Perspective: Reducing Health Inequalities: Britain's Latest Attempt

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Reducing Health Inequalities: Britain’s Latest Attempt

A noted observer of the British health scene criticizes the Acheson Report’s approach to assessing and reducing health inequalities in Britain.

by Raymond Illsley

Britain’s Acheson report is the latest in a long series of reports and scientific studies dealing with inequalities in health among socioeconomic groups in Britain. When the National Health Service (NHS) was introduced, it was widely expected that these inequalities would be reduced or even eliminated. Their continued existence led a previous Labour administration to set up a scientific committee that confirmed not only that inequalities persisted but that they had widened. It concluded that health inequalities resulted largely from social inequalities, specifically from poverty. By the time the report emerged, Labour had been replaced by Margaret Thatcher’s Tory administration, which rejected the report and its radical, expensive recommendations with a savagery that gave the so-called Black Report instant national and international fame.

After nearly twenty years the New Labour government asked for another review “to identify priority areas for future policy development.”

Major Thesis And Shortcomings

The major thesis of the new report, like that of its predecessor, is that the primary causes of health inequalities derive from social and economic factors rather than from the NHS itself, and again poverty is a central concept. After a brief review of the relationship among occupational class, death rates, and rates of reported mental health problems, the report works its way through identifying major sectors of society in which policy development might bring about reductions in ill health: poverty, income, taxes, and benefits; education; employment; housing and environment; mobility, transportation, and pollution; nutrition; mothers, children, and families; young people and adults of working age; older people; ethnicity; gender; and the NHS. (Only nine of the report’s 119 pages deal with the latter.)

Unlike the Black Report, this review has been politely welcomed by government. In the scientific community, political circles, and the media, its publication has been a nonevent. Why such indifference in a period when British society is again concerned with fairness and collective action? The report has some severe shortcomings: lack of rigorous epidemiological analysis and the consequent failure to identify the long-term structural issues, the long wish list of reforms only loosely related to the health inequalities, and the political naiveté of the recommendations.

Lack of analysis. The report’s slight descriptive review of the relationship between occupational class and selected death rates is based on the assumption that inequalities in health have widened over the past fifty years or more. Failure to examine this assumption has sad consequences. If the introduction of the postwar welfare state and the NHS, the vast increases in affluence, the admitted 62 percent increase in real disposable income of Britain’s poorest citizens, and the enormous fall in death rates (particularly

Raymond Illsley was previously director of the Medical Sociology Unit of Britain’s Medical Research Council and is now visiting professor with the Department of Social and Policy Studies at the University of Bath.
for those most closely related to poverty) have only resulted in a widening of inequalities in health, why should the relatively minor recommendations of the Acheson committee lead to a happier outcome?

No doubt the authors feared to enter this minefield. Transfixed by the notion that occupational-class death rates have fallen in parallel with occupational-class wealth increases, they overlooked the fact that the sizes and properties of such classes have been transformed by technological and social change and that today’s illnesses and deaths occur at different ages from different social and clinical causes. In both periods “the poor” were less healthy, but the poor of a poor society were absolutely poor, and many died in infancy and at young ages of infectious and respiratory diseases, common among the poor. The relatively poor of a relatively rich society are surviving until late middle age and are dying or suffering from behaviors such as smoking, unhealthy eating, lack of exercise, and drug use—some of which were previously more characteristic of the well-to-do. The poverty of the poor now resides in poorer education and knowledge and consequent exclusion from full participation in society.

■ Failure to identify long-term issues. Lack of rigorous epidemiological analysis has other consequences. There is no data-based evidence in the report by which to identify the nature and scale of the diseases, illnesses, or disabilities involved or their presumed social causes and hence the priorities for policy. The result is a loosely organized trawl through each sector of society in which health targets are chosen by the authors rather than demonstrated by the evidence. Too frequently use of the words “health” and “ill health” obscures the underlying clinical conditions.

■ Naive recommendations. When six people sit around a table, with no epidemiological or sociological framework to guide and restrain them, the recommendations they make are bound to have the flavor of personal wish lists—and so they do. Some recommendations cover huge areas of political responsibility such as, “We recommend policies which will further reduce income inequalities and improve the living standards of households in receipt of social security benefits.” The thirty-nine main and thirty-five subsidiary recommendations range over diverse areas such as breastfeeding, walking and cycling, and fluoridation of the water supply. The health minister asked for priorities. “The only expression of priority is for policies aimed at improving health and reducing health inequalities in women of childbearing age, expectant mothers, and young children.”

The minister is personally committed to a reduction in health inequalities. Many of the recommended measures were already government policy and are likely to be implemented. The report makes no attempt to show whether they are “cost-effective” or “affordable,” criteria that are specified in the terms of reference. Many of the recommended measures are so large and empty of specifics that neither cost nor effectiveness is calculable.

I suspect that the minister needed powerful scientific demonstration that some of the more costly policies, already seen as morally desirable, could be presented to Cabinet colleagues as practical, affordable policy. The Acheson Report will not help.

NOTES
1. Officially titled Independent Inquiry into Inequalities in Health (London: Her Majesty’s Stationery Office, 1998), the report was named for the study committee’s chairman, Sir Donald Acheson.