scale implementation of smoking cessation services in deprived areas the evaluation study showed that they only made a tiny contribution to reducing inequalities in smoking (Bauld, Judge, & Platt, 2007).

The second barrier to reducing health inequalities is that the scale and intensity of policy change that is necessary to make a real difference are likely to be in excess of what western state machineries can deliver. What they can deliver is, first of all, dependent on the democratic mandate of their governments. Many scientists believe that health inequalities cannot be reduced without a reduction of inequalities in income, wealth and other "upstream" determinants of health. One possible analysis of the causes of the failure of the English strategy to reduce health inequalities, hinted at in the Marmot Review, then is that this failure is due to the fact that inequalities in income and wealth in England have remained unchanged or even widened during 13 years of Labour government (Government Equalities Office, 2010). This inference may be correct or not, but the point is that it is unlikely that a majority of the English electorate would have supported the substantial redistribution of income and wealth that would have been necessary. Although the Labour government was committed to improving the material living conditions of the worst off, it was indifferent to income inequalities as such, as illustrated by Peter Mandelson's famous 1998 statement, "we [i.e., Labour] are intensely relaxed about people getting filthy rich."

Delivery on reduction of health inequalities is also restricted by the inability of state bureaucracies to change themselves quickly enough. As the Marmot Review has clearly exposed, it has been much easier to implement specific single-purpose projects than to "mainstream" health inequalities reduction in all governmental policies and in the whole of the National Health Service (Department of Health, 2010). The House of Commons review contains an illuminating analysis of the slowness of change within the National Health Service, where despite a resource allocation formula which prioritizes those in most need, primary care trusts in disadvantaged areas still receive much less than their full needs-based allocations (House of Commons, 2009). It is perhaps fortunate that no analysis has yet been made of the scale and intensity of policy change within and outside the health care system which would be necessary to really reduce health inequalities – this is likely to be so extensive that much more than 13 years of political determination may be required.

The third barrier to reducing health inequalities is that health inequalities are the result of the cumulative impact of decades of exposure to health risks, some of them intergenerational, of those who live in socioeconomically less advantaged circumstances. It would be too easy to say that inequalities in life expectancy can therefore not be reduced within a decade – life expectancy does change, even on a shorter time-scale, and it is all a matter of the relative speed of change in lower and higher socioeconomic groups. Achieving a higher speed of change in the lower socioeconomic groups does not only require massive efforts, in view of the fact that their higher mortality risks reflect many years of biological and psychological damage which cannot easily be undone. In view of the unrelenting rise of life expectancy in the more advantaged sections of society it also requires a massive re-allocation of societal resources. In an economy totalling £2700 trillion per year, redirecting less than 1% of the annual £1100 trillion of public expenditure to inequalities reduction is simply unlikely to make much of a difference.

The main conclusion therefore is that reducing health inequalities is currently beyond our means. That is the sad but inevitable conclusion from the story of the English strategy to reduce health inequalities. Health inequalities are a stubborn phenomenon. Getting policies delivered at the scale and intensity that are required to make a difference has proved to be very difficult. And even if they had been delivered as they should in view of the available evidence on determinants of health inequalities it is uncertain whether they would have worked.

Should we therefore give up? Perhaps not, if only because reducing avoidable health inequalities for many is a moral imperative. But for the foreseeable future we need less ambitious aims, more focused approaches, and much more and better evaluation.

References

Bauld, L., Judge, K., & Platt, S. (2007). Assessing the impact of smoking cessation services on reducing health inequalities in England: observational study. *Tobacco Control, 16*, 400–404.

Department of Health. (1998). *Independent inquiry into inequalities in health (the Acheson report)*. London: Department of Health. Also available at http://www.archive.official-documents.co.uk/document/doh/ih/ih.htm.

Department of Health. (1999). *Reducing health inequalities: An action report*. London: Department of Health. Also available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006054.

Department of Health. (2002). *Tackling health inequalities: Cross-cutting review*. London: Department of Health. Also available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4098280.

Department of Health. (2003). *Tackling health inequalities: A program for action*. London: Department of Health. Also available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008268.

Department of Health. (2007). *Tackling health inequalities: 2007 status report of the program for action*. London: Department of Health. Also available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH_083471.

Department of Health. (2009). *Tackling health inequalities: 10 years on*. London: Department of Health. Also available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098936.

Department of Health. (2010). *Fair society, healthy lives (the Marmot Review)*. London: Department of Health. Also available at http://www.ucl.ac.uk/gheg/marmotreview.

Department of Health and Social Services. (1980). *Inequalities in Health: Report of a research working group*. London: Department of Health and Social Services. Reprinted by Penguin Books, 1982. Also available at URL. http://www.sochealth.co.uk/Black/black.htm.

Government Equalities Office. (2010). *An anatomy of economic inequality in the UK. Report of the National Equality Panel*. London: Government Equalities Office. Also available at http://www.equalities.gov.uk/pdf/NEP%20Report%20bookmarkedfinal.pdf.

House of Commons. (2009). *Health inequalities*. London: Health Committee of the House of Commons. Also available at http://www.publications.parliament.uk/pa/cm200809/cmselect/cmhealth/286/28602.htm.

Judge, K., & Bauld, L. (2006). Learning from policy failure? Health action zones in England. *European Journal of Public Health, 16*, 341–344.

MacIntyre, S., Chalmers, I., Horton, R., & Smith, R. (2001). Using evidence to inform health policy: case study. *British Medical Journal, 322*, 222–225.

Mackenbach, J. P. (2006). Socio-economic inequalities in health in western Europe: from description to explanation to intervention. In J. Siegrist, & M. Marmot (Eds.), *Social inequalities in health. New evidence and policy implications*. Oxford/New York: Oxford University Press.

Mackenbach, J. P., Bakker, M. J., & the European Network on Interventions and Policies to Reduce Inequalities in Health. (2003). Tackling socioeconomic inequalities in health: an analysis of recent European experiences. *Lancet, 362*, 1409–1414.

Melhuish, E., Belsky, J., Leyland, A. H., Barnes, J., & the National Evaluation of Sure Start Research Team. (2008). Effects of fully-established Sure Start Local Programmes on 3-year-old children and their families living in England: a quasi-experimental observational study. *Lancet, 372*, 1641–1647.