Research Findings: 5
FROM THE HEALTH VARIATIONS PROGRAMME

E·S·R·C ECONOMIC & SOCIAL RESEARCH COUNCIL

Understanding health variations and policy variations

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- A major concern of the current Labour Government's health policy is to achieve the goal of reducing health inequalities using the means of local partnerships. However, while much evidence exists on the manifestations and causes of health inequalities, much less is known about how policies to tackle health inequalities are formulated and implemented.

- Policy variations may occur on vertical and horizontal dimensions. The vertical dimension focuses on the 'implementation gap' between central government and local agencies. The horizontal dimension is concerned with variations between and within different local areas and organisations.

- The aim of this project was to examine the policy variations associated with health inequalities; that is, the policy process designed to achieve equity in the NHS, with a focus on local stakeholders' views of concepts and operational definitions of equity and the mechanisms to achieve it. Our approach fused a number of conceptual models in order to explain how the vertical and horizontal dimensions interacted.

- The methods were both quantitative and qualitative. A study of national and local documents was carried out to examine equity objectives. A questionnaire was sent to 2000 individuals in local health and social care agencies. Three contrasting case-studies were identified for in-depth investigation of the policy process.

- Policy success is likely to be related to clear objectives, mechanisms to carry out those objectives and resources to finance the policy. However, the documentary review showed that these policy streams did not always flow together. The questionnaire survey found that there was no clear 'shared vision' regarding the specific objectives and priority of health inequalities policy. There was some differences between the desirability ('in an ideal world') and feasibility ('in the real world') of policy objectives.

- Local respondents (in the case-studies) perceived that the importance of health inequalities as transmitted down the vertical dimension took second place in relation to competing national imperatives ('must do's'). Performance management entailed 'soft' targets compared to 'hard' measures associated with waiting lists. Policy continued to travel down vertical silos from the centre, with the lack of joined-up government at the centre undermining local partnerships.

- Responsibility for tackling health inequalities is shared between health authorities (HAs) and local authorities, but its place on the agenda varied between and within organisations. HAs viewed health inequalities as more central to their responsibilities than NHS Trusts and Primary Care Groups. In local authorities, ownership of policies was more patchy. Within all organisations, health inequalities remained largely the domain of certain individuals rather than being seen as everyone's responsibility.

- The fusion of analytical models helped explain the interaction between the vertical and horizontal dimensions. The local (horizontal) context had some effect, with different degrees of policy success in different areas. However, the vertical dimension had a significant force in all three case-study areas.

- Central and local levels have made some progress in health inequalities policies. However, policy objectives, instruments and priorities all remain unclear. Central government needs to ensure that goals are clear and achievable; that it is more joined-up, and that performance assessment increases the profile of health inequalities. In turn, local agencies should foster long term ownership of policy within and between agencies such that all partners work towards a shared vision; all must therefore play their respective parts towards reducing health inequalities.

Background

Evidence about the causes and manifestations of health inequalities has been accumulating for some time. However, little is known about how policies to tackle health inequalities are formulated and implemented. This gap is significant given the Labour government's emphasis on tackling health inequalities and promoting joined-up government centrally and inter-agency partnerships locally, as outlined in documents such as The New NHS, Partnerships in Action, and Saving Lives, and the 1999 Health Act.

This project examined the policy variations associated with health inequalities; that is, the policy process designed to achieve equity in the NHS with a focus on stakeholders' views of concepts and operational definitions of equity and the mechanisms to achieve it. Policy variations were explored in two dimensions: the vertical and the horizontal. The vertical dimension involves the translation of policy as it passes from national and central government to the local agencies. The horizontal dimension refers to the effect of local contexts in terms of differences in approach and understanding between and within local organisations. Our approach fused a number of models in order to explain how the vertical and horizontal dimensions interacted. Policy outcomes can be explained by identifying the interaction between inner (local) and outer (national) context, policy content and policy process. Analytical models addressing factors associated with 'policy failure' and 'policy streams' were also used.

The project had six main aims:

1. to examine how policy towards health inequalities is formulated and implemented;
2. to examine how and why national policy towards health inequalities becomes translated vertically into local policies;
3. to examine how and why local policy towards health inequalities differs between and within health authorities and other agencies;
4. to determine which concepts and operational definitions of equity inform these processes;
5. to determine how initiatives to tackle health inequalities are evaluated at local levels;
6. to establish whether examples of good practice can be detected so as to inform evidence-based policy making.

Data and methods

Policy processes are disparate phenomena and hence data triangulation is essential. Quantitative and qualitative methods were employed to address the project's aims. National and local documents were examined to examine whether equity objectives were explicit, clear, comprehensive and consistent over time. Their feasibility, in terms of being matched with policy instruments, was also explored. A questionnaire was sent to over 2000 individuals in local health and social care agencies to ascertain their understanding of different concepts of equity and inequality and which aspects of equity policies they thought were desirable and feasible. (The response rate by individual was 12%). Three contrasting case-studies (in rural, urban and mixed suburban areas) were identified for in-depth investigation of the policy process. Each case-study consisted of one Health Authority and its partnership network. Data were collected through in-depth interviews, observation and documentation over several months. Interim conclusions were validated at feedback meetings in each case-study.

Results

1. *Policy means and ends:*

   Policy success is likely to be related to clear objectives, mechanisms to carry out those objectives and resources to finance the policy. The documentary review showed that these streams did not always flow together. The questionnaire survey found that there was no clear 'shared vision' regarding the priority of health inequalities policy, and regarding the *what* and *who* questions of policies: what aspects of policy (expenditure, access, provision etc.) were directed to which social groups (gender, social class etc.). Distinctions between health inequalities and health care inequalities were often implicit, and few defined health inequalities in terms of the 'health gap.' There were some differences between the desirability ('ideally') and feasibility ('in reality') of policy objectives: while local stakeholders considered that the ideal objective was equality of outcome, they tended to view objectives such as equality of access for equal need as more feasible. These differences did not appear to be pronounced between clinical and managerial staff although there were some organisational (and geographical) differences. Respondents from the case studies confirmed such concerns.

2. *The vertical dimension:*

   There was a widespread enthusiasm locally to tackle health inequalities and many practitioners welcomed the legitimacy that national policy gave to such action. However, this concurrence of national and local policy agendas was confounded by several factors. Many questionnaire respondents considered that health inequalities were influenced by income inequalities, implying a central policy responsibility. However, the case-studies showed that the number of competing national imperatives ('must dos') was considered "overwhelming." Health inequalities became a rhetorical priority, as 'must dos' took priority over health inequalities. Although health inequalities were included in performance management mechanisms, it was often done so less rigorously than other imperatives like waiting lists or financial balance. Whilst the latter were seen as 'hard' targets, those for health inequalities were seen as 'soft'. Policy impacts were not expected within 5 years and yet organisations were assessed annually. Health inequalities were perceived as less important in individual performance assessment; as several respondents explained, 'no one loses their job over health inequalities.' Performance management was transmitted down vertical silos from the centre, with the lack of joined-up government at the centre undermining local partnerships. Thus, not only were central expectations being dashed locally, local expectations were dashed centrally.

3. *The horizontal dimension:*
Responsibility for tackling health inequalities is shared between health and local authorities, recognising the partial role that health services play in tackling health inequalities. Whilst health inequalities may be on the agenda of health and local authorities, its place on the agenda varied between and within organisations. The questionnaire revealed differences between organisations regarding the desirability, feasibility and priority of health inequalities. The case studies confirmed differences in policy ownership: HAs saw health inequalities as more central to their responsibilities than NHS Trusts and Primary Care Groups. Within organisations, health inequalities remained the domain of certain individuals. This variation was partly related to the local context, which included dealing with budget deficits, organisational change (such as the introduction of PCGs and Best Value initiatives) and forming local partnerships. Inter-agency partnerships have long been recognised as problematic given differing goals, structures and resource streams. Evidence pointed towards the continuation of these constraints despite the government's new partnership arrangements. The term 'health inequalities' and its public health focus were often inimical to developing a wider ownership, especially in non-health agencies. However, examples of where these were being overcome in the health inequalities context included joint appointments (e.g. health inequalities impact assessment managers), joint strategy/partnership groups and exercises developing joint performance indicators.

4. *Evidence-based policy-making:*
The case-studies identified an enthusiasm to address measurement and evaluation, indicative of evidence-based policy-making. However, the time over which policy impacts were measured conflicted with organisational and individual performance management. Outcome measures were problematic and so process measures dominated. Many local practitioners explained that they lacked basic data on which to base policy which was further compounded by the transient and excluded groups which policy was targeting. Also data were often not shared between agencies. Evaluative systems were not widespread but where they did exist, there appeared to be a weak link into mainstream decision-making processes. Without such a link, many feared that health inequalities would remain marginal.

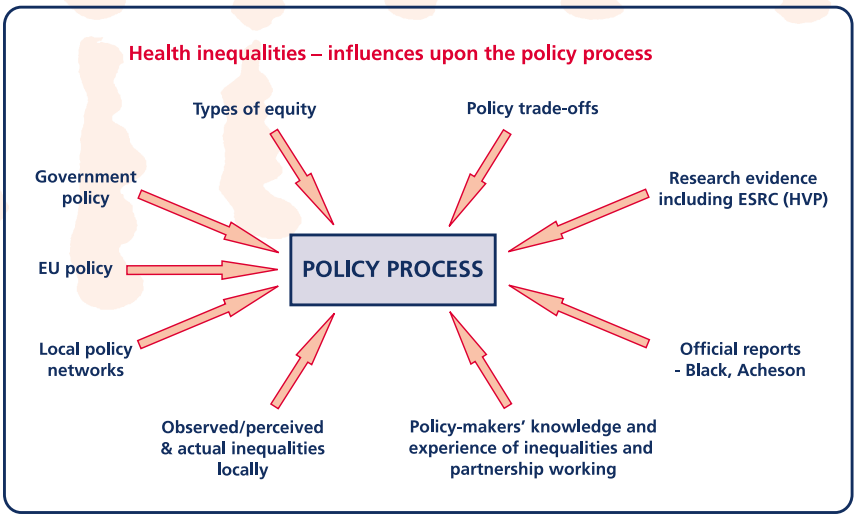
Conclusions and policy implications

The fusion of analytical models explained the interaction between the vertical and horizontal dimensions. The models explained why, despite widespread support, policy is likely to have a limited impact on health inequalities. However, local (horizontal) contexts may mean different degrees of policy success in different areas. The local context had a moderate effect upon the policy process and its (intermediate) outcomes. Local context is a significant factor in explaining local policy outcomes but the vertical dimension is probably the most significant force across all three case-study areas.

Furthermore, health inequalities policy remains 'muddy' rather than clear. There are few signs of the integration of 'policy streams' at local or national levels. Policy objectives remain confused; the processes translating desirable objectives into feasible outcomes have not been demonstrated; the resources to achieve the objectives are scarce, especially given competition with other imperatives.

The Government has made some progress in emphasising the importance of equity as a major goal of the NHS, and partnerships as the means to achieve it, and locally, examples of good practice can be identified. However, issues relating to clarity of objectives, feasible policy processes and adequate resourcing must be clarified in order that central and local agencies can make greater progress towards reducing health inequalities.

Central government needs to ensure that goals are clear and achievable by being matched by appropriate policy instruments and resources. The Departmental, silo mentality must be replaced by a more joined-up performance framework that should transmit compatible rather than conflicting measures. Mechanisms of performance assessments for health inequalities (including targets) must be given higher priority, but must be achievable given the long term nature of the problem and the fragmented policy ownership, locally and centrally. Local agencies must develop a shared vision such that all can play their respective part towards reducing health inequalities.



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Selected papers drawn on for these Findings

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Information about Programme

The Health Variations Programme was established by the Economic and Social Research Council in 1996 to focus on the causes of health inequalities in Britain. Over the last two decades, Britain has got healthier and richer, but inequalities in health and income have increased. Death rates have fallen but mortality differences between social classes I and V have widened; real incomes have risen but so has the proportion of the population living in poverty. The Programme aims to:

- advance understanding of the social processes which underlie and mediate socioeconomic inequalities in health;
- advance the methodology of health inequalities research;
- contribute to the development of policy and practice to reduce the health gap between socioeconomic groups.

There are 26 projects in the Programme, based in university departments and research units across the UK. The projects have been established in two phases: in 1996/7 and in 1998/9. They address questions at the cutting-edge of health inequalities research, including the influence of material and psycho-social factors across the lifecourse, the influence of gender and ethnicity and whether and how areas have an effect on the socioeconomic gradient over and above the influence of individual socioeconomic status. The potential contribution of policy, at national and local level, is also addressed.

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