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Divergence or convergence? Health inequalities and policy in a devolved Britain

Abstract

Since the advent of political devolution in the UK, it has been widely reported that markedly different health policies have emerged. However, most of these analyses are based on a comparison of health *care* policies and, as such, only tell part of a complex and evolving story. This paper considers official responses to a shared *public health* policy aim, the reduction of health inequalities, through an examination of national policy statements produced in England, Scotland and Wales respectively since 1997. The analysis suggests that the relatively consistent manner in which the 'policy problem' of health inequalities has been framed combined with the dominance of a medical model of health have constrained policy responses. Our findings differ from existing analyses, raising some important questions about the actuality of, and scope for, policy divergence since devolution.

Key words: Britain, critical discourse analysis, devolution, health inequalities, policy divergence

Introduction

Although the political devolution of power to a Scottish Executive¹ and a Welsh Assembly Government in 1999 was limited, it was still welcomed by many as a process which opened up 'the potential for the development of radically different social policies' (Mooney et al., 2006: 483).² Indeed, commenting on the discussions which led up to devolution in Scotland, Parry (1997: 34) claims that 'The ability to take distinctive action on social policy has been one of the main justifications for a Scottish Assembly or Parliament'. Similarly for Wales, Mooney and Williams (2006: 610) claim it was the 'potential of [devolved] social policy making to produce a more socially cohesive society' which persuaded the electorate to vote in favour (albeit narrowly) of a Welsh Assembly. Furthermore, a perception that both Wales and Scotland faced distinct social problems which required context-specific responses formed a significant part of the rationale for political devolution (see, for example, Dewar, 1999; National Assembly for Wales, 2001). However, the extent to which Wales and Scotland have developed into the 'policy laboratories' some expected (e.g. ESRC Devolution and Constitutional Change Programme, 2003) remains the subject of much debate (Mooney and Scott, 2005; Silburn, 2004; Stewart, 2004).

The dominance, until recently, of one political party (Labour) in all three polities,³ the restricted nature of devolution arrangements (e.g. Cairney, 2004; Mooney et al., 2006), processes of 'path dependency' or historical institutionalism (see Fawcett, 2003) and a global, 'neoliberal onslaught' (Mooney et al., 2006) have all been cited as factors which have operated to constrain the possibility of significant policy divergence. However, health policy, one of the most significant policy areas in which the devolved governments have been granted extensive responsibilities, is one area in which there appears to be some consensus that important policy distinctions have emerged. For example, some of the most widely reported policy divergences to date relate to health, such as the Scottish Executive's prominent early decisions to provide free personal care for the elderly and to ban smoking in public places and, and the Welsh Assembly Government's decision to phase out prescription charges. Indeed, Scott Greer's analyses

(2001, 2003, 2004, 2005) appear to dominate a current consensus that policymakers concerned with health issues in the devolved governments have responded to 'their particular problems and debates in ways that vary territorially and produce territorial policy divergence that matters' (Greer, 2005: 501).

Put simply, Greer's claim is that whilst English health policies have focused on the introduction of markets to the National Health Service (NHS), Scottish health policies have concentrated on strengthening the role of medical professionals, and Welsh health policies have emphasized the importance of localism. This thesis is widely, and often uncritically, cited (e.g. Cairney, 2006, 2007; Chaney and Drakeford, 2004; Keating, 2005; Poole and Mooney, 2005) and has led to claims that we are now experiencing a natural policy experiment in the health arena (e.g. Smith and Babbington, 2006). Amid such enthusiastic claims, there has been only limited acknowledgement that some not insignificant differences between the three countries existed long before political devolution (see, for example, the pre-devolution analysis of diversity in the field of community care by Hunter and Wistow, 1987). Perhaps more remarkably, there has been little reflection on the way in which analyses purporting to consider divergences in 'health policy' focus almost entirely on health *care* policies. For example, only one of Greer's analyses specifically considers how each government has approached *public health* policy issues and, as this was published only two years after devolution, the findings provide only a snapshot of post-devolution policies in their infancy (Greer, 2001). Furthermore, although Greer (2001) finds some similarities between approaches to public health in Scotland and England, he does not suggest that public health policy is any less divergent than health care policy, and seems to include this part of the analysis in his general conclusion that 'distinct logics' are governing each polity's approach to 'health policy'.

This gap in the literature is particularly surprising when public health has formed a key concern of all three governments. Indeed, as has been widely reported, the election of a Labour government in 1997 marked a key moment for many in the public health community as it represented the first time in 18 years that a government had made an explicit commitment to reducing health inequalities (see Berridge and Blume, 2003). Since then, the issue has been consistently highlighted as a policy priority in all three mainland British countries (e.g. Department of Health, 2000; Health Improvement Strategy Division, 2002; Public Health Strategy Division, 2002). Health inequalities are

a particularly interesting social issue to explore from the perspective of devolution as they represent a cross-cutting and complex problem to which solutions remain unclear and contested. In other words, health inequalities constitute a 'wicked issue' of the sort one might expect different policymaking contexts to approach experimentally (Blackman et al., 2006).

This paper attempts to redress the service-orientated bias of current analyses of the impact of devolution on 'health policies' by focusing specifically on policy responses to health inequalities. By this term we mean the preventable variations in individuals' health status which are associated with differences in their social (or geographical) position.⁴ In exploring the ways in which policy statements from each country frame and discuss this issue, the findings presented in this paper contrast significantly with most existing analyses of post-devolution health policy, revealing a surprising degree of convergence across the three countries, as well as some continuity with the past (Parry, 2003). It is argued that the similar ways in which health inequalities have been conceptualized and framed as a policy problem in the three policy contexts, combined with the dominance of a medical model of health, are likely to have played an important role in constraining policy responses. This paper forms part of a larger Economic and Social Research Council (ESRC)-funded project looking at the impact of varying performance assessment arrangements on making progress with tackling health inequalities across Britain (see Blackman et al., 2006).

Methodology

Written texts form an important part of social worlds in all literate societies and are often under-analysed compared to research that focuses on interactions with people (Atkinson and Coffey, 2004). Public policy statements are a distinctive kind of text which frame the nature of public policy problems, shape the boundaries of possible responses and act as points of reference for a wide variety of actors to justify subsequent actions (see Freeman, 2006). As a result of their authorship, policy documents are able to impose a particular kind of power through the words they use. What seems to be presented as fact within policy statements, often represents policy decisions (or non-decisions) which, in turn, may be based on implicit assumptions (Iannantuono and Eyles, 1997: 1620).

Analysing these texts in order to uncover what these assumptions are and how they are likely to shape the way in which other actors conceive of and respond to particular policy problems therefore provides a key method of understanding policy processes. Unsurprisingly, then, Hanney and colleagues (2003) conclude that the analysis of policy documents is a crucial method of understanding policy responses to health problems.

This 'linguistic turn' within social sciences has stimulated a wide range of approaches to exploring language and several alternative approaches to analysing the policy texts were initially piloted on some of the key documents included in the analysis. The eventual approach chosen combined elements of Critical Discourse Analysis techniques, pioneered by academics such as Fairclough (2000), with a focus on exploring how health inequalities have been constructed as a 'policy problem' (see Gamble and Stone, 2006). On this basis, a framework of key questions was compiled to aid the analysis of each document. This framework focuses on three sets of questions: i) the first explores how health inequalities are constructed as a 'policy problem'; ii) the second focuses on how the texts present the causes of, and solutions to, health inequalities and the assumptions which underlie these claims; and iii) the third aims to uncover where responsibility for taking action to tackle health inequalities (and achieve results) lies and on what assumptions these allocations are made. Both the framework for analysis and the inclusion criteria for policy statements were approved by the authors of this paper who, between them, have a range of disciplinary backgrounds and are dispersed across England, Scotland and Wales.

Given that health inequalities only moved back on to the official policy agenda in 1997, with the arrival of a Labour government, this year was taken as the starting point for the analysis and May 2007 was chosen as the end point on the basis that it was in this month that new governments were formed in Wales and Scotland and, shortly afterwards, that a new Prime Minister took office in England. It is important to state at the outset that this paper is based solely on the discourse analysis of national policy statements and it does not aim to capture the views of local or national actors, which may well tell a different story. Nor can it explore how the differing structures of the NHS and local government in each country impact on the way in which policies are implemented. However, both these issues are being explored in the broader ESRC project (Blackman et al., 2006).

Owing to the volume of official publications relating to health inequalities in each country (especially in England), it was necessary to establish clear inclusion criteria for the study. It was decided to include only national policy statements of significant relevance to health inequalities, notably White Papers and national guidance on how other organizations/individuals should tackle health inequalities. It did not include advisory documents, such as the Acheson (1998), Wanless (2002, 2003, 2004), Beecham (2006), or Kerr (2005) reports. Nor, for England and Scotland, did it include consultative documents. This decision was made on the basis that where aspects of consultative or advisory documents had been taken up by policymakers, they should be visible in subsequent policy statements. The inclusion criteria had to be adjusted somewhat for Wales in light of the fact that Wales has not had primary legislative making powers. As a result, key consultative documents were included for Wales, especially those, such as *Well Being in Wales*, which are referred to in later documents as having set the national agenda (Public Health Strategy Division, 2002). Based on these criteria, 75 statements were included in the analysis (33 from England, 24 from Scotland, and 18 from Wales). Given the extent of the data arising from this analysis, this paper does not attempt to provide a detailed account of the selected policy statements but rather summarizes aspects of the overall findings which, firstly, illustrate the extent of policy similarities with regards to the issue of health inequalities and, secondly, provide insights into the reasons underlying this convergence.

Health inequalities in post-1997 English, Scottish and Welsh health policy statements

The construction of health inequalities as a 'policy problem'

The policy statements from all three countries employ the term 'health inequalities' to refer to a variety of forms of health stratification, including health differences between men and women and between ethnic groups. However, although there are some minor but noticeable differences between the emphases of each country in this respect,⁵ policy conceptualizations generally echo the UK research literature by most frequently focusing on health differences between social classes and geographical areas.⁶

Moving beyond *types* of health inequality, the issue can be further conceptualized in the following three ways (see Graham and Kelly, 2004): i) as a problem of 'health disadvantage', resulting from the poor health of poor people (or people in poor areas); ii) as a 'health gap', in which the issue requiring attention is the health difference between poor groups and others ('others' possibly representing the wealthiest groups or, perhaps, the national average); or iii) as a 'social gradient in health', involving a health slope which cuts across the whole of society. These three conceptualizations are not entirely incompatible. However, as Graham and Kelly (2004) demonstrate, the way in which the problem of health inequalities is conceived within policy has important consequences for the kinds of solutions which consequently appear most logical. A crucial difference is that the first and second conceptualizations locate the 'problem' of health inequalities largely at the poorer end of the spectrum (i.e. with lower social classes or with people living in deprived areas). Such conceptualizations are therefore likely to encourage policy interventions which are targeted specifically at these groups. Notions of social gradients in health, on the other hand, challenge the logic of focusing only on people at one end of a spectrum by framing the problem as one which cuts across the whole of society and therefore requires a societal (and not just a targeted) response. A societal response would need to address the full range of inequality in incomes and wealth, and their manifestation as a health gradient, rather than the position of the poorest (either in absolute or relative terms).

Echoing Graham and Kelly's (2004) analysis of the English policy context, the analysis on which this paper is based found rather more evidence of the first two conceptualizations of health inequalities than of a 'social gradient in health'. Table 1 provides some illustrative extracts from policy statements of each country which demonstrate the way in which health inequalities have been described as an issue of 'health disadvantage' and 'health gaps'. There are no examples of references to social gradients in health because none were found in either the Welsh or Scottish policy statements and, although a few references to social gradients in health were found in some English policy statements (e.g. Department of Health, 2003; Health Inequalities Unit, 2005), these remained far outnumbered by discussions focusing on 'health gaps' and 'health disadvantage'.

The key point about the way in which health inequalities have been conceptualized as a policy problem in each country is that, even where

'health gaps' are referred to, the focus remains on the need to improve the poor health of poor people. This conceptualization is evident in the targets (or, in the case of Wales, aspirations) which were eventually set in relation to health inequalities in each country.

Table 1 Policy conceptualisations of health inequalities in the three countries

<i>Policy context</i>	<i>Illustrative examples of conceptualisations of 'health disadvantage'</i>	<i>Illustrative examples of conceptualisations of 'health gaps'</i>
England	<i>Programme for Action</i> (Department of Health, 2003): 'To reduce health inequalities and achieve the targets will require us to improve the health of the poorest 30–40 per cent of the population where the greatest burden of disease exists.'	<i>Our Healthier Nation</i> (Secretary of State for Health, 1998): 'No one should doubt the seriousness of our approach. In particular, our determination to narrow the health gap between the worst off in society and the better off . . .'
Scotland	<i>Towards a Healthier Scotland</i> (Secretary of State for Scotland, 1999): '[This document] is about health for all, but children and groups disadvantaged by poor health have a special place.'	<i>Partnership for Care</i> (Minister for Health and Community Care, 2003): '[There is] an unacceptable health gap between the richest and the poorest communities.'
Wales	<i>Promoting Health and Well Being</i> (Minister for Health and Social Services, 2001): 'Addressing inequalities in health by targeting action on hard to reach and disadvantaged groups within the population will be a major consideration in the roll-out of the programme and its component parts.'	<i>Better Health – Better Wales</i> (Secretary of State for Wales, 1998): 'Despite the considerable reduction in premature mortality across the whole population, the gap between those with the best health and those with the worst is widening.'

In 2001, England became the first of the three countries to introduce specific, national targets for reducing health inequalities. Initially there were two separate targets focusing on a reduction in the infant mortality 'gap' between manual groups and the rest of the population and a reduction in the 'gap' between the fifth of areas with the lowest life expectancy at birth and the population as a whole, both of which were to be achieved by 2010 (see Department of Health, 2001a, 2001b). However, following several amendments,⁷ these targets were combined into a single Public Service Agreement focusing on area-based differences (HM Treasury, 2004). The way in which these targets have been constructed underlines the conceptualization of health inequalities as an area-based 'health gap'. The national policy focus, therefore, has been on improving the health outcomes of these areas (such as the Spearhead areas) at a faster rate than the national average.

Although the Scottish Executive had not officially introduced any national health inequality targets when the English ones were announced, the performance assessment framework for the NHS introduced in Scotland in 2001 did include a commitment to tracking indicators of inequality. This form of monitoring health inequalities also relied on a conceptualization of the issue as a 'health gap' but, in contrast to England (which focused on the differences between the most deprived areas and the national average), for Scotland the gap to be measured was the more ambitious one of that between the most deprived and the most affluent areas. Following a report from an expert group (Measuring Inequalities in Health Working Group, 2003), Scotland later introduced national targets for reducing health inequalities. However, despite a previous commitment to setting targets around the narrowing of a 'health gap' (Scottish Executive Health Department, 2003), the targets that were eventually introduced were, in fact, health improvement targets with a specific focus on the most deprived areas of Scotland (Scottish Executive, 2004). Until 2006 'health gaps' continued to be monitored as part of the performance assessment framework but the recent introduction of a new performance management system, referred to as HEAT (Health, Efficiency, Access and Treatment targets), has effectively removed any commitment to measuring 'health gaps' in Scotland and reinforced a conceptualization of health inequalities as a problem of 'health disadvantage'.

Much of the language in the statements that were analysed suggests Welsh policymakers have, to date, been less concerned with targets than their colleagues in England and Scotland. However, Wales also decided

to establish an expert group to advise on measuring health inequalities (Expert Group on Indicators of Health Inequality, 2001). This group recommended that 'health gaps' between areas should be officially monitored (a recommendation that has not yet been followed up) but advised against setting specific targets for reducing health inequalities on the basis that it would allow the government to take a longer-term (but more effective) approach to the issue by focusing on wider, social determinants. Between 2003 and 2004, several new 'health gain' (health improvement) targets were announced and these include what are referred to as 'health inequalities targets'. However, these 'targets' are essentially statements of aspiration. The Welsh Assembly Government has, therefore, continued to avoid specific, quantified targets for health inequalities (against which the success or failure of its policies in this area might be measured).

The contrasting decisions that each government made about health inequalities targets to some extent support Greer's (2001) claims that different 'logics' are governing each country's approach to health policy. The fact that England was the first to set specific national health inequality targets may reflect its much-discussed 'target-culture' (see Blackman et al., 2006). Whilst the decision in Wales initially not to set targets for health inequalities, and even its more recent decision to outline only aspirational 'targets', suggests there is notably less of a belief amongst Welsh policymakers that quantifiable targets are an effective way of promoting desirable change. Scotland's decision to outline health inequality targets suggests the logic at work here may not be so different from that in England (even if, as discussed, the Scottish targets are not dependent on the reduction of a 'health gap'). From this perspective, it is the Welsh Assembly Government that has most noticeably diverged from the other two countries, supporting Greer's (2003) and Chaney and Drakeford's (2004) claims that, despite more limited policymaking powers, the approach to health policy has been more long-term and, perhaps, more radical in Wales. However, whether the contrasting approaches taken to targets mean that the broader approach to health inequalities also differs, and whether the lack of specific targets has enabled Wales to take a longer-term strategy, remains questionable, as the next sections discuss. Crucially, in all three countries, health inequalities have consistently been conceptualized as a policy problem relating to the poor health of poor people (or people in poor areas).

How the policies portray the causes of, and solutions to, health inequalities

In explaining the existence of health inequalities, the initial policy statements of each country place a significant amount of emphasis on wider determinants of health such as social exclusion, poor housing and inequalities in educational and employment opportunities, as well as on differential patterns of lifestyle behaviour:

The worst health problems in the country will not be tackled without dealing with their fundamental causes – poverty, lack of education, poor housing, unemployment, discrimination and social exclusion. (*From Vision to Reality*, Department of Health, 2001a: 1)

Poverty, poor housing, homelessness and the lack of educational and economic opportunity are the root causes of major inequalities in health in Scotland. We must fight the causes of illness as well as illness itself. (*Our National Health*, Scottish Executive, 2000: 14–15)

The mix of social, economic, environmental and cultural factors that affect individuals' lives determines their health and well being. We can only improve well being in the long term by addressing these factors. (*Well Being in Wales*, Public Health Strategy Division, 2002: 5)

The above three quotations are illustrative of the emphasis placed on broader determinants of health in the policy statements from each country published prior to 2003. However, despite such rhetorical commitments to tackling 'wider determinants', explanations as to *how* such determinants are to be tackled are limited, often consisting of no more than referencing existing or forthcoming initiatives from non-health departments (with little indication that the initiatives were designed to reduce health inequalities). The best example of this is in the Scottish White Paper, *Towards a Healthier Scotland* (Secretary of State for Scotland, 1999), which provides a table outlining the 'three-level' approach to tackling health inequalities, incorporating 'life circumstances', 'lifestyles' and 'health topics'. As Table 2 illustrates, whilst specific foci for action are provided in the columns for the latter two foci, the column for 'life circumstances' is left completely empty.

Table 2 Reproduced from *Towards a Healthier Scotland* (Secretary of State for Scotland, 1999: Chapter Two)

Scotland's health: National priorities

Tackling inequalities

Improved Life Circumstances*	Lifestyles	Health Topics
	<ul style="list-style-type: none"> • Less smoking, drug and alcohol misuse • A healthier diet • More physical activity 	<ul style="list-style-type: none"> • Child health • Dental and oral health • Sexual health, including teenage pregnancies and sexually transmitted diseases • Coronary heart disease (and stroke) • Cancer • Mental health • Accidents and safety

*Life circumstances include, for example, unemployment, poverty, poor housing, limited educational achievement, the general environment and all other forms of social exclusion.

In explaining the empty first column, the document says that 'expert groups' are investigating how to set targets relating to life circumstances and that the consultation process is ongoing. This may reflect a genuine desire to ensure that appropriate foci are chosen, although it is unclear why the factors listed as a footnote to the table could not have been included in the first column. Overall however, it cannot be ignored that, whilst frequent references are made to tackling the 'wider determinants' of health inequalities throughout many of the policy statements, few attempts are made to specify how this will be achieved.

Additionally, it is noticeable that in all three contexts the emphasis placed on policy interventions designed to tackle the wider determinants of health (at least those mentioned within health policies) has lessened over time. This shift is accompanied by a noticeable increase in the emphasis placed on the role of lifestyle behaviours (especially smoking) in explaining and responding to health inequalities. Within Scottish and English statements, this change is reflected in a shift in the focus of phrases such as 'determinants of health and health inequalities'. Prior to 2003, these types of phrase are frequently employed to describe social and economic

determinants, such as poverty and deprivation, as well as various lifestyle behaviours, such as smoking and diet. However, in the documents published from 2003 onwards, such phrases increasingly emphasize the latter rather than the former. For example, *Delivering Choosing Health* (Department of Health, 2005: 18) specifically states that one of its key objectives is to: 'Tackle the *underlying* determinants of ill health and health inequalities' [our emphasis], a phrase which is often employed in the academic literature to refer to the social and economic contexts within which people are situated. However, the way in which the document claims this objective will be achieved relates solely to tackling three lifestyle-behavioural issues (reducing adult smoking, childhood obesity and under-18 conception rates). In other words, as Graham and Kelly (2004) point out, all-encompassing phrases such as 'wider (or underlying) determinants of health' can facilitate confusion between the policy aim of tackling the determinants of health inequalities and that of merely improving determinants of health. This is important because improving the latter could, potentially, lead to widening health inequalities (as seems to have been the case within the UK over the past twenty years).

The way in which health inequalities have been conceptualized as a policy problem relating to the poor health of poor people may well underlie this confusion as it appears to have resulted in an assumption (evident across statements from all three countries) that policy interventions designed to improve health will, if targeted correctly, reduce health inequalities. This assumption is apparent in the following quotations:

In order to close the gap, we must ensure that the most marginalised and excluded groups and areas in society see faster improvements in health. (*Choosing Health*, Secretary of State for Health, 2004: 11)

{The challenge is} to narrow the opportunity gap and improve the health of our most disadvantaged communities at a faster rate, thereby narrowing the health gap. (*Improving Health in Scotland: The Challenge*, Scottish Executive Health Department, 2003: 4)

Imagination and courage are needed to tackle and overcome the health and social inequalities that are related to each other. . . . We are committed to

providing additional funding that is targeted at groups with the greatest health and social need . . . (*Improving Health in Wales*, Health Service Strategy Team (WAG), 2001: 6)

Each of the above quotations implies that a policy focus on improving the health of poorer groups will necessarily reduce health inequalities. Further evidence of the apparent policy belief that approaches designed to *improve* population health can also be employed to help reduce health *inequalities* is provided in claims that targets for health improvement (reducing rates of major chronic diseases and/or rates of contributory lifestyle behaviours), which have been set in all three countries (Secretary of State for Health, 1998; Secretary of State for Scotland, 1999; Welsh Office, 1997), were expected to contribute to the aim of reducing health inequalities.

In Wales, whilst there is less evidence of a rhetorical shift in the meanings attached to terms like 'wider determinants of health', or of confusion between interventions designed to tackle health inequalities and those designed to promote health improvement, there is a clear policy shift away from tackling wider determinants of health and reducing health inequalities and towards a focus on health improvement (a shift associated with the high-profile replacement of Health Minister, Jane Hutt, in January 2005). Despite Greer's (2003) and others' (e.g. Chaney and Drakeford, 2004) optimistic claims that the medical model of individualized health may be being abandoned in Wales, the publication of the online statement, 'Health Challenge Wales' (Welsh Assembly Government, 2004), marks a return to a focus on individuals and their lifestyle behaviours. Unlike the Scottish and English documents published around this time, 'Health Challenge Wales' makes no direct claims that its approach will aid the reduction of health inequalities. Instead, it seems to mark a complete overshadowing of the health inequalities agenda.

Overall, whilst a nuanced account of the documents could potentially highlight differences in the ways in which health policy statements in all three countries have promoted the need to tackle lifestyle behavioural determinants vis-à-vis wider determinants, the 'bigger picture' reveals some striking similarities and a common direction of travel. All three governments were initially keen to discuss the need to tackle wider determinants of health in order to effectively address health inequalities but, following something of a watershed in 2003–4, there seems to be a shift in concern, away from wider determinants

and towards lifestyle behaviours (especially smoking). It is a change of direction that seems to conflict with statements in the early policy documents which point out that previous policy attempts to try to change lifestyle behaviours may have contributed to widening health inequalities. This finding suggests that a medical model of health has remained remarkably persistent within health policy, despite evidence of initial attempts to shift the focus to a more complex, social model.

Further evidence of the dominance of a medical model of health is provided by the noticeable increase in emphasis placed on the role of health services in tackling health inequalities, which again occurs in Scotland and England in 2003–4. Initially, whilst the policy statements from all three countries suggest that unequal access to, use and quality of health services are likely to compound health inequalities (for example, references to Julian Tudor Hart's (1971) 'inverse care law' are evident), health services appear to have little place in either explanations for or strategies to tackle health inequalities. Furthermore, the statements from each country acknowledge that differences in the use and quality of health services do not explain why poorer groups tend to experience symptoms of chronic diseases at an earlier age than more affluent groups. Over time, however, as the illustrative quotations in Table 3 demonstrate, the contribution that the health services are expected to make to reducing health inequalities expands significantly in the Scottish and English documents within the period of study. The first quotations in each of the two rows in Table 3 illustrate the supportive role that health services are encouraged to play in earlier documents, whilst the second quotations in each row demonstrate the far more central role outlined for the health services in more recent policy statements.

This post-2003 emphasis on 'anticipatory care' and 'secondary prevention'⁸ in Scotland and England seems likely to have been driven, at least in part, by the short-term nature of the national health inequality targets (see Blackman, 2007). This might not be expected in Wales, with its longer-term and more aspirational perspective. Yet, once again, a generally similar shift in emphasis is visible at around the same time. Whilst the Welsh documents do not place as much emphasis as the other two countries on secondary prevention as a means of tackling health inequalities, there is a similar shift in the focus of health policy. For example, the current health strategy, *Designed for Life* (Minister for Health and Social Care, 2005), makes it clear that there is to be a change in emphasis towards clinical priorities, especially the reduction of waiting times for treatment. This occurred in the wake of a media

Table 3 Role of health care services in tackling health inequalities: Examples from England and Scotland

<i>Policy context</i>	<i>Illustrative examples</i>
England	<p data-bbox="291 306 980 451"><i>A First Class Service</i> (Department of Health, 1998): ‘Improving the quality and consistency of NHS services is an important part of improving the overall health of the population and tackling inequalities in both health and access to care.’</p> <p data-bbox="291 472 980 949"><i>Delivering Choosing Health</i> (Department of Health, 2005) identifies the following ‘big wins’ for tackling health inequalities: ‘Improving access to primary and secondary care, especially for disadvantaged groups by making services more accessible and responsive; reducing delays before patients’ first visit to their GP; increasing uptake of screening; improving access to diagnostics and specialist referral, management of high blood pressure, cholesterol reduction and emergency care for treatment for heart attack, ensuring variations in prescribing (e.g. statins and cancer drugs) are explained and minimised; action focused on the big killers (cancer, CVD and respiratory disease, including action on smoking); identifying and treating those at high risk of disease, especially the over 50s.’</p>
Scotland	<p data-bbox="291 977 980 1160"><i>Our National Health: Delivering Change</i> (Scottish Executive Health Department, 2001): ‘Personal Medical Service pilots are being used to improve access to primary care services, reduce inequalities and address recruitment and retention problems, particularly in remote, rural and deprived areas.’</p> <p data-bbox="291 1181 980 1363"><i>Delivering for Health</i> (Scottish Executive, 2005): ‘We believe the most significant thing we can do to tackle health inequalities is to target and enhance primary care services in deprived areas. Strengthening primary care teams and promoting anticipatory care in disadvantaged areas will reduce health inequalities . . .’</p>

and political storm about rising waiting lists in the Welsh NHS, including adverse comparisons with England (see Drakeford, 2006). This means that, despite quite different reasons for doing so, Wales has mirrored England and Scotland in placing an increased emphasis on clinical priorities in health policy since 2003.

*The location of responsibility for health inequalities
(including for targets)*

It would be too simplistic to claim that there are clear shifts in the location of responsibility in each policy context between 1997 and 2007 as the findings suggest a more fluctuating and complex picture. However, once again, the analysis does reveal some striking cross-country similarities. Most of the pre-2003 policy statements are rather vague about how health inequalities will be tackled and who should take responsibility but they do clearly suggest that health inequality is a cross-cutting issue affecting a range of government departments. Although these documents acknowledge that success can only be achieved by working in partnership with local public bodies, the private and voluntary sectors and the public, they often suggest that the role of central government will be significant. In contrast, the messages in the post-2003 documents seem more focused on underlining the limited role central government can play and on maximizing the responsibility of local NHS and local government bodies and of individuals.

Primary responsibility for reducing health inequalities (including, for Scotland and England, meeting the relevant targets) is placed with local NHS bodies in all three countries (these are Primary Care Trusts in England and Health Boards in Scotland and Wales), although partnership with other agencies, especially local government, is emphasized. Guidance on precisely how the NHS is expected to achieve these reductions is initially hazy and revolves around suggestions that it needs to change from being a 'national illness service' to a 'national health service'. The lack of discussion about how this shift is expected to take place is problematic when, as Hunter (2003: 111) points out, 'All available evidence suggests that the NHS, essentially a "sickness" service, will never take the wider public health seriously.' However, following the publication of the Wanless Reports in England (Wanless, 2002, 2004) and Wales (Wanless, 2003) and the Kerr Report in Scotland (Kerr, 2005), all of which emphasize the need for the NHS to play a greater role in preventing ill-health, the level of responsibility for reducing health inequalities that is located with health services increases.

In addition, the growing emphasis on lifestyle behaviours from 2003 onwards (as discussed in the previous section) is accompanied by a greater emphasis on individual responsibility for health. For example:

In our survey, 88% of respondents agreed that individuals are responsible for their own health. Health is a very personal issue. People do not want to be told how to live their lives or for Government to make decisions for them. (*Choosing Health*, Secretary of State for Health, 2004: 12)

We are working to encourage people to take greater control over their own health. (*Delivering for Health*, Scottish Executive, 2005: vi)

Health Challenge Wales asks every individual to consider what they are doing, and what more they could do, to improve their health and the health of their family. ('Health Challenge Wales', Welsh Assembly Government, 2004)

With this shift towards individual responsibility comes an increasingly obvious tension between statements in the policy texts that acknowledge some of the key factors influencing health are beyond individuals' control and statements which repeatedly underline the importance of individual decision-making. In England, and to a lesser extent in Scotland, individual responsibility is often couched in terms of 'choice'. Where material, structural and social determinants *are* referred to in post-2003 statements, it tends to be local (rather than central) government with whom responsibility for delivery is placed. Yet the guidance provided for local government is, like that for the NHS, often vague and revolves around suggestions that local government bodies should act as 'public health organizations', focusing on the likely impact that each of their activities will have on local population health.

Concluding discussion

In contrast to existing claims about the divergent direction of post-devolution health policy in England, Scotland and Wales, the findings in this paper suggest that, at least for the issue of health inequalities, the approaches taken by the three governments have been remarkably similar, with a marked cross-country shift in policy direction occurring from 2003 onwards. In particular, despite some differences in relation to the establishment of targets for health inequalities, the 'policy problem' of health inequalities has been framed in a relatively

consistent manner – as a problem of a ‘health gap’ relating to the ‘health disadvantage’ of deprived communities. As Graham and Kelly (2004) underline, the framing of the problem in this way invites responses which focus on trying to improve the health of the poorest people (or people in the poorest areas) as quickly as possible, rather than tackling the broader, societal responses advocated by many researchers in the field (e.g. Graham, 2006; Dorling et al., 2007). This suggests that the possibilities for policy divergence were restricted from the start by a concern not to open up debates about income and wealth inequalities, a concern which may reflect the limited fiscal powers of the devolved governments (especially the Welsh Assembly Government) as well as Labour’s 1997 election manifesto pledge not to increase public spending above the rate projected by the Conservative government for at least two years.

The findings also suggest that, despite a great deal of emphasis on social determinants of health in the policy statements which initially emerged from each country, a medical model of health was never entirely absent and, since 2003–4, it is this approach to health (and health inequalities) which has dominated official statements. Hence, both the Scottish and English documents place much of the responsibility for reducing health inequalities (and meeting the related targets) with the NHS. This implies (as some of the most recent statements explicitly state) that policymakers in Scotland and England perceive the major policy tools with which to tackle health inequalities to be those relating to health service treatments and secondary prevention measures (particularly smoking cessation and pharmacological interventions). Whilst the Welsh statements are less prone to locate responsibility for health inequalities with NHS bodies, the initial focus on a social model of health was also challenged in 2004, when the focus of policy statements began to shift towards clinical priorities such as the reduction of waiting times (see Drakeford, 2006). Further evidence of the dominance of a medical model of health is provided by the increasing emphasis (especially from 2003 onwards) in statements from all three polities on the importance of individual responsibility for adopting ‘healthy’ lifestyle behaviours. Interventions to tackle health inequalities which focus on people who are considered ‘at risk’ of ill-health, either by trying to change their lifestyle behaviours or by employing health service and pharmacological interventions, fail to address the factors which cause the differential patterning of those who are considered more ‘at risk’ of ill-health in the first place. However,

such interventions are likely to remain politically popular because (as some of the statements implicitly acknowledge) they have the potential to produce the kinds of short-term gains which rapidly moving political cycles demand.

At a rhetorical level, there is plenty of evidence that, as Greer (2003) and Chaney and Drakeford (2004) claim, the Welsh Assembly Government initially attempted to take a more radical approach to public health by placing an even greater emphasis on the wider determinants of health than did either England or Scotland. However, as Drakeford (2006) argues, this commitment appears to have faltered in the face of media and political pressure to focus on clinical issues such as waiting times. As a consequence, the initial indications of divergence within the field of health policy that are highlighted by analysts such as Scott Greer (2001) now seem outdated. Whilst it may remain the case that different logics are promoting the emergence of rather different health service structures, there is less evidence of contrasting approaches to public health issues such as health inequalities.

What is apparent from our analysis is that, while much of the language and the detail of policymaking conveys an impression of difference, it is the similarities that invite explanation. As already discussed, two important considerations are the limited nature of devolution arrangements within the UK (especially for Wales) and the dominance, until recently, of one political party in all three contexts. At an institutional level, Parry's (2003, 2004) account of post-devolution Scotland may shed further light on our findings. He argues that the frameworks for post-devolution policies, including health, were largely set in the pre-devolution documents published between 1997 and 1999. Furthermore, Parry (2004) claims that the Scottish civil service has tended to mimic the institutional traditions of Whitehall – a situation which may also have occurred in Wales (see Laffin, 2007). This suggests that institutional factors may have played an additional role in promoting policy convergence. Yet, the fact that Scotland was able to introduce free care for the elderly and take the lead in banning smoking in public places, and that Wales was able to phase out prescription charges, all demonstrate that policy divergence is possible. Questions therefore remain about the reasons for the lack of policy divergence in relation to health inequalities.

The apparent convergence of policy approaches to health inequalities may be the result of 'policy transfer' between the three

polities (although it is impossible to make a judgement about this based on the analysis of policy statements alone). Alternatively, to understand policy approaches to a 'wicked issue' such as this, it may be necessary to reflect on wider cultural and societal trends, such as rising individualism and its relation to happiness (see Layard, 2005) or the pressures of economic globalization and the influence of neo-liberal ideologies in reducing the role of the state (Mooney et al., 2006). Each of these explanations underlines the need for further research to explore the processes involved in post-devolution policymaking.

Political devolution is, of course, a process rather than an event and it will take more than ten years to be able to assess its eventual impact on social policy. Indeed, as the arrangements for devolution continue to evolve and new political parties assume power (as has happened in Scotland following the parliamentary election in May 2007),⁹ we will be better able to reflect on the extent to which it has been the specific political and policy contexts of the past decade which have constrained policy divergence or whether other, more deep-seated forces are at play, either within Britain or emanating from perceptions of, and responses to, wider societal or global pressures.

In the meantime, the findings discussed in this paper raise important questions about the extent to which divergence has been possible at the local (sub-national) level, a point which the findings from the wider project will address (Blackman et al., 2006). These are not, however, questions which can be answered through the analysis of national policy statements. The aim of this paper has been more modest, namely, to explore how health inequalities have been constructed as a policy problem in England, Scotland and Wales and, in so doing, to challenge existing claims about the extent of health policy divergence between the three polities over the past decade.

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Notes

1. Since their election to government in 2007, the Scottish National Party have renamed the 'Scottish Executive' the 'Scottish Government'. However, the title 'Scottish Executive' has been retained for the purposes of this paper, given that this was the title in use during the period of study.
2. The Government of Wales Act (2006) somewhat extended the powers devolved to Wales. However, for the period in which this paper is interested, the Welsh Assembly Government has only been able to legislate where it was empowered to do so by a complex and vast array of Westminster laws.

Devolved powers were also granted to a Northern Ireland Assembly but as the political situation here has been so volatile and uncertain (with direct rule being re-imposed for over three months in 2000, twice in 2001, and again from 2002 until the spring of 2007), developments in relation to health policy have been significantly restricted. Consequently, we decided not to include it in this comparative study.
3. This dominance is no longer the case in Scotland, where the Scottish National Party formed a minority government following the 2007 elections, and has been weakened in Wales by the forced coalition of Labour with Plaid Cymru.
4. The meaning of the term varies widely and is one of the issues that the overall project explores.
5. For example, whilst the English documents pay a little more attention to health differences between ethnic groups, gender health differences and inequalities in mental health are most discernible in the Scottish documents, and the Welsh discussions more frequently highlight the issues facing traveller communities and the differences between language groups. Additionally, discussions of health inequalities in Scottish policy statements are often linked to notions of social justice, whilst in Wales the emphasis has been more around the concept of well-being.
6. Whilst this policy emphasis may seem unsurprising, it is worth noting that it is a focus which contrasts significantly with the broader equalities strategies of the three countries, which tend to focus on ethnicity, gender, sexuality and religion, and pay almost no attention to differences between social classes.
7. The wording of the life expectancy target was later revised (Department of Health, 2002), following the replacement of local Health Authorities with much larger Strategic Health Authorities, to focus on 'Local Authorities' (rather than 'Health Authorities') so as to retain the focus on local areas.

8. This involves clinical and pharmaceutical interventions such as the prescription of statins to people at high risk of heart disease or angioplasty surgery for people experiencing angina.
9. See note 3.

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