

The british government policy to address health health and social care essay



Minimising health inequalities has always been put alongside health gain as a focal point of governmental policy. Leading organisations such as the Department of health, standards and planning framework together with the National Improvement Plan focus on the need for healthcare bodies to provide set up, leadership and joint partnership with other agencies in order to reduce the rising of health inequalities. Government policy aim is to address a wider range of determinants of health including lifestyle, employment, housing, crime and environment with conjunction with the action across government, the community, various voluntary and business sectors. PSA targets are commonly dominated by several government departments which relate to health inequalities some of which are ODPM; improving social housing, Department of transport; reducing fatal accidents, DEPRRA; well known in tackling fuel poverty in order to reduce it and Department of work and pensions, providing higher employment while reducing child poverty. My assignment is aimed to assess the progress of the UK government by implementing the Acheson Report and examine the means and measures in which the UK government sought to counteract health inequalities policies. The UK approach towards tackling health inequalities can be divided in two enquiries: The Black Report and the Acheson Report. Due to the fact that they are markedly different with regards to impact they are crucial in establishing the relationship linking evidence and policy. (Oliver and Exworthy 2003). In 1977 the Labour party commissioned a report known as the Black Report (1980) on health inequalities in which 4 determinants of health inequalities were identified: Artefact, Natural selection, Cultural, Structural. Taking into consideration the above (Mackenbach Stronks, and Kunst 1989) stated that no intervention in <https://assignbuster.com/the-british-government-policy-to-address-health-health-and-social-care-essay/>

healthcare was being carried out in order to reduce health inequalities. The conservative government which, back then, was in power rejected the report due to the high costing proposals and antipathy to the issue, therefore the black report had minimum or no impact on policy for over 10 years (Davey-Smith, Bartley, and Blane 1994). In 1997 the newly selected government initiated an independent inquiry which is also known as the " Second Black Report" (Exworthy 2003), the evaluation involved a balanced review of the latest available detailed information on inequalities in Health and identified priority areas for future development policies. The Acheson Report (Acheson 1998a) determined that the burden on scientific evidence supports a socio-economic explanation on health inequality existence. The report collaborated different environments including individual lifestyles and socio-economic factors. (Dahlgreen and Whitehead 1991). On evaluating social determinants the report considered the following:

Poverty Education Employment Housing Transport Nutrition Ethnicity Gender Healthcare

The report pointed out 3 crucial factors out of the 39

recommendations namely: " All possible policies having impact on health should be analysed with regards to their impact on Health inequalities".

High priority should be given to health of families with children". Further steps are required to reduce income inequalities and improve standard of

living in poor households". The Acheson Report was " welcomed" by the government, noting its implication of the reports recommendation

(Department of Health [DOH] 1998a). Although the report was not universal

a variety of academics and practioners collaborated with the report yet on evaluation brought forward 5 areas of criticism (Exworthy 2003). No

Priorities: Recommendations carried equal burden. Illsley (1999) stated that <https://assignbuster.com/the-british-government-policy-to-address-health-health-and-social-care-essay/>

the recommendations were similar to a "shopping List". No Mechanism: The process where policymakers convert recommendations into required actions were necessary. Illsley (1999) argued that the recommendations are "politically naïve" yet the enquiry terms sought "areas for policy development" (Macintyre 1990). Evidence Policy Mismatch: The non-collaborating evidence between evidence and collaboration caused an undetermined report (Klein 2000). Whilst those showing strong evidence generated recommendations such as water fluoridation (Davey-Smith 2001). Elaborated studies laid down to monitor the effects of intervention on health inequalities were lacking yet the missing parts were not considered enough to inactivate (Macintyre et al 2001). Specificity of Recommendations: Health of families with children and other high priority recommendations were too indistinct for policy makers to implement (Davey-Smith, Morris and Shaw 1998). Others such as health promoting schools were too distinguishing and therefore no implementations of mechanisms were considered. Cost effectiveness: Williams (1999) and Oliver (2001) stated that the lack of evidence regarding cost effectiveness brought about concerns since there was no direct tackling of policies against health inequalities. Thus, it is significant since earlier we mentioned that the Black Report was rejected due to costly recommendations. Association of new or adapted policies are commonly associated with most of the recommendations and one can easily interpret my evaluation and influence upon policy in 4 ways: Acts on methods which tackle health inequalities. Existing policies are being collaborated with existing policies. Contribution with regards to tackling methods for health inequalities. Is acting as a reference in conjunction with the policies analysed. Typology or better known as the study of types <https://assignbuster.com/the-british-government-policy-to-address-health-health-and-social-care-essay/>

dissolves policy interventions into identifiable domains such as policy measures, mechanisms, population etc. This helps my analysis to better understand the combination of political and organizational resources needed for effective implementation. Caution is required when examining policies aimed to tackle health inequalities since they may not be the primary aim and time factor which often lags policy. Inception, formulation and implementation can take up to many years, this means that health outcomes will not be noticeable in short-medium terms; process indicators are ideal only if the cause and effects of policies with regards to health are well understood. Processes are not all the same, tackling health inequalities may cause several boundaries resulting from acting upon socio-economic factors.

Domains of Policy Examples of new policies or approaches, Related to Health Inequalities

Life-course approach: Early childhood years Sure Start program Child poverty reduction Area-based initiatives: Focus on disadvantaged communities Health Action Zones Redistribution: " welfare-to-work" Health Care Tax credits Health Care Organisational reform in the NHS Primary Care Trusts Targets and performance culture Public Service Agreements Health Inequality targets Structures and Processes: Joined-up government Cross-cutting review of health inequalities

The study of types: U. K Policy Addressing Health Inequalities

Adapted from Exworthy (2003, p. 19) Life-course initiative is the main focus of health inequality literature in connection with the early years of childhood hence within itself contains a key explanatory approach (Blane 1999). Sure Start initiative in the UK is aimed to improve the possibility that young

children and families inhabiting in poor areas will be able to have a change in their existing services, some 500 programs introduced by 2004 will reach 1/3 of children living in poverty; this will be available to sure areas inhabitants. Children living in poverty elsewhere will not qualify for such benefits unless the policies are converted from a sure area to an unsure start area (Glass N 1999). Child Poverty in 2004 was the government's main aim in reducing it by $\frac{1}{4}$ since the UK over the past years has been suffering from the highest rates of child poverty, this is calculated by households with income below 60% of the median income; the organization for Eco-Cooperation and Development (CED) stands round 20% (Brewer and Gregg 2001, P. 4). Policies implemented are targeted for those disadvantaged communities and their inputs include raising welfare benefits and introducing benefits which impact those low-paid workers and by subsidizing child care. Progress regarding this matter is inconclusive but statistics show that from 1996 to 2001 " there was a downfall of 1. 3M in the amount of children below 60% of 1996-1997 median income" (Office of National Statistics 2002). Although it is difficult to apprehend these changes to policies alone, many children have been raised from the poverty range in which the nearest to poverty line resulted in a lack of residual group creation thus existing policies seemed to be unreachable. Area-Based Initiatives in 2003 where the government's main focus in which policies were targeted in close relation with geographical communities targeting poverty and its disadvantages. Such initiatives include: Health Action Zone in England was composed of joint companies of which 26 areas of deprivation and poor Health were identified, with a total coverage of 13 million people. Every HAZ attempted to organize strategies and implementations with an aim to cut down health inequalities. However,

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HAZ have suffered from continuous change in operations since they were founded in 1997 and are constantly being used by governments as a body of reform in other sectors, this could be visible in the newly established Primary Care big institutions (Office of The Deputy Prime Minister 2003). Such organizations have experienced or rather created short term projects leading to difficulty in the integration within the " mainstream" organizations (Lawson et al. 2002) Redistribution-Welfare-to-Work on the whole provided a humble shift to poorer groups across the social gradient. C:

UsersOwnerDesktopincome. pngAccustomed forms of redistribution with emphasis on taxation have been deserted by the government. Paid employment is considered the ideal escape for poverty and therefore bridged benefit payments to employment, a scheme named " welfare-to-work". Similar policies amalgamate minimum levels but do not necessarily target inequality by itself since they do not redistribute progressively. Tax Credits involve examples such as Family Tax Credit and Children Tax Credit in which have been brought forward in order to provide employment-based benefits for adults. Tax credits are combined with programs meant for those lone parents and disabled persons offering inducement, for example childcare expenses and employer allowance which allow groups into employment. The result is predicted to be humble on employment; one instance of this is the raise in WFTC with regards to the employment rate of single mothers by 3% points (Paull, Taylor, and Duncan 2002). Health care in most cases provides minimum effect in reducing health inequalities and is usually the primary mechanism in policy application. However the National Health Services remains the main focal point in UK health policy. The NHS is constantly within the nation's attention, often suffocating public health <https://assignbuster.com/the-british-government-policy-to-address-health-health-and-social-care-essay/>

issues. An example of this is clearly visible in the debate on whether responsibility for public health should cling solely within the ministerial DOH and eclipsed by the NHS. With regards to the above mentioned, the health select committee advised that responsibility should rest in the DOH hands increasing peripheral profiles and keeping in mind targets that need to be set in order to reduce morbidity and mortality from the " main killers" which include: Cancers: " To reduce at least 1/5 deaths in cancer patients below age of 75." Coronary Heart disease and Stroke: " To reduce deaths in patients below the age of 75 by at least 2/5." Accidents: " To reduce deaths by at least 1/5 and serious deaths by at least 1/10." Mental Illness: " To reduce death by suicide and undetermined injuries by at least by 1/5."(Department of Health 1999). The above targets are not defined through inequality; in fact they are an introduction of several minimum targets. In the past public attention has been dismissed by several distraught organizations and dominant special services (Exworthy, Berney, and Powell 2002). Primary Care Trusts (PCT's) and other newly formed organizations are bound for retraction of hospital services, establishing primary care and dealing with health inequalities. Targets and Performance Culture implemented by the government's protection objectives aims to introduce employed targets in which operation at all levels take place: Public Service Agreements (PSA's) are similar to a contract bound between the ministry of finance and the consuming departments. These departments in many occasions possess PSA's which contribute in the reduction of health inequalities; this is clearly visible when analyzing problematic PSA linkages between spendings and their outcome. PSA's bring out a clear view of the expanding roles with regards to the finance ministry vis-à-vis social

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procedures (Deackin and Parry 2000). Health Inequality Targets are said to be absent in Acheson Report since no recommendations for the minimizing of health inequalities were never targeted. The government in his public health strategy failed to propose such targets and stated that " at this stage to set national targets.., because the conception is complex and many factors interact" (Department of Health 1998). Following this in the year 2001 the government introduced two national targets: Children under the age of 1 by the end of 2010, to be reduced by at least 10% the mortality between the manual groups vis-à-vis the population on the whole. By the year 2010 the health authorities are aimed to reduce by at least 10% the gap between fifth of areas with the minimum life expectancy at birth vis-à-vis the population on the whole.

Structures and Processes

Joined-up government (JUG): Convolutated problems are perpetually multicasual and so policy intervention strongly requires collaboration between the government and the departments. Although various accessions towards health inequalities are beneficial, JUG may often be irrelevant (Lurie 2002). Evidence of policy formulation involves various departments yet authority may rest with one single body, hence financial replacement policies may be less affected to queries of joint governments. Cross-cutting Review: The finance minister ingrained such review in order to communicate with the government with regard to unnecessary spending in areas beyond their ministry job description. This was clearly visible in the Health inequality cross-cutting review of 2001. A group of civil service workers originating from different departments carefully analyzed statistical data evidence and

identified an urge for a government spread strategy to tackle health inequalities and aiming to influence prevailing policies within all areas of the government (Her Majesty's Treasury 2002). They fully supported the idea to focus on impoverished areas, better positively safeguarded healthcare, introduction to better nutrition and exercise, and better housing conditions. An abstract evaluation of policy progress and pitfalls can be explained in various policy models in which policies are put into motion, for example in the model "Policy Window" set by Kingdon (1995) where he explains why such issues occupy policy agenda as a commencement to implementation. In Kingdon's model one can observe arguments regarding the opening/closing of policy windows by the coupling/decoupling caused by three main streams; problems, policy and politics. The total adding up of health inequalities is considered necessary yet not ideal enough to bring policy change hence issues must be treated as problems in order to extract responsive advice to policy intervention. Stake holders together with and around the government involve policy streams consisting of initiatives and strategies which float in a "primordial soup" which then is chosen if the three points of criteria are satisfied; Technical feasibility Coherence with values Future methods of dominant constraints Politics consists of a stream in which bargaining, negotiation and compromise between groups and power bodies are put in place, this occurs when all these are put side by side which in many cases brought about by natural cycles and/or "policy entrepreneurs" creating opportunities for change yet when separated have little or no effect to change. In this section I will try to explain and use such models in order to explain the coupling of the above mentioned streams. Problem Streams: The accumulation of facts with focal reference to the Acheson report has been a <https://assignbuster.com/the-british-government-policy-to-address-health-health-and-social-care-essay/>

special aid in pointing out Health inequalities. The report plus the cross-cutting reviews on health inequalities, involve new accessions to policy making that in most cases depend on research and evidence. Whilst the government emphasizes that " what counts works" (Davies, Nutley, and smith 2000) evidence based policy making will stutter dissolving in little or no antagonistic evidence (Evans 2002). Therefore ongoing calculations will provide a further clear image of the problem. Policy criteria involving policy streams are not yet met; through facts constraints remain common with commotion of policy activity including those not involving health inequalities. In the past, redistribution took place yet one must ask whether it was enough in tackling incoming inequality since the Labour government. Secondly, coherence appears stable with reduction of health inequalities being viewed as a desirable policy target yet it is still unclear whether the government's intentions are to address inequalities inputting greater effort at for example redistribution. Thirdly, future coercion still requires confrontation alongside policy ownership with departments aimed in monitoring improvement yet segregation of policies with regards to health inequalities is ambiguous (Macintyre 1999). This is experienced by the long awaiting of policies for instance in the health inequality targets were a timetable was set and by 2010 time Ministers and policy makers were no longer in their posts. Most enthusiasm exhibited to tackle health inequalities have been limited to a single short term assignments resulting in marginal policy and arrangement. In long-term policy activity, the mainstream requires adjustment with health inequalities yet alteration of the mainstream is difficult due to ongoing pressure predominance. Queries still arouse suspicion on whether there are a number of civil workers and ministries who

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are loyal to change through tackling of health inequalities. Policy makers haven't yet incorporated a policy society formed from various experience and networks, this results from the lack of expertise with regards to cross-departmental association. Therefore one can conclude that prominence in relation to reforming the public service may be "far away" in health inequality targets and other initiatives due to light burden weigh in political agreements. Thus the government's action towards health inequalities may be "flowery" and powerful yet politically very guarded. Every stream demonstrates some kind of positive aspect and "coupling" of stream, thus opening the policy window wide open. Yet many factors may narrowly restrict its closure including ministerial adjustments, emanation of policy makers, declining in tax income including funding of social programs and competing contenders (eg: National Health Services). The composition of configurations and methods include, evidence regarding effective interventions and intermediate scope of progress which in return will assist in wedging it open thus the policy window will not be kept certain of remaining ajar. Evaluation, analysis and conclusion for such reason of opening/closing will clarify the progress and downfall of policy. After many years in a "disorientated state," social impact issues and Health Inequalities are on the UK policy to do list; the issue has been described as a policy "problem." The Acheson report alongside other research have acted as an aid in the escalation of health inequalities across the government and provided the foundation for policy development. As this was much required, policy has experienced progress but also faced some downfalls, getting the difficulties into policy agenda is considered to be progress in itself. Studies have proved that programs have been very straight forward in the structuring and policy

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making with emphasis of the possible clarification impacts on all policies faced by health inequalities. Downfalls are conspicuous in the "flimsy" evidence regarding productive interventions, controlled evidence of change in middle markers and outcomes, weak inducement in order to support JUC, and lacking unification of the "Health Inequality" policy within the mainstream system. Ways and measures taken in tackling policy progression and policy downfall provide a clear picture to those countries "craving" achievement in the same manner, hence balancing progression and downfall elsewhere. This supports the "Policy Window" model which renders contextual explanations, provides worldwide contrasting and supports policy alteration. The mentioned three streams have been joined together forcing the policy window to remain wide open; yes this provides a better and healthier future in policy development but one must keep in mind that continuous and ongoing maintenance is needed if health inequalities are required to remain at their least. In accomplishing this, the disposition and aim of health policy fluctuates, from just queries of healthcare (cost, quality, access) to enclosed social determinants of Health.