Research on ethnicity and health, Leeds, 30 March 2010

Influencing policy

Dr. Mark Exworthy

Royal Holloway, University of London

M.Exworthy@rhul.ac.uk

Policy process

Walt, G. (1994)

- Content:
  - Objective of policy
  - Institutional policies & technical policies
- Process:
  - Policy as action
  - Formulation & implementation
- Power:
  - Who makes policy & who benefits
  - Politics

Policy process: linear & rational?

- In theory:

  Policy process often presented as linear
  - Devise goals, design mechanisms, then implement

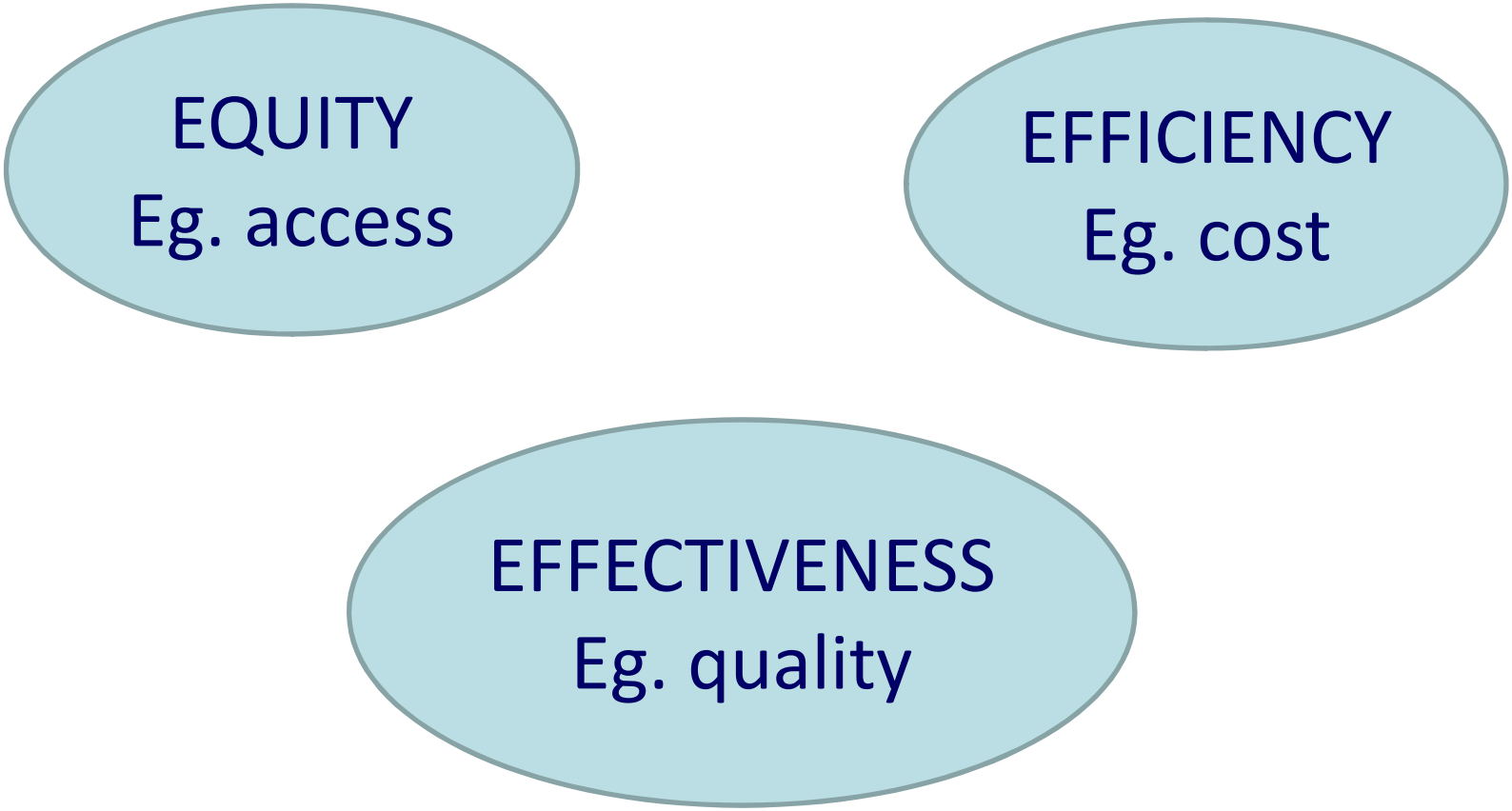
- In practice:

  Policy process is disjointed and messy
  - No start or end, just “middle”
    - Policies rarely reach completion
  - Policies developed within a pre-existing context
    - Process is often static
    - Most decisions involve marginal change = “Incrementalism”

Issues in policy analysis

1. Time:
   - Most decisions rarely take place at one point in time but are protracted over months. When was the decision `made'?
2. Non-decisions:
   - Sometimes, policy process results in no decision or non-decision
3. Power:
   - Whose view or interest prevails? Includes:
   - Overt use of authority
   - Subtle shaping of preferences

Equity as a major policy objective in health systems



Equity of what for whom?

What?

- Resource allocation
- Expenditure / inputs
- Access
- Use
- Outcome / impact

For whom?

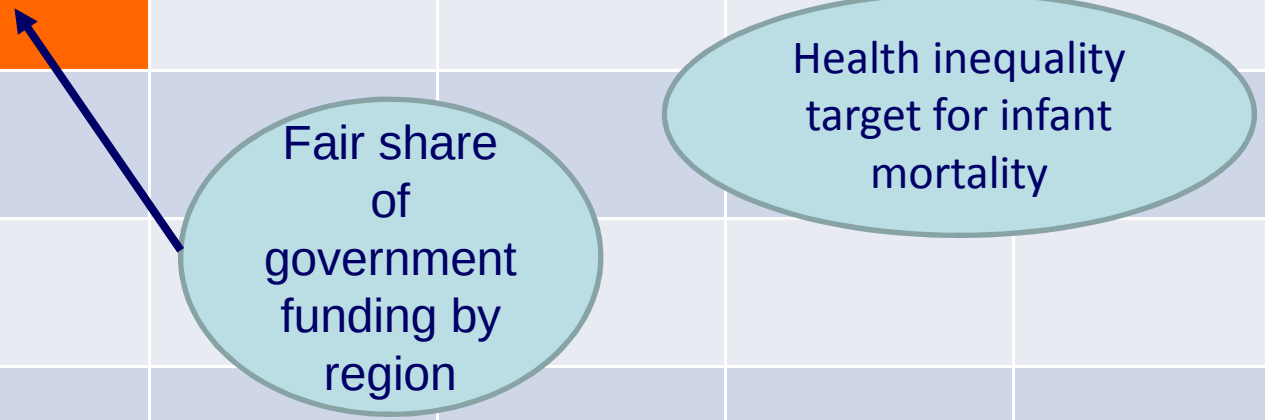
- Socio-economic status
  - Income, education, social class
- Geography:
  - Location, place, urban/rural
- Age
- Gender
- Ethnicity

Equity grid

	Resource allocation	Expenditure	Access	Use	Outcome
Socio-economic status					
Geography					
Age					
Gender					
Ethnicity					

Equity grid applied to recent policies

	Resource allocation	Expenditure	Access	Use	Outcome
Socio-economic status					
Geography					
Age					
Gender					
Ethnicity					



Policy trade-offs

Compromises / choices

1. Health improvement *versus* health inequality
2. Health *versus* health-care
3. Disadvantage, gaps and gradients
4. Upstream *versus* downstream
5. Universal *versus* selective

Tackling inequality: policy problems

1. Multi-faceted phenomena
2. Life-course
3. Partnerships
4. Competing priorities
5. Cause-effect relationships
6. Data
7. Globalisation

Evidence into policy?

- From `Enlightenment' to `Pure' models (Weiss)
- Acheson Report:
  - Fostered climate of opinion favouring of tackling inequalities
  - Prompted new policies
  - Generated inequality dimension to existing policies
  - Acted as a source-book / reference

  Ref: Exworthy et al 2003

Ethnicity – a priority?

- **Marmot Review (2010)**
  - Ethnic* = 2 figures and 1 in text (p.16)
  - Race = 1 in text (p.16)
- **Acheson Report (1998)**
  - Part 2, chapter 10
  - Recm: *We RECOMMEND that the needs of minority ethnic groups are specifically considered in the development and implementation of policies aimed at reducing socioeconomic inequalities.*
  - Related reconmmendatio = 3, 8, 10, 13-18, 1.2
- **Black Report (1980)**
  - Index: Ethnicity, Race,
    - mortality & provision of health-care
  - Index: Ethnic minorities:
    - Adult mortality, definitions, explanations, health & social services initiatives

10th anniversary of the amendment to the Race Relations Act

BBC Radio 4: Tuesday 14 January 2010

Sarah Montagu: John Denham, your argument is that things have got better because of what your government has done in the past 10 years

John Denham: I think what government has done has made a huge difference but it clearly takes people to change, not governments to change people but because government has recognised these problems, not only legislated against racism but we put a responsibility on public bodies to make sure that they promote equal opportunities, you have seen real changes. There is still a lot to be done before we are a genuinely equal society but we should take comfort from real progress…

Health Select Committee, 2009
Inquiry into health inequalities

http://www.publications.parliament.uk/pa/cm200809/cmselect/cmhealth/286/286.pdf

…health inequalities are evident across a number of different measures—not only socio-economic status, but ethnicity, gender, age, disability and regional area. This suggests that health inequalities should perhaps be measured and targeted in a multidimensional way. There is evidence that some PCTs are already doing this. Alwen Williams, Chief Executive of Tower Hamlets PCT, told us:

"*For us, given our population, issues of ethnicity are key. One of the challenges the NHS has is: how do we measure, so we can measure the impact of what we are doing in relation to the different population groups within our communities? We have implemented, for example, patient profiling in our general practices so that we are starting now to measure ethnicity in a much more comprehensive way. That will help us ensure we can then measure equity of access, equity of health outcomes in relation to some of those factors that are part and parcel of our population make-up. We are not doing that because that has been a target set for us: that is because we understand that for us to be successful in what we are trying to do around health improvement that is a key component—for us to be able to understand and measure our achievements and successes in future years."*

P.58