Policy Implications

Tackling Health Inequalities in the United Kingdom: The Progress and Pitfalls of Policy

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Goal. Assess the progress and pitfalls of current United Kingdom (U.K.) policies to reduce health inequalities.

Objectives. (1) Describe the context enabling health inequalities to get onto the policy agenda in the United Kingdom. (2) Categorize and assess selected current U.K. policies that may affect health inequalities. (3) Apply the “policy windows” model to understand the issues faced in formulating and implementing such policies. (4) Examine the emerging policy challenges in the U.K. and elsewhere.

Data Sources. Official documents, secondary analyses, and interviews with policy-makers.

Study Design. Qualitative, policy analysis.

Data Collection. 2001–2002. The methods were divided into two stages. The first identified policies which were connected with individual inquiry recommendations. The second involved case-studies of three policies areas which were thought to be crucial in tackling health inequalities. Both stages involved interviews with policy-makers and documentary analysis.

Principal Findings. (1) The current U.K. government stated a commitment to reducing health inequalities. (2) The government has begun to implement policies that address the wider determinants. (3) Some progress is evident but many indicators remain stubborn. (4) Difficulties remain in terms of coordinating policies across government and measuring progress. (5) The “policy windows” model explains the limited extent of progress and highlights current and possible future pitfalls. (6) The U.K.’s experience has lessons for other governments involved in tackling health inequalities.

Conclusions. Health inequalities are on the agenda of U.K. government policy and steps have been made to address them. There are some signs of progress but much remains to be done including overcoming some of the perverse incentives at the national level, improving joint working, ensuring appropriate measures of performance/progress, and improving monitoring arrangements. A conceptual policy model aids understanding and points to ways of sustaining and extending the recent progress and overcoming pitfalls.

Key Words: Health inequalities, policy, implementation, U.K., central government

This article is based on the premise that many of the causes and manifestations of health inequalities in the United Kingdom and the United States have been described and are largely understood (Marmot and Wilkinson 1999; Berkman and Kawachi 2000). While further understandings are still required, much less is understood about the formulation and implementation of policies to tackle such identified inequalities in health status between and within population groups, areas, and other divisions (Exworthy, Berney, and Powell 2002; Lurie 2002). In the United Kingdom and elsewhere, general improvements in health have not benefited all social groups equally and it is less clear how policies can reduce these health inequalities.

Health inequalities are the systematic, structural differences in health status between and within social groups within the population. The term "health inequalities" is closely linked to "social determinants of health" (Marmot and Wilkinson 1999) as it refers to the multiple influences upon health status, including socioeconomic status, diet, education, employment, housing, and income. It is thus concerned with the "causes of the causes" of disease. Inequalities in health care do exist (notably in access to care) but these are not considered the principal cause of inequalities in health status (Marmot 1999).

The social determinants of health and health inequalities pose particular problems for policymakers. The causes are multifaceted and the solutions must be too. Policies may need to be long-term, require the collaboration of multiple agencies, and generate few outcomes measures initially. Unless policy processes are understood, current and future policies may not achieve their goals. Indeed, some policies such as those that have reduced overall levels of smoking have unwittingly increased socioeconomic inequalities in smoking (Jarvis 1997; Evans 2002). Also, the lack of evidence about effective

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Conflict of interest: Michael Marmot was a member of the Independent Inquiry into Inequalities in Health (the Acheson Inquiry) and has been a member of United Kingdom's Department of Health's Inequalities and Public Health Taskforce and the Treasury's Cross-cutting review on health inequalities.

policies is significant given the policies to tackle health inequalities that have been recently proposed by the U.K. government. Other countries have also begun to develop similar public health programs (Lurie 2002); for example:

- Australia: “Better health outcomes for Australians: national goals, targets and strategies for better health outcomes into the next century.” (1994)
- New Zealand: “The New Zealand Health Strategy.” (2000)
- United States: “Healthy People 2010” (2000) is a set of national health objectives. It aims “to improve quality and years of healthy life, and to eliminate health disparities.”

This article describes and explains the ways in which the U.K. government has sought to tackle health inequalities, and examines the effect of these policies. The article is divided into four sections. A brief description of methods precedes the second section, which examines the origins and impact of two scientific inquiries concerning health inequalities. Third, a purposive sample of policies is examined to illustrate the dimensions of a typology of approaches to tackling health inequalities. Fourth, the conceptual “policy windows” model is used to appraise the extent to which the U.K. government has been able to tackle health inequalities.

METHODS

This article reports the findings from a study that aimed (a) to assess the progress of the U.K. government in implementing the recommendations of the Acheson Report, and (b) to examine the ways in which the U.K. government has sought to formulate and implement policies to tackle health inequalities. Conducted in 2001 and 2002, the study comprised two phases. The first “mapped” the policies associated with each recommendation. Civil servants in central government reviewed this analysis; their responses were appraised and integrated. The second phase involved three case studies of policymaking relevant to health inequalities: tax and welfare benefit policies, and performance management of policies and transport. The study used three sources of evidence: documentary analysis from government departments (e.g., official reports and performance indicators), secondary data sources (e.g., published literature and commentaries), and 32 key informant interviews with civil servants. Triangulation was strengthened by an advisory group of experts from academia, research agencies, and health care organizations. Analyses

applied the findings to a conceptual policy model that helped to explain progress and pitfalls in policy formulation and implementation.

The Role of Inquiries in Shaping U.K. Policy toward Health Inequalities

The U.K.'s approach to tackling health inequalities is characterized by two inquiries: the Black Report and the Acheson Report (named after their respective chairs). As their impact upon policy is markedly different, they are crucial in understanding the relationship between evidence and policy (Oliver and Exworthy 2003).

a. The Black Report. The Black Report (1980) on health inequalities was commissioned by the Labour government in 1977. It identified four possible explanations of health inequalities: artifact, natural selection, cultural, and structural, but saw no role for health care in reducing health inequalities (Mackenbach Stronks, and Kunst 1989). The report was published just before a public holiday and only 260 copies were made available (Townsend, Davidson, and Whitehead 1988). The report was rejected by the Conservative government (then in power) because the proposals were too costly and because of their political antipathy to the issue. Thus, the Black Report had little or no impact on policy for more than a decade (Berridge and Blume 2003; Davey-Smith, Bartley, and Blane 1990).

b. Independent Inquiry into Inequalities in Health. The newly elected government commissioned an independent inquiry in 1997—the “second Black Report” (Exworthy 2003). The inquiry was asked to “moderate a review of the latest available information on inequalities in health” and “to identify priority areas for future policy development.” The Acheson Report (Acheson 1998a) concluded that the “weight of scientific evidence supports a socio-economic explanation of health inequalities.” It supported a model that was composed of different layers including individual lifestyles and the socioeconomic environment (Dahlgreen and Whitehead 1991). Addressing social determinants, the report considered poverty, education, employment, housing, transport, nutrition, the life-course, ethnicity, gender, and health care. The report made 39 recommendations, three of which were claimed to be “crucial,” namely:

- “All policies likely to have an impact on health should be evaluated in terms of their impact on health inequalities,”
- “A high priority should be given to the health of families with children,” and
- “Further steps should be taken to reduce income inequalities and improve the living standards of poor households” (p.xi).

The report made only three recommendations on health care, denoting its perceived contribution to tackling health inequalities.

The Acheson Report was “welcomed” by the government, noting that it was already implementing some of the report’s recommendations (Department of Health [DOH] 1998a). Academics and practitioners generally welcomed the report though this was not universal. Critiques of the Acheson Report fall into five areas (Exworthy 2003).

1. *No Priorities.* The recommendations apparently carried equal weight (Illsley 1999), implying that the recommendations were a “shopping-list.” Acheson (1998b) argued that the first three recommendations were “crucial” but remaining recommendations were not ranked in priority order.
2. *No Mechanisms.* The means by which aid policymakers would translate recommendations into action were absent. Illsley (1999) described the recommendations as “politically naïve.” However, the inquiry’s terms of reference sought “areas for policy development” and not to advocate specific targets, to the criticism of some practitioners (see Macintyre 1999).
3. *Evidence–Policy Mismatch.* The disconnection between evidence and some recommendations apparently undermined the report (Klein 2000). Strong evidence tended to generate specific recommendations; for example, regarding water fluoridation (Davey-Smith 2001). By contrast, Birch (1999) cites the example of income inequality. Evidence from “well controlled studies designed to assess the effects of interventions on health inequalities” was often lacking but these lacunae were not seen as a reason for inaction (Macintyre et al. 2001).
4. *Specificity of Recommendations.* Some recommendations (such as giving a high priority to the health of families with children) were considered too vague for policymakers to implement (Davey-Smith, Morris, and Shaw 1998; Evans 2002). Others (such as the further promotion of the concept of “health promoting schools”) were considered too specific, especially when no implementation mechanisms were proposed.
5. *Cost-effectiveness.* The lack of evidence concerning cost-effectiveness of policies to tackle health inequalities was concerning (Williams 1999; Oliver 2001). The terms of reference required recommendations to be “affordable” and yet, no economist sat on the inquiry. This is significant since the Black Report was (in part) rejected on the grounds that recommendations were too costly.

Most recommendations are associated with new or adapted policies (Exworthy et al. 2003). The study (upon which this article is based) appraised the influence of the report upon policy in four ways (Exworthy et al. 2003):

1. It prompted new policies to tackle health inequalities,
2. It introduced a health inequality dimension to existing policies,
3. It encouraged or contributed to a climate of opinion in favor of tackling health inequalities, and
4. It acted as a source-book or reference against which policies are examined and tested.

It is difficult to determine how far the policies would have been implemented anyway, without the report (Macintyre 1999).

An Assessment of Current U.K. Policies to Tackle Health Inequalities

Typology of Policies. A typology disaggregates policy interventions into distinct domains (such as policy means and ends, mechanisms, or population). This aids analysis of the combinations of political and organizational resources required for the effective implementation. Analysis for this study generated a six-fold typology of U.K. policies.

However, caution is needed in examining policies to tackle health inequalities. First, policies that might affect health inequalities may not have been specifically designed with them in mind. Second, the time-lags between policy inception, formulation, and implementation can be several years, which means that intermediate measures or (health) outcomes will not be evident in the short to medium term. Third, intermediate markers (such as process indicators) are appropriate only if the cause and effect of policies upon health inequalities are clearly understood. Fourth, policy processes are not linear; policies to tackle health inequalities may be confounded by countervailing socioeconomic factors. Evaluation of policy developments is thus provisional.

Recent U.K. Policy Developments. While the examples (Table 1 and below) are not a comprehensive assessment of all examples, they are a purposive sample to illustrate the nature and scope of current policies and provide the evidence for the conceptual model (below). (For a fuller description of relevant policies, see Exworthy et al. 2003.)

Life-course—Early Years and Children. The “health inequalities” literature has increasingly focused on the life-course as a key explanatory approach

Table 1: A Typology of U.K. Policy Addressing Health Inequalities

<i>Domains of Policy</i>	<i>Examples of New Policies or Approaches, Related to Health Inequalities</i>
Life-course approach: Early childhood years	<ul style="list-style-type: none"> • Sure Start program • Child poverty reduction
Area-based initiatives: Focus on disadvantaged communities	<ul style="list-style-type: none"> • Health Action Zones
Redistribution: "Welfare-to-work"	<ul style="list-style-type: none"> • Tax credits
Health care	<ul style="list-style-type: none"> • Organizational reform in the NHS • Primary Care Trusts
Targets and performance culture	<ul style="list-style-type: none"> • Public Service Agreements • Health inequality targets
Structures and processes: Joined-up government	<ul style="list-style-type: none"> • Cross-cutting review of health inequalities

Adapted from Exworthy (2003, p. 19).

(Blane 1999). A policy emphasis on early years development is consistent with the life-course thesis.

- *Sure Start*. With antecedents in the U.S. Head Start program, the U.K.'s Sure Start policy initiative aims to improve the life-chances for young children and their families, especially those living in poverty, by changing the pattern of existing services. The 500 programs by 2004 will reach only about one-third of children living in poverty and are available only to those children who live in the Sure Start areas (Sure Start, nd). It is unclear how children living in poverty elsewhere will benefit unless policies can be successfully transferred to non-Sure Start areas.
- *Child Poverty*. The government aims to reduce the number of children in poverty by a quarter by 2004. The U.K. has one of the highest rates of child poverty (measured as households with income below 60 percent of the median income) of Organization for Economic Cooperation and Development (OECD) countries; it stands at about 20 percent (Brewer and Gregg 2001, p. 4). The policies include targeting disadvantaged communities, raising welfare benefit levels and introducing new benefits (that aim to support low-paid workers and subsidize child care). Progress is inconclusive but some positive signs are evident. From 1996–1997 to 2000–2001, "there was a fall of

1.3M in the number of children below 60 percent of the 1996/7 median income” (Office of National Statistics 2002). Yet, it is difficult to attribute these changes to the policies per se. Yet, many of the children who have been “lifted out” of poverty were closest to the poverty line, thereby creating a residual group which existing policies do not or cannot reach.

Area-Based Initiatives. The current U.K. government has targeted policies on specific geographical communities to tackle poverty and disadvantage (Office of the Deputy Prime Minister 2003).

- *Health Action Zones (HAZ).* These interagency partnerships were established in 26 areas of deprivation and poor health in England, covering 13 million people. Each HAZ aims to devise and implement a strategy that reduces health inequalities. However, the HAZs have suffered from continual organizational change since they were formed in 1997 and have increasingly been used by central government as the vehicle for reform in other sectors. For example, HAZ resources have been given to the new Primary Care Trusts (Office of the Deputy Prime Minister 2003). The HAZs have often created short-term projects that have proved difficult to integrate within “mainstream” organizations (Lawson et al. 2002).

Redistribution—Welfare-to-Work. Overall, there has been modest redistribution to poorer groups across the social gradient (Institute for Fiscal Studies [IFS] 2002) (Figure 1).

However, traditional forms of redistribution (mainly taxation) have been rejected by the government. It considers paid employment to be the best way out of poverty and has thus linked benefit payments to employment, a policy termed “welfare-to-work.” Policies like this incorporate minimum levels but do not necessarily address inequality per se since they do not seek to redistribute incomes progressively.

- *Tax Credits.* Several “Tax Credits” (e.g., Working Families Tax Credit [WFTC] and Children’s Tax Credit, akin to the U.S. Earned Income Tax Credit and Child Tax Credit) (Dolowitz 2003) have been introduced that provide employment-based benefits for adults. These tax credits are linked to “New Deal” programs (for lone parents and disabled persons) that offer incentives (e.g., child care costs or employer subsidies) to enable certain groups into employment. Their impact is expected to be modest on employment; for example, the

Fig. 1: Income Redistribution: 1997–2001 and 1997–2002

WFTC is predicted to raise “the employment rate of single mother by 3 percent points” (Paull, Taylor, and Duncan 2002).

Health Care. Though health care generally contributes little to reducing health inequalities, it is often a primary mechanism for policy implementation. However, the National Health Service (NHS) remains the center of gravity in U.K. health policy. National attention is invariably directed toward NHS, often stifling public health issues. For example, there has been debate as to whether the ministerial responsibility for public health should remain within the DOH, overshadowed by the NHS. The Health Select Committee (House of Commons 2001) recommended that the responsibility should rest with DOH but that its external profile should be raised. Also, despite continual NHS reform, targets have been set to reduce morbidity and mortality from the “big killers”:

- *Cancer:* “To reduce the death rate in people under 75 by at least a fifth.”
- *Coronary Heart Disease and Stroke:* “To reduce the death rate in people under 75 by at least two fifths.”

- *Accidents*: “To reduce the death rate by at least a fifth and serious injury by at least a tenth.”
- *Mental Illness*: “To reduce the death rate from suicide and undetermined injury by at least a fifth” (Department of Health 1999).

These targets are not expressed in terms of inequality, though they sometimes include minima targets. (By contrast, U.S. “Healthy People 2010” targets cover 28 areas). Attention on public health has previously been distracted by organizational restructuring and the dominance of specialist services (Exworthy, Berney, and Powell 2002). Newly formed organizations—Primary Care Trusts (PCTs)—are responsible for commissioning hospital services, developing primary care, and tackling health inequalities. Similar pressures persist but PCTs are apparently giving more attention to health improvement (Wilkin et al. 2002).

Targets and Performance Culture. The government has extensively employed targets to secure its policy objectives; they operate at all organizational levels.

- *Public Service Agreements (PSAs)*. Public service agreements are a form of “contract” between the finance ministry and spending departments. Most departments have PSAs that could contribute to significant reductions in health inequalities, but most were not devised with that in mind. Analysis of PSAs highlights the need for greater linkage between policy (spending) and outcomes, and clearer accountability. The PSAs denote the expanding role of the finance ministry in social policy (Deakin and Parry 2000).
- *Health Inequality Targets*. The Acheson Report did not recommend targets for reducing health inequalities. In its draft public health strategy, the government did not propose “at this stage to set national targets... because the causation is complex and many factors interact” (Department of Health 1998b). Two national targets were introduced in 2001:
 1. “Starting with children under one year, by 2010, to reduce by at least 10 percent the gap in mortality between manual groups and the population as a whole.”
 2. “Starting with health authorities, by 2010, to reduce by at least 10 percent the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole.”

Intermediate indicator have been developed to support these two long-term objectives. This contrasts with 10 leading health indicators and 28 focus areas associated with “Healthy People 2010” in the United States.

Structures and Processes

- *Joined-up Government (JUG).* Complex problems are invariably multicausal and so policy interventions require governments to work laterally across departments—issues faced by other countries that have sought strategies similar to the United Kingdom (Ling 2002). Though a “systems-wide” approach to health inequalities is beneficial (Lurie 2002), JUG may sometimes be inappropriate. For example, policy formulation may involve multiple departments but responsibility for implementation may rest with one. Alternatively, fiscal redistribution policies may be less prone to the dilemmas of fragmented government.

Since the 1970s, organizational and policy reform has fragmented public services between different service providers, thereby confounding coordination (Osbourne and Gaebler 1992; Rhodes 1997). Departments have traditionally ensured reasonably effective service delivery but these “vertical” policy silos have hindered “horizontal” coordination (Cabinet Office 2000). Issues that fall outside vertical silos are neglected because no effective central coordination exists (Flinders 2002). Thus, “wicked” or intractable issues such as health inequalities pose particular problems (Richards 2001). Departmental culture has also hampered collaboration because personal and institutional incentives discourage JUG. Policymakers and Ministers are generally not promoted for pursuing cross-departmental initiatives. As departments compete for resources, cross-departmental activities represent an opportunity to defend departmental “territory” (Flinders 2002). These inhibiting factors apply strongly to health inequalities. Though many departments’ policies affect health inequalities, few mechanisms exist to exert leverage over their activities.

- *Cross-cutting Review.* The finance ministry established “cross-cutting reviews” to inform government spending in areas that fall outside the portfolios of spending departments. Health inequalities were the subject of a cross-cutting review in 2001. A committee of civil servants from all departments reviewed research evidence and official data sources. They identified the need for a long-term government-wide

strategy to tackle health inequalities and the importance of influencing mainstream policy in all areas of government (Her Majesty's Treasury 2002). They advocated a stronger focus on deprived areas, better preventative health care, programs to improve nutrition and physical exercise, and improved housing conditions. Published in late 2002, it is too early to judge the review's outcomes.

DISCUSSION

A Conceptual Assessment of Policy Progress and Pitfalls

Various policy models can explain the ways in which policies are formulated and implemented (e.g., Wolman 1981; Challis et al. 1988). The "policy windows" model by Kingdon (1995) is especially useful because it explains how and why issues get onto the policy agenda, as the prelude to implementation. Kingdon argues that policy windows open (and close) by the coupling (or decoupling) of three streams: problem, policy, and politics.

The accumulation of evidence about health inequalities is a necessary, but not a sufficient condition for policy change. Issues need to be seen or defined as "problems" that are amenable to policy interventions. This is not straightforward because "public policies in seemingly unrelated areas may have population health affects" (Lurie 2002, p. 96). The policy stream comprises initiatives and strategies advanced by stakeholders inside and outside government. Initiatives float in a "primeval soup" and are only selected when they satisfy three criteria: technical feasibility, congruence with the dominant values, and anticipation of future constraints. The politics stream consists of bargaining, negotiation, and compromise between interest groups and power bases. When all three streams are coupled, often with the aid of natural cycles (e.g., elections) or a "policy entrepreneur," opportunities for change occur. Equally, when separated, change is less likely. This section uses the model to assess the coupling of these streams.

Problem Stream. The accumulation of evidence, and specifically the Acheson Report, have helped established health inequalities as a "policy problem." (Similar "inquiries" elsewhere have also shaped the "problem") (e.g., Smedley, Stith, and Nelson 2002; Guy 1997). This has been a necessary but not sufficient condition. The Acheson Report and the cross-cutting review on health inequalities are part of a new approach to policymaking that increasingly relies on research and other evidence. While the government stresses that "what counts is what works" (Davies, Nutley, and Smith 2000),

evidence-based policymaking will falter with limited or contradictory evidence (Evans 2002). Ongoing measurement will thus need to ensure the “problem” remains clearly (Evans 2002).

Policy Stream. Criteria for the policy stream have not been met. First, evidence about the “technical feasibility” of policies (notably their effectiveness) remains limited. Despite this, there has been a flurry of policy activity, sometimes seemingly unrelated to health inequalities. It is debatable whether policies are sufficiently comprehensive to overcome the countervailing forces that generate and sustain health inequalities. For example, redistribution has occurred but is this sufficient to counteract widening income inequality (as measured by Gini coefficient) since the Labour government was elected? Also, the appropriate combination of policies (say, between universal and targeted programs) required to achieve policy aims related to health inequalities is unknown.

Second, values congruence appears moderate. Reduction of health inequalities is seen as a desirable policy objective, though it barely registers as a public issue. It is uncertain whether the government is willing to address inequality (rather than poverty, *per se*) by making stronger efforts at redistribution, for example.

Third, several future constraints have yet to be confronted. Sustaining policy ownership by departments will require measures of improvement. However, isolating the impact of policies to tackle health inequalities is problematic (Macintyre 1999). This is exacerbated by the long timescale of some policies; for example, the health inequality targets have a timetable of 2010 by which time Ministers and policymakers may no longer be in post. Similar issues are faced by the U.S. “Healthy People 2010” policy. Most initiatives to tackle health inequalities have been one-off, short-term projects; projects remain marginal to mainstream policy and provision. In the longer-term, mainstream activities must be adapted to address health inequalities but bending the mainstream is difficult when other pressures (such as health care reform) are prevalent.

Politics Stream. It is unclear whether there is a critical mass of civil servants and Ministers across government who are committed to tackling health inequalities. These policy entrepreneurs do not yet constitute a policy community with networks of information and experience. This is partly because their careers do not rely on such cross-departmental collaboration. The Minister for Public Health is a relatively junior position, the occupants of which have not lasted long in post. (In the United States, despite Joint Congressional Hearings on health disparities in 2002 and legislative proposals

by Senator Bill Frist [for example], policy communities [concerning health inequalities] are probably more nascent than in the United Kingdom). With emphasis on reforming public services, initiatives such as the cross-cutting review and health inequality targets may carry little weight in political negotiations. Thus, the government's approach to health inequalities may be "rhetorically powerful but politically very cautious" (Evans 2002, p. 79).

Each stream shows some progress and there has been some "coupling" of the streams; thus opening the U.K. "policy window" ajar. (By comparison, the U.S. policy window may be less open as each stream still faces numerous obstacles.) It may be open now, but many factors may force its closure, including Ministerial changes, departure of policy entrepreneurs, declining tax revenues (funding social programs), and competing priorities (e.g., NHS reform). The formation of structures and processes, evidence about effective interventions, and intermediate measures of progress will help wedge it open. Thus, the policy window cannot be guaranteed to remain ajar. Understanding the reasons for such opening/closing will explain the progress and pitfalls of policy.

CONCLUSIONS

After many years in the "wilderness," social determinants and health inequalities are on the U.K. policy agenda; the issue has been defined as policy "problems." The Acheson Report and other research helped raise the profile of health inequalities across government and provided the basis for policy development. As this was essential, policy has made some progress but has also encountered some pitfalls. Getting the problem onto the policy agenda is significant progress in itself. Additionally, progress has been evident in the structures and processes of policymaking and in recognizing the potential impact of all policies upon health (inequalities). Pitfalls are manifest in the scant evidence about effective interventions, limited evidence of change in intermediate markers and outcomes, weak incentives to sustain JUG, and poor integration of "health inequality" policy within mainstream systems. These ways in which progress has been made and the pitfalls addressed provide lessons for other countries engaged in such policy endeavors. Moreover, accounting for progress or pitfalls elsewhere is aided by the application of the "policy windows" model as it overcomes contextual explanations, facilitates international comparisons, and aids policy transfer. The three streams have largely been coupled and the policy window opened

ajar. While this augurs well for future policy development, the confluence needs to be continually maintained in the long-term to make significant reductions in health inequalities. In doing so, the nature and scope of *health policy* shifts, from concerns about just *health care* (cost, quality, and access) to encompass the social determinants of health.

REFERENCES

- Acheson, D. (chair) 1998a. *Independent Inquiry into Inequalities in Health*. London: The Stationery Office.
- . 1998b. "Report on Inequalities in Health Did Give Priority for Steps to Be Tackled." Letter. *British Medical Journal* 317 (12): 1659.
- Berkman L., and I. Kawachi, eds. 2000. *Social Epidemiology*. Oxford: Oxford University Press.
- Berridge, V., and S. Blume. 2003. *Poor Health: Social Inequality before and after the Black Report*. London: Frank Cass.
- Birch, S. 1999. "The 39 steps: The Mystery of Health Inequalities in the UK." *Health Economics* 8: 301–8.
- Black, D. (chair) 1980. *Inequalities in Health*. London: Penguin.
- Blane, D. 1999. "The Life-course, Social Gradient and Health." In *Social Determinants of Health*, edited by M. Marmot and R. G. Wilkinson, chap. 4, pp. 64–80. Oxford: Oxford University Press.
- Brewer, M., and P. Gregg. 2001. *Eradicating Child Poverty in Britain: Welfare Reform and Children since 1997*. Report no. WP01/08. London: Institute for Fiscal Studies.
- Cabinet Office 2000. *Wiring It Up: Whitehall's Management of Cross-cutting Policies and Services: A Performance and Innovation Unit report*. London: Cabinet Office.
- Challis, L., S. Fuller, M. Henwood, R. Klein, W. Plowden, A. Webb, P. Whittingham, and G. Wistow. 1988. *Joint Approaches to Social Policy*. Cambridge: Cambridge University Press.
- Dahlgren, G., and M. Whitehead. 1991. *Policies and Strategies to Promote Social Equity in Health*. Stockholm: Institute of Future Studies.
- Davey-Smith, G. 2001. "How Policy Informs the Evidence." *British Medical Journal* 322 (27): 1884–5.
- Davey-Smith, G., M. Bartley, and D. Blane. 1990. "The Black Report on Socio-economic Inequalities in Health: Ten Years on." *British Medical Journal* 301: 373–7.
- Davey-Smith, G., J. N. Morris, and M. Shaw. 1998. "The Independent Inquiry into Inequalities in Health." *British Medical Journal* 317 (28): 1465–6.
- Davies, H. T. O., S. Nutley, and Smith, eds. 2000. *What Works? Evidence-based Policy and Practice in the Public Services*. Bristol: Policy Press.
- Deakin, N., and R. Parry. 2000. *The Treasury and Social Policy: The Contest for Control of Welfare Strategy*. Basingstoke: Palgrave.
- Department of Health. 1998a. "Government Committed to the Greatest Ever Reduction in Health Inequalities, Says Dobson." Press release 98/547, 26 November.

- Department of Health. 1998b. *Our Healthier Nation. Green Paper Command 3852*. London: The Stationery Office.
- Department of Health. 1999. *Saving Lives: Our Healthier Nation. White Paper Command 4386*. London: The Stationery Office.
- Dolowitz, P. 2003. "A Policy-maker's Guide to Policy Transfer." *Political Quarterly* 74 (1): 101–8.
- Evans, R. G. 2002. "Interpreting and Addressing Inequalities in Health: From Black to Acheson to Blair to ...?" Seventh annual lecture, Office of Health Economic, London.
- Exworthy, M. 2003. "The Second Black Report? The Acheson Report as Another Opportunity to Tackle Health Inequalities." In *Poor Health*, edited by V. Berridge and S. Blume, pp. 175–97. London: Frank Cass.
- Exworthy, M., L. Berney, and M. Powell. 2002. "How Great Expectations in Westminster May Be Dashed Locally": The Local Implementation of National Policy on Health Inequalities." *Policy and Politics* 30 (1): 79–96.
- Exworthy, M., M. Stuart, D. Blane, and M. Marmot. 2003. *Tackling Health Inequalities Since the Acheson Inquiry*. Bristol: Policy Press.
- Flinders, A. 2002. "Governance in Whitehall." *Public Administration* 80 (1): 51–75.
- Guy, K., ed. 1997. *Our Promise to Our Children*. Ottawa, ON: Health Canada.
- Her Majesty's Treasury/Department of Health. 2002. *Tackling Health Inequalities: Summary of the 2002 Cross-Cutting Review*. London: HM Treasury.
- House of Commons (Health Select Committee). 2001. *Inquiry into Public Health. HC30-1*. March. London: The Stationery Office.
- Illsley, R. 1999. "Reducing Health Inequalities: Britain's Latest Attempt." *Health Affairs* 18 (3): 45–6.
- Jarvis, M. 1997. "Patterns and Predictors of Smoking Cessation in the General Population." In *Progress in Respiratory Research: The Tobacco Epidemic*, edited by C. Bolliger and K. Fagerstrom, chap. 7, pp. 151–64. Basel: S. Karger.
- Kingdon, J. 1995. *Agendas, Alternatives and Public Policy*. New York: HarperCollins.
- Klein, R. 2000. "From Evidence-Based Medicine to Evidence-Based Policy?" *Journal of Health Services Research and Policy* 5 (2): 65–6.
- Lawson, L., M. Mackenzie, J. Mackinnon, F. Meth, and J. Truman. 2002. *Health Action Zones: Integrated Case Studies: Preliminary Findings from Fieldwork in Spring 2001*. Glasgow: Glasgow University.
- Ling, T. 2002. "Delivering Joined-Up Government in the UK: Dimensions, Issues and Problems." *Public Administration* 80 (4): 615–42.
- Lurie, N. 2002. "What the Federal Government Can Do about the Non-medical Determinants of Health." *Health Affairs* 21 (2): 94–106.
- Macintyre, S. 1999. "Reducing Health Inequalities: An Action Report." *Critical Public Health* 9 (4): 347–50.
- Macintyre, S., I. Chalmers, R. Horton, and R. Smith. 2001. "Using Evidence to Inform Policy: Case-Study." *British Medical Journal* 322 (27): 222–5.
- Mackenbach, J. P., K. Stronks, and A. E. Kunst. 1989. "The Contribution of Medical Care to Inequalities in Health." *Social Science and Medicine* 29 (3): 369–76.
- Marmot, M. 1999. "Introduction." In *Social Determinants of Health*, edited by M. Marmot and R. G. Wilkinson, chap. 1, pp. 1–16. Oxford: Oxford University Press.

- Marmot, M., and M. Shipley. 1996. "Do Socio-economic Differences in Mortality Persist after Retirement? Twenty-five-year Follow-up of Civil Servants from the First Whitehall Study." *British Medical Journal* 313: 1177–80.
- Marmot M., and R. G. Wilkinson, eds. 1999. *Social Determinants of Health*. Oxford: Oxford University Press.
- Office of the Deputy Prime Minister. 2003. *Review of Area-Based Initiatives: Impacts and Outcomes*. London: Regional Coordination Unit.
- Office of National Statistics. 2002. "Households below Average Income Statistics." First release: 11 April 2002. London: Office of National Statistics.
- Oliver, A. 2001. *Why Care about Health Inequalities*. London: Office of Health Economics.
- Oliver, A., and M. Exworthy, eds. 2003. *Health Inequalities: Evidence, Policy and Implementation*. London: Nuffield Trust.
- Osbourne, D., and T. Gaebler. 1992. *Reinventing Government: How the Entrepreneurial Spirit is Transforming the Public Sector*. Reading, MA: Addison-Wesley.
- Paull, G., J. Taylor, and A. Duncan. 2002. *Mothers' Employment and Childcare Use in the UK*. London: Institute of Fiscal Studies.
- Rhodes, R. A. W. 1997. *Understanding Governance*. Buckingham, U.K.: Open University Press.
- Richards, S. 2001. "Four Types of Joined Up Government and the Problem of Accountability." In *Joining It Up to Improve Public Services 2001–2002*. Appendix 2, pp. 61–70, report no. HC383. London: National Audit Office.
- Smedley, B., A. Stith, and A. Nelson. 2002. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*. Washington, DC: Institute of Medicine.
- Sure Start. (nd). *Sure Start's Public Service Agreement 2001–2004: Technical Note*. London: Department for Education and Skills.
- Townsend, P., P. Davidson, and M. Whitehead. 1988. *Inequalities in Health*. London: Penguin.
- Wilkin, D., A. Coleman, B. Dowling, and K. Smith. 2002. *The National Tracker Survey of Primary Care Groups and Trusts 2001/2002. Taking Responsibility?* Manchester: National Primary Care Research and Development Centre.
- Williams, A. 1999. "Commentary on the Acheson Report." *Health Economics* 8: 297–9.
- Wolman, H. 1981. "The Determinants of Program Success and Failure." *Journal of Public Policy* 1 (4): 433–64.