Health inequality and public policy: one year on from the Acheson report

Health inequalities and the social determinants of health are moving up the policy agenda in most industrialised nations.[1–3] Britain may be slightly ahead of the field in this respect, so its experience is of more than parochial interest.

Health inequalities in Britain have been the subject of intellectually heavyweight official publications in each of the past three years. Drever and Whitehead's decennial supplement[4] was published in 1997 and is widely held to rank near John Fox's benchmark 1971 supplement.[5] The Report of the Independent Inquiry into Inequalities in Health[6] (*Acheson report*) was published in the following year 1998 and marks the end of a century that began in Britain with the publication of Rowntree's, distressingly similar, *Poverty*.[7] And now this year 1999 has seen the policy responses to the Acheson report—health inequalities installed at the centre of British government attempts to produce a healthier nation[8] and a prime target of joined up government.[9] The concern of official Britain, it would seem, has never been greater.

The Acheson committee was able to build on the nearly two decades of ground clearing work that had followed their eminent predecessors' *Black report*.[10] Black and his colleagues had emphasised that, in their view, social class differences in health were caused mainly by social class differences in the material conditions of life. They acknowledged, however, that alternative explanations were possible in theory. Such inequalities, for example, could be a mirage, an artefact of the processes by which they are measured, or a manifestation of eugenic logic, in which the constitutionally fit achieve dominance through upward social mobility and the inferior are consigned to the depths of working class life.

These then current ideas were systematically examined and largely found wanting during the 1980s and 1990s by a whole raft of research, most notably from the OPCS (now ONS) Longitudinal Study[11–13] and the British birth cohort studies.[14 15] Artefact and selection, in consequence, were barely mentioned by the Acheson report, which straightforwardly treated health inequalities as a consequence of socially structured differences in the conditions of people's lives.

A second great strength of the Acheson report was its insistence that efforts to reduce health inequalities would require input from many government departments, not simply from the Department of Health. In some respects this is the most remarkable part of the policy response. Civil servants seem genuinely surprised by the seriousness of the government's commitment to the reduction of health inequalities and that this commitment is supported actively by such a wide range of British government departments and ministers. Efforts to emulate the successes of the US Perry Pre-School Project, for instance, involve the Department of Health and the Department for Education and Employment, in the Sure Start scheme, and the Treasury, through the Working Families Tax Credit.

The astonishment of civil servants is matched by the delight of many health inequality researchers. In the view of one elated researcher this is probably the first Labour government in history that has redistributed more wealth and resources than it claims. To which, another adds, that this redistribution is informed by an understanding of the health gradient. Rather than tackling the extremes of affluence and deprivation, resources have been taken from the middle of the upper half of the income distribution and redistributed to the middle of the lower half, thereby flattening the gradient. Crucial sections of the medical profession are also on board. General practitioners have taken ownership of efforts to reduce health inequalities by the element of local targeting in Health Improvement Plans; and they will receive active support from the UK Faculty of Public Health Medicine, through its National Public Health and Primary Care Group.

With so much energy and thought being directed at the problem, it can seem churlish to express reservations. Three thoughts nevertheless occur. So far, on the ground, not much has changed. The Government says it is playing for the long term. Many of its new programmes are detailed and complex, and their net outcome results are difficult to predict. Most will not come on stream until the latter part of the government's first term in office. Their promise, and the timing of their introduction in the run up to the next general election, may be designed to win back the Labour Party's core support, so giving the government a second term. There is a danger that only afterwards will the possibly disadvantageous net outcomes become clear—the future of Housing Benefit, the British welfare payment of housing costs, is likely to be a key issue here.

Secondly, there is the ever present danger of unintended consequences, for example, conflict between Sure Start and educational league tables. Will there not be an incentive for local authorities to divert resources from Sure Start, with its focus on the most disadvantaged youngsters, to more affluent areas where the same investment may produce greater examination success? Finally, even if all the programmes are implemented properly, how profound will be the changes they introduce? Will welfare benefit levels and the minimum wage still be below the minimum cost of a healthy life? Will those on benefits still pay the highest rates of effective taxation when they enter paid employment? And will being working class still be among the most powerful predictors of premature death?

Funding: tenured academic, no additional funding.
Conflicts of interests: none.

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