

Divergence or Convergence? The post-devolution health policies of England, Scotland and Wales

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 healthcare 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 the national policy statements produced in England, Scotland and Wales since 1999. Our findings differ from existing analyses, raising some important questions about the actuality of, and scope for, policy divergence since devolution.

Key words: Health inequalities; devolution; policy divergence; UK.

Introduction:

In 1997, the UK elected a Labour government on a manifesto which included a commitment to holding public referenda on devolving political power to Scotland and Wales. The results led to devolution in both countries (although in Wales this was secured by only a slim majority). The first Scottish and Welsh elections were held in 1999 and the new devolved governments, the Scottish Executive (SE) and the Welsh Assembly Government (WAG), formed later that year. Devolution arrangements for each country differ: Scotland, which had already enjoyed quite high levels of administrative devolution since the transfer of the Scottish Office's functions from London to Edinburgh in 1939, was given primary legislative powers for all areas except those specifically listed as reserved in Schedule 5 of The Scotland Act (1998); whilst the Government of Wales Act (1998) only afforded secondary legislative powers to Wales, consequently leaving it more dependent on decisions made in Westminster^{ii,iii}. Additionally, the resources available to both governments have remained constrained; the WAG has no power to raise revenue through central taxation, whilst Scotland's 3% tax varying powers remain untested.

Despite the limited nature of political devolution (especially in Wales), it was welcomed by many as an opportunity to create distinctive and innovative policies (see Mooney, Scott, & Williams, 2006). Health is one of the most significant policy areas in which the devolved governments have been granted extensive responsibilities, making it one of the key areas of

interest for academics studying the impact of devolution (e.g. Chaney & Drakeford, 2004; Greer, 2003; Keating, 2005; McClelland, 2002).

Some broader analyses of post-devolution policies indicate that the dominance, until recently, of one political party (Labour) in all three polities^{iv} and the restricted nature of devolution arrangements have allowed only limited policy divergence (e.g. Mooney et al., 2006). Health policy, however, is one area in which there appears to be some consensus that important policy distinctions have emerged, especially following the SE's prominent early decisions to ban smoking in public places and provide free personal care for the elderly, and the WAG's decision to phase out prescription charges. Scott Greer's analyses (2001, 2003, 2004, 2005) appear to dominate a current consensus that policymakers of 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). Greer's claim is that whilst English health policies have focused on the introduction of markets to the NHS, Scottish health policymakers have concentrated on strengthening the role of medical professionals, and Welsh health policies have emphasised the importance of localism.

This thesis is widely, and often uncritically, cited (e.g. Cairney, 2006, 2007; Chaney & Drakeford, 2004; Keating, 2005; Poole & Mooney, 2005) and has led to claims that we are now experiencing a natural policy experiment in the health arena (e.g. Smith & Babbington, 2006). Amid such enthusiastic claims, there has been only limited acknowledgement that some not insignificant differences between the countries existed long before political devolution (see, for example, the pre-devolution analysis of diversity in the field of community care by Hunter & 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 *healthcare* 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 healthcare policy, and appears to include this part of the analysis in his general conclusion that 'distinct logics' are governing each polity's approach to 'health policy'.

This paper forms part of a larger 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). It attempts to redress the service-orientated bias of current analyses of ‘health policies’ by focusing on policy approaches to the more complex issue of ‘inequalities in health’. By this term we mean the preventable variations in individual’s health status which are associated with differences in their socioeconomic (or geographical) position^v. 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, revealing a surprising degree of convergence across the three countries and some continuity with the past (Parry, 2003).

The rise of health inequalities on the UK policy agenda

The election of a Labour government in 1997 brought the issue of health inequalities firmly onto the policy agenda across the UK for the first time (see Berridge & Blume, 2003). Since then, the need to reduce health inequalities has been consistently highlighted as a policy priority in all three mainland UK countries. Table 1 shows the similarity of statements about health inequality that appear in some key post-devolution policy documents.

Table 1: Policy statements about health inequality: England, Wales and Scotland

Country	Illustrative examples
England	<i>The NHS Plan</i> (Department of Health, 2000): ‘No injustice is greater than the inequalities in health which scar our nation. The life expectancy of a boy born into the bottom social class is over nine years less than a boy born into the most affluent social class.’
Scotland	<i>Putting The Pieces In Place - Scotland's Health Improvement Fund</i> (Health Improvement Strategy Division, 2002): ‘The promotion of public health and health improvement – and, specifically, the reduction of health inequalities – are at the heart of the SE’s programme for forging a confident, competitive and compassionate Scotland.’
Wales	<i>Well Being in Wales</i> (Public Health Strategy Division, 2002): ‘Life expectancy in Wales is rising but good health is not evenly distributed across the population. Average life expectancy in some parts of Wales is 5 years less than in others and there are marked differences between different social groups. That is unacceptable.’

These statements make it clear that 'health inequalities' represent a key policy problem for each of the three post-devolution governments. In light of the possibilities for policy divergence opened up by political devolution, it might be expected that each government would address the issue rather differently. Indeed, 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 Dewar, 1999; National Assembly for Wales, 2001).

Method:

In order to explore how health inequalities have been approached by the three governments, key policy statements concerning the issue published between May 1997 and May 2007 were analysed. In other words, this represents the period of time immediately prior to devolution (1997-1999), when the UK government was responsible for health policy in all three polities, together with the documents published by the constituent governments (including Westminster) during the first (1999-2003) and second (2003-2007) terms of devolved government in Scotland and Wales. It is important to state at the outset that as this paper is based solely on documentary analysis of national policy statements, it does not aim to capture the views of local or national actors, which may well tell a different story, and 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 (both of these issues are being explored in the larger project).

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 related documents and national guidance on how other organisations/individuals should tackle health inequalities. It did not include any 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 documents 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 summarises overall findings in order to draw out significant patterns within and across the three countries.

Following the constructivist shift in the social sciences, there has been a consensus amongst those studying policy that the way in which a 'policy problem' is framed shapes the ways in which an issue can conceivably be responded to (see Rein & Schön, 1991). On this basis, the approach taken to analysing the policy documents involved (a) unpicking how health inequalities are constructed as a 'policy problem'; (b) exploring how the documents present the causes of, and solutions to, health inequalities; and (c) reflecting on the location of responsibility for taking action and achieving results.

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

(i) The construction of health inequalities as a 'policy problem'

As noted earlier, 'health inequalities' is rather a vague term which can be employed to describe a wide variety of health differences and, indeed, the policy statements from all three countries refer to a variety of forms of health stratification under this heading, including health differences between genders and between ethnic groups. However, although there are some minor but noticeable differences between the emphases of each country^{vi}, it is clear that policy conceptualisations of 'health inequalities' in all three countries are dominated by a concern with differences between social classes and geographical areas. Given the way in which the research on health inequalities in Britain has also prioritised the stratification of health by social class and area (e.g. Marmot, 2004; Shaw, Dorling, & Brimblecombe, 1998), this policy emphasis may seem unsurprising. However, 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 (Cabinet Office, 2007).

Moving beyond a focus on types of health inequality, a recent article by Graham and Kelly (2004) highlights three further ways in which health inequalities can be understood: as an issue of 'health disadvantage'; as 'health gaps'; or as 'social gradients in health'. Table 2 provides evidence of references to the first two ways of conceptualising health inequalities in statements from each country.

Table 2: Policy conceptualisations of health inequalities

Policy context	Illustrative examples of references to 'Health disadvantage'	Illustrative examples of references to 'Health gaps'
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. [...] Our intention is to improve the health of the poorest fastest.'	<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.'	No overt references to 'health gaps' in post-devolution statements.

As Table 2 indicates, a noticeable difference between the way in which policy documents in the three countries discuss health inequalities is that Scottish and English documents discuss 'health gaps' and 'health disadvantage' (often linking the two), whilst the post-devolution Welsh documents tend to focus solely on 'health disadvantage' and rarely mention 'gaps'. Despite this difference, the three countries share a conceptualisation of health inequalities as a problem resulting from the poor health of poor communities (and/or areas), rather than as a problem traversing society in the form of a 'social gradient' of health^{vii}. Conceived of as either an issue of health disadvantage or a health gap, policy interventions which aim to improve the health of

the most deprived groups in society can rationally be viewed as interventions which will address health inequalities, a view evident in the quotations in Table 3.

Table 3: Policy conceptualisations of health inequalities as an issue which can be tackled through targeted interventions

Policy context	Illustrative examples
England	<i>Choosing Health</i> (Secretary of State for Health, 2004): '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.'
Scotland	<i>The Challenge</i> (Scottish Executive Health Department, 2003): '[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.'
Wales	<i>Improving Health in Wales</i> (Health Service Strategy Team (WAG), 2001): '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...'

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). The fact that all three contexts framed the policy problem of health inequalities in a similar manner suggests the possibilities for policy divergence were restricted from the start by a concern not to open up debates about income and wealth relativities.

(ii) Targets for reducing health inequalities:

The newly elected Labour government in 1997 soon made it clear that they believed targets would act as a key motivator for change across a range of public policy issues, including health. Initially, targets for health improvement (reducing rates of major chronic diseases and/or rates of contributory lifestyle behaviours) were set in all three countries (Secretary of State for Health, 1998; Secretary of State for Scotland, 1999; The Welsh Office, 1997). Although these could not be described as health inequalities targets, it is noticeable that

subsequent policy statements give the impression, and in the case of England and Scotland specifically state, that efforts to meet these targets were expected to contribute to the aim of reducing health inequalities. This reveals the apparent policy belief that approaches designed to *improve* population health can also be employed to help reduce health *inequalities* (especially if they are implemented in a targeted manner, as discussed above). An initial reluctance to set specific targets for reducing health inequalities in any of the three countries was seen by some as an indication that health *inequalities* were not being taken seriously. This, however, was to change.

In 2001, England became the first of the three countries to introduce specific, national health inequality targets. 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 to be achieved by 2010) (see Department of Health, 2001a, 2001b). However, following several amendments^{viii}, the targets were combined into a single Public Service Agreement (HM Treasury, 2004). The way in which these targets have been constructed supports the idea that English policymakers tend to conceptualise health inequalities as an area-based 'health gap' which requires the local authority areas with the worst health and deprivation indicators to improve at a faster rate than the national average^{ix}.

Although the SE had not officially introduced any national health inequality targets when the English ones were announced, the introduction in Scotland of a performance assessment framework for health services that same year (2001) did include a commitment to using track indicators of inequality. As in England, this form of monitoring health inequalities relied on a conceptualisation of the issue as a 'health gap' but, unlike England, the gap to be measured was a more ambitious one of that between the most deprived and the most affluent areas (rather than between the most deprived and the national average). Although Scottish policymakers do not appear to have been as dedicated to the necessity of having national targets to drive action, they did decide to appoint an expert group to advise them further on target-setting (The Measuring Inequalities in Health Working Group, 2003). Eventually a decision was made to introduce national health inequality targets but, despite a previous commitment to setting the targets around narrowing a 'health gap' (Scottish Executive Health Department, 2003), the targets that were eventually introduced were in fact merely 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 introduction of a new performance management system based on a core set of key Ministerial targets, referred to as HEAT (Health, Efficiency, Access and Treatment targets), brought the performance management of health inequalities into line with the national targets. This has effectively removed any commitment to measuring 'health gaps' in Scotland and reinforces a conceptualisation of health inequalities as a problem of 'health disadvantage'.

Much of the language in the documents 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 the WAG should monitor 'health gaps' between areas (a recommendation that has not yet been followed up) but advised against setting specific, national health inequalities targets. Instead, the group suggested that avoiding short or medium term targets would allow the government to take a longer-term (and more effective) approach to the issue by focusing on the wider social determinants of health. This was one of a number of ways in which the pre-2003 policy statements differ in Wales, suggesting policy divergence was taking root here in this period. However, although the new 'health gain' (i.e. health improvement) targets variously announced in 2003-2004 include what are referred to as 'health inequalities targets', the absence of any quantified objectives makes it impossible to assess the success or failure of Welsh policies to tackle health inequalities by reference to a specific policy commitment. The Welsh 'targets' are essentially statements of aspiration.

The different decisions each government has made about health inequality targets to some extent support Greer's (2001) assessment 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 the 'health gap').

From this perspective, it is the WAG 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.

(iii) Explanations for, and responses to, health inequalities

In terms of explaining the existence of health inequalities within each country, the initial statements all place a significant amount of emphasis on wider determinants of health such as social exclusion, poor housing and inequalities of opportunity (including factors like education and employment) as well as on differential patterns of lifestyle behaviour. Table 4 presents some key quotes that illustrate this initial commonality of perspective.

Table 4: Policy emphasis on the wider determinants of health

Policy context	Illustrative examples
England	<i>From Vision to Reality</i> (Department of Health, 2001a): ‘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.’
Scotland	<i>Our National Health</i> (Scottish Executive, 2000): ‘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.’
Wales	<i>Well Being in Wales</i> (Public Health Strategy Division, 2002): ‘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.’

As the quotations in Table 4 illustrate, broader determinants of health are consistently put forward as an essential part of each country’s health policy strategies. However, despite these

rhetorical commitments to tackling 'wider determinants', explanations as to *how* they will be tackled are extremely limited and often consist of no more than referencing existing or forthcoming initiatives emerging from non-health departments (with little indication that the initiatives were designed to reduce health inequalities).

Furthermore, it is noticeable that in all three contexts the emphasis placed on wider determinants of health has lessened over time. Whilst Scottish and English statements published from 2003 onwards usually still refer to tackling the 'wider determinants of health', the meaning of this term begins to shift, increasingly identifying 'downstream' determinants, such as lifestyle-behaviours, rather than the more material, structural and economic factors identified in earlier documents. As Graham and Kelly (2004, p5) point out, all-encompassing phrases like wider determinants of health 'can create the impression that policies aimed at tackling the determinants of health are also and automatically tackling the determinants of health inequalities. What is obscured is that tackling the determinants of health inequalities is about tackling the *unequal distribution* of health determinants.'

The documents analysed in this research did indeed reveal a frequent blurring of factors thought to determine individual health (or, more often, ill-health), such as 'risky' lifestyle behaviours, and factors thought to contribute to societal inequalities in health, such as poverty and deprivation. A consequence of this confusion is that it is often unclear whether the interventions and activities advocated in policy statements are intended to achieve health improvement, reductions in health inequalities or both. Combined with an overall lack of clarity in the distinction between health improvement and health inequalities, this allows (or helps create) vagueness and uncertainty about the kinds of local interventions that are likely to reduce health inequalities and whether or not they are sufficient to have an effect. For example, investing more resources in smoking cessation services is likely to improve health but may also widen health inequalities if people from deprived areas quit smoking at a slower rate than people elsewhere. This is particularly important given the way in which responsibility for reducing health inequalities is increasingly being located at the local level (as discussed in the following section).

In addition, the Scottish and English documents published from 2003 onwards make far fewer references to any direct health impacts of broader social, material and economic determinants and instead discuss these factors mostly in relation to their impact on lifestyle behaviours. The

Choosing Health White Paper (Secretary of State for Health, 2004) in England is a particularly good example of this (see Hunter, 2005). 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.

In Wales, whilst there is less evidence of a rhetorical shift in the meanings attached to terms like 'wider determinants of health', an actual policy shift away from material, social and economic factors and towards lifestyle behaviours is similarly evident and occurs around the same time as in England and Scotland (a shift which, in Wales, has been associated with the high-profile replacement of the Health Minister, Jane Hutt). Despite Greer's (2003) and others' (e.g. Chaney & Drakeford, 2004) optimistic claims that the medical model of individualised health may be being abandoned in Wales, the publication of the on-line focus 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 this approach will aid the reduction of health inequalities, but rather seems to mark an overshadowing of the health inequalities agenda by health policy concerns about access to treatment. Whilst *Health Challenge Wales* does refer to notions of shared responsibility for health, its key themes revolve around specific lifestyle behaviours and medical problems.

Overall, whilst a nuanced account of the documents could potentially highlight differences in the ways in which each government has promoted the need to tackle lifestyle behavioural determinants *vis-à-vis* wider determinants, the 'bigger picture' reveals some striking similarities and a direction of travel in policy that is common to all three countries. 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 2003-2004, there seems to be a shift in concern away from wider determinants and towards lifestyle behaviours (especially smoking), a shift which is particularly apparent in a lecture Tony Blair recently gave on public health issues (Blair, 2006). 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.

In addition, a noticeable increase in the emphasis placed on the role of health services in tackling health inequalities occurs around the same time. Initially, whilst the policy statements from all three countries suggest that unequal access to, use and quality of health services are likely to be compounding health inequalities (for example, references to Julian Tudor Hart’s (1971) ‘inverse care law’ are evident), health services had little place in either explanations or strategies to tackle health inequalities. Furthermore, the documents from each country acknowledge that differences in the use and quality of health services do not explain why people from disadvantaged backgrounds tend to experience symptoms of chronic diseases at an earlier age than members of more affluent groups. Over time, however, as Table 5 demonstrates, the kind of contribution that the health services are expected to make to reducing health inequalities expands in the Scottish and English documents, moving away from initial concerns with variations in health service access and quality to focusing on specific clinical interventions as a means of actively reducing health inequalities and meeting targets.

Table 5: Role of health care services in tackling health inequalities: examples from England and Scotland

Policy context	Illustrative examples:
England	<p><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><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	<i>Our National Health: Delivering Change</i> (Scottish Executive Health Department, 2001):

	<p>‘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><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>
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This post-2003 emphasis on ‘anticipatory care’ and ‘secondary prevention’^x 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 shift in the focus of health policy and 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, however, in the wake of a media and political storm about rising waiting lists in the Welsh NHS, including adverse comparisons with England (Blackman et al., 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.

(iv) The location of responsibility for health inequalities (including for targets):

This section considers where responsibility for reducing health inequalities has been located in each of the three national policy contexts. It would be too simplistic to claim that there are clear shifts in the location of responsibility between 1997 and 2007 as the findings suggest a more fluctuating and complex picture. However, once again, the statements reveal some striking cross-country similarities. Initially, all of the statements analysed are rather vague about how health inequalities will be tackled and who should take responsibility but, prior to 2003, many of the documents do clearly suggest that health inequality is a cross-cutting issue affecting a range of central government departments. Although these documents do 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.

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 (Primary Care Trusts in England and Health Boards in Scotland and Wales), although partnership with other agencies – especially local government – is emphasised. 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 emphasise 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 further.

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, as Table 6 illustrates.

Table 6: The policy shift to individual responsibility for health

Policy context	Illustrative examples:
England	<i>Choosing Health</i> (Secretary of State for Health, 2004): ‘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.’
Scotland	<i>Delivering for Health</i> (Scottish Executive, 2005): ‘We are working to encourage people to take greater control over their own health.’
Wales	<i>Health Challenge Wales</i> (Welsh Assembly Government, 2004): ‘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.'
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With this shift towards individual responsibility comes an increasingly obvious tension between statements in the policy documents 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, this 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. 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 organisations', focusing on the likely impact that each of their activities will have on local population health.

(v) Charting policy progress with addressing inequalities in health

In light of the fact that 1997 marked the first time that reducing health inequalities was adopted as an explicit policy priority by any UK government, discussions about progress with this agenda do not begin to appear until 2001 and remain sketchy until 2003-2004. For England and Scotland, the policy statements published around this time begin to reflect on the lack of progress in reducing health inequalities. In both contexts these reflections are accompanied by suggestions that fresh approaches to health inequalities may be required. In Scotland, the 2003 White Paper, *Partnership for Care* (Minister for Health and Community Care: 10), states that the SE feels 'a new approach to improve health in Scotland and to reduce health inequalities'. In England, the 2004 White Paper, *Choosing Health* (Secretary of State for Health: 11), expresses similar sentiments: 'With new problems coming to the fore and health inequalities persisting, the time is right for new action and fresh thinking.' Whilst none of the statements are explicit about what the 'new' approaches to health inequalities involve, the statements coincide with the shifts in emphasis highlighted by this paper. In Wales, although the same level of reflection on progress in tackling health inequalities is absent from policy statements (probably in light of the fact Wales chose not to officially monitor health inequalities to the same extent as England and Scotland), the evidence of a shift in direction from 2003 onwards is, as already discussed, even more overt, albeit for different reasons.

Concluding discussion

In contrast to existing analyses of the various directions of health policy in England, Scotland and Wales since devolution, 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. There is, however, a notable difference between the three countries in the extent to which quantified targets to narrow health inequalities have been established. At a rhetorical level, there is plenty of evidence that, as Greer (2003) and Chaney and Drakeford (2004) claim, the WAG initially attempted to take a more radical approach to public health by placing an even greater emphasis on the wider determinants of health than England or Scotland. However, the subtle shifts away from a commitment to addressing wider determinants, towards clinical interventions and health promotion, evident in the post-2003 English and Scottish documents, is paradoxically more overt in Wales. Indeed, the 2004 online strategy *Health Challenge Wales* (Welsh Assembly Government, 2004) fails to mention inequalities in health at all and the 2005 document, *Designed for Life* (Minister for Health and Social Care, 2005), is clear about the decision to shift the emphasis of Welsh health policy away from public health issues.

These findings raise some important questions, not least of which is why these similarities and differences have occurred. As already discussed, two important considerations are the limited nature of devolution arrangements within the UK (especially for Wales), including the fiscal constraints, and the dominance, until recently, of one political party in all three contexts. Recently, as endnote^{iv} outlines, the political dominance of Labour has been challenged in both Scotland and Wales. The arrangements for devolution are also unlikely to remain unchanged and, as they evolve and new political parties assume power, 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, societal or global pressures.

At an institutional level, Richard Parry's (2003, 2004) account of post-devolution Scotland may shed further light on our findings. Parry 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 (2003) claims that the Scottish civil service has tended to

mimic the institutional traditions of Whitehall (Parry, 2004), a situation which may also have occurred in Wales (Laffin, personal communication). This suggests that institutional factors may also have played a role in promoting policy convergence. Yet, the fact that Scotland was able to introduce free care for the elderly and ban smoking in public places, and that Wales was able to phase out prescription charges, all demonstrate that policy divergence is possible, so questions remain about the reasons for the lack of policy divergence in relation to health inequalities. 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 (see Layard, 2005), the pressures of economic globalisation narrowing domestic policy options, or the influence of neo-liberal ideologies in reducing the role of the state. What is apparent from our analysis is that, while much of the language and the detail of policy-making convey an impression of difference, it is the similarities that invite explanation.

The findings discussed in this paper raise questions about the extent to which divergence has been possible at the local level, a point which the findings from the wider project will hopefully address (Blackman et al., 2006). This is not, however, the place to explore these issues. The aim of this paper has been more modest, namely, to challenge existing claims about the extent of health policy divergence between England, Scotland and Wales by reviewing, and reflecting upon, the respective national policy statements published over the past decade.

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ⁱ Defence, foreign and home affairs, fiscal, economic and monetary policy, energy and transport policy, social security (including pensions and benefits), regulation of 'the professions' (including the medical professions), employment policy (including health and safety regulations) and equal opportunities legislation are the major policy areas which remain reserved to the UK.

ⁱⁱ The Government of Wales Act (2006) somewhat extended the powers devolved to Wales. However, for the period in which this paper is interested, the WAG has only been able to legislate where it was empowered to do so by a complex and vast array of Westminster laws.

ⁱⁱⁱ 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.

^{iv} 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. Where this leaves the commitment to tackling health inequalities is unclear, although all the parties of government acknowledge the issue.

^v The meaning of the term varies widely and is one of the issues that the overall project explores.

^{vi} 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 wellbeing.

^{vii} Although references to social gradients in health are made in several recent English policy statements (e.g. Department of Health, 2002a, 2003; Health Inequalities Unit, 2005), the main discussions within these documents remain dominated by ideas about health gaps and health disadvantage.

^{viii} The wording of the life expectancy target was later revised (Department of Health, 2002b), 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.

^{ix} Initially, the infant mortality target was designed to focus on the gap between social groups (manual groups compared to the population as a whole) but when this target was combined with the life expectancy target, it too became area-based.

^x 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.