POLICY FORUM

SETTING TARGETS TO REDUCE POVERTY AND HEALTH INEQUALITIES

Professor Brian Nolan, Economic and Social Research Institute

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About the Author

Brian Nolan joined the Economic and Social Research Institute in 1987, and is currently a Research Professor. He previously worked as an economist in the Central Bank of Ireland. He studied economics at University College, Dublin and McMaster University, Ontario, and was awarded a doctorate from the London School of Economics for a thesis entitled 'Income Distribution and the Macroeconomy'. His main areas of research are income inequality, poverty, tax and welfare reform, the economics of social policy, and health economics. He co-authored with Christopher Whelan *Resources, Deprivation and Poverty* (Clarendon, 1996), setting out a new approach to measuring poverty in advanced countries and applying it to Ireland.

Since 1994 he has been collaborating with colleagues on a programme of research based on the European Community Household Panel Survey which began in that year. This includes studies on income distribution, women and poverty, child poverty, deprivation and deprivation dynamics, and tax/welfare reform. This research has been contributing to the development of Ireland's National Anti-Poverty Strategy and to the design of poverty measures and indicators at European level.

FOREWORD

Combat Poverty is a state advisory agency developing and promoting evidence-based proposals and measures to combat poverty in Ireland. It works for a poverty-free Ireland through its statutory functions of policy advice, research, project support, innovation and evaluation and public education.

Despite continuing economic growth, poverty and health inequalities persist within Irish society. It is widely accepted that socio-economic factors, including poverty, are key in determining health status. People experiencing poverty become sick more often and die younger than those who are better off. Measures of health inequalities, including mortality rates, low birth weights and poor nutritional status, are linked to deprivation measures such as income poverty, poor nutrition, unemployment and inadequate housing and accommodation.

Combat Poverty provides advice on appropriate policy responses, particularly in the context of the National Anti-Poverty Strategy or National Action Plan against Poverty and Social Exclusion (NAP/Inclusion). The NAP/Inclusion is innovative in that it recognises the link between poverty and health inequalities by identifying high-level targets to tackle these inequalities. Such targets should lead to policy choices that align the health outcomes for people living in poverty with the rest of society. However, concerns have been expressed about the level of coherence or 'fit' between the current targets, the policies to achieve them and the mechanisms to measure performance and outcomes.

Combat Poverty commissioned the Economic, Social and Research Institute (ESRI) to propose a coherent approach to setting targets for the new NAP/Inclusion 2006-2008, specifically to inform the work of the NAPS Health Working Group convened by the Department of Health and Children, the Office for Social Inclusion, and other departments tasked with developing, monitoring and reviewing anti-poverty targets.

Professor Brian Nolan undertook the analysis on behalf of the Combat Poverty Agency. In his report, he highlights the pivotal contribution that NAP/Inclusion can play in stimulating a multi-sectoral response to tackling health inequalities and the key role that quantified targets can play. A strong case is made to ensure that targets are framed in terms of outcomes rather than inputs or outputs, as the overall rationale for setting targets should be to achieve a societal goal - in this case reduced health inequalities.

These current high level targets should be complemented by more intermediate term targets, and underpinned by detailed policies and clear demarcation of roles and responsibilities at all levels to ensure their implementation. Systems to monitor and review performance must be rigorous and meaningful - implying better data collection and analysis and more investment in research. As such, there is a need to resource the participation of communities affected by poverty and health inequalities and those delivering services in decision-making.

Meeting the health targets set out in NAP/Inclusion and in Quality and Fairness - A Health Service for You, the National Health Strategy should be a priority, as their achievement would significantly reduce health inequalities in Ireland. This report sets down a challenge for more coherence and joined-up thinking at national and local policy levels. Underpinning this challenge is the need for a comprehensive implementation framework, designated responsibilities, adequate resources and a systematic inclusion of communities affected by health inequalities in monitoring and review.

The NAP/Inclusion process, in particular the work of the NAPS Health Working Group and developments within the Health Service Executive (HSE) offer opportunities to put the measures in place to improve the health status of people experiencing poverty in line with the rest of society.

Combat Poverty Agency, April, 2006

INTRODUCTION

Health inequalities represent a major societal concern in Ireland as in other countries, both in themselves and as a reflection of deep-seated socio-economic inequalities. These inequalities are to be seen across the range of available indicators, and mean that both overall life expectancy and healthy years of life differ markedly across socio-economic groups.

Ireland's National Anti-Poverty Strategy is innovative in containing specific targets for the reduction in socio-economic health inequalities, as well as targets relating to other aspects of poverty and social exclusion. As part of the European Union's Social Inclusion Process a new NAP/Inclusion is to be prepared and submitted to the EU Commission by September 2006.

This paper discusses the rationale for setting targets for the reduction of health inequalities and how these might best be framed, in order to inform that process. It builds on the Report of the 2001 Working Group on NAPS and Health, and has been informed by the on-going work of the current Research Subgroup of the Working Group on NAPS and Health, as well as the presentations and rich discussion at the conference on Target Setting to Reduce Health Inequalities and Poverty: Lessons for the Future held by Combat Poverty in December 2005 (see the Conference Report, Combat Poverty 2006).

This paper discusses the rationale for setting targets for the reduction of health inequalities

The paper begins by describing the targets relating to health inequalities adopted in the current national anti-poverty strategy, and where they fit in the official strategy for health and the health services. It then steps back to discuss at a general level the role that such targets can play, and some general principles that can usefully be taken into account in setting them.

A general approach to setting targets for the reduction of health inequalities respecting these principles, but also reflecting the need to link targets to policy, is then suggested. The identification of relevant indicators and development of data sources and analysis required to implement this approach are then discussed. The ways in which targets can be used for monitoring and evaluation, mechanisms for involving key stakeholders, and implications for local delivery of services are then discussed and conclusions summarised.

The key messages of the paper may usefully be previewed at the outset:

- Socio-economic inequalities in health outcomes are deep-seated, and the National Anti-Poverty Strategy can play a central part in mobilising the multi-sectoral response that will be needed if they are to be tackled effectively.
- Specific quantified targets can play an important role as part of that strategy.
- These targets could be framed at different levels: high-level outcome targets for reducing health inequalities over a lengthy period could be combined with shorter-term targets for intermediate outcomes and goals.
- These could then be underpinned with a detailed set of policies aimed at attaining those goals, with a clear identification of who is to be responsible for delivery and with roles and responsibilities from central to local level clearly set out.
- Systems to monitor and review performance, including addressing the significant gaps in information available, need to be put in place, together with a supporting research programme.
- Key stakeholders from national to local level, including those in the communities most affected and those delivering key services, need to be engaged. The linkage between national and local level is critical.

CURRENT HEALTH INEQUALITY REDUCTION TARGETS

In *Building An Inclusive Society* - the Government's Review of the NAPS, published in 2002, both a broad objective and a number of specific targets in relation to health inequalities were set out. The overall stated aim is to reduce the inequalities in the health of the population, to be achieved by making health and health inequalities central to public policy, by acting on the social factors influencing health, by improving access to health and personal social services for those who are poor or socially excluded, and by improving the information and research base in respect of the health status and service access for the poor and socially excluded.

The following specific quantified targets, to be met by 2007, were adopted:

- To reduce the gap in premature mortality between the lowest and highest socio-economic groups by at least 10 per cent for circulatory diseases, for cancers and for injuries and poisoning.
- To reduce the gap in low birth weight rates between children from the lowest and highest socio-economic group by 10 per cent from the current level.
- To reduce the gap in life expectancy between the Traveller community and the whole population by at least 10 per cent.

The anti-poverty strategy also set out some commitments with respect to specific services (such as putting in place national guidelines for the provision of respite care services to carers of older people, improving access to hip

replacements, and improving access to planned respite care for carers of disabled people). For vulnerable groups such as women and rural dwellers the aim of improving access to services including health services was also set out.

The development of the national anti-poverty strategy targets with respect to health was informed by the Report of the Working Group on NAPS and Health established by the Department of Health and Children in 2001. As well as the targets incorporated into the strategy, this Report proposed some other important and fundamental targets referring to access to health and personal social services, the need for multi-sectoral working, and research and monitoring systems to support the implementation of NAPS.
The government's health strategy *Quality and Fairness - A Health System for You* (2001) highlights equity as one of its goals, and includes in its action plan that 'a programme of action will be implemented to achieve the National Anti-Poverty Strategy and Health targets for the reduction of health inequalities'. The NAPS targets are also listed among the commitments set out in the health strategy under its objective of reducing health inequalities.

SETTING TARGETS - WHY AND HOW

Targets can play an important role in directing public policy towards the achievement of societal goals. Targets can first of all represent a public declaration that the current situation - in the present context the current level of health inequalities in Ireland - is unacceptable, a significant step in seeking to bring about change. They also encapsulate a clear commitment to addressing the problem in question by developing and implementing appropriate policies, ones that hold out the realistic prospect of significantly reducing these inequalities. They can provide a rallying-point for mobilising the type of multi-sectoral response required to bring this about, and a set of benchmarks against which overall progress can be measured.

On the other hand, there are clear dangers associated with target-setting, as recent experience elsewhere (notably in the UK where targets have been playing a particularly prominent role) demonstrates. Targets can at worst be a substitute rather than a spur to action. Targets can also take on a life of their own, with unintended side-effects. In particular they can lead to behaviour designed to narrowly meet the specific target rather than attain the underlying goal it is trying to represent; such 'gaming' behaviour with a poorly-framed target could be so pronounced as to actually produce worse outcomes. Failure to reach stated targets can have a de-motivating effect on those involved in trying to bring about change, both at front-line and political levels.

Targets can be framed so as to minimise these dangers but the target-setting process cannot avoid them entirely (as recognised in the 2001 Report of the NAPS and Health Working Group). At the same time, a strategy that does

not set out some basis on which its success or failure can be assessed will not be taken seriously. Furthermore, high-level targets may be less likely to have a distortionary impact on behaviour than intermediate or lower-level ones focused on service delivery. So framing targets with an awareness of both the general dangers, and of particular issues that arise in the context of health inequalities and services, is critical.

To guide the choice of targets and help distinguish between ones that are and are not likely to be helpful, it is worth trying to agree first on some underlying principles. It is conventional in a business context to argue that targets should be SMART - Specific, Measurable, Achievable, Realistic and Time-related (or some variant of these that still fits the acronym!). These principles clearly have relevance in setting socio-economic targets as well, and while they can at one level be seen as innocuous and hard to disagree with, in practice they have very serious implications for the way targets are set.

Ambiguous or non-specific targets are of as little use in the health inequalities context as elsewhere, and only targets that stretch the system but are achievable stand much chance of having the desired impact. Aspirations framed in general terms such as 'reducing health inequalities' or 'improving access to health care', while potentially important as statements of overall aims, do not represent specific targets against which progress could be monitored. (See also the discussion on criteria for selection of targets in the 2001 Report of the Working Group on NAPS and Health, and Burke 2001 on experience in setting targets.)

However, going beyond the need to be SMART, some other considerations also need to be highlighted in thinking about targets in the socio-economic context, and specifically in focusing on health inequalities. A fundamental choice to be made is whether targets should be framed in terms of social outcomes or the means by which these are to be achieved. It is all too tempting to specify detailed targets in terms of what policy-makers themselves are to do - in terms of expenditure on specific interventions or numbers of cases to be processed by, for example, the health services. This is tempting firstly because these can (usually) be readily measured, and secondly because there can be a reasonably high degree of confidence that

the specified spending or intervention will actually happen. However, the over-arching aim and rationale for setting targets is to achieve a social goal - in this case the reduction of health inequalities - and there may well be multiple ways of achieving it. If at all possible, targets should be set first in terms of key outcomes relating to that goal. Policy can only be guided, and success or failure judged, by a clear statement of the outcomes one is trying to achieve.

Means should not be confused with ends in setting targets, most obviously because policy interventions may not have the desired impact, and even if they do other factors may work in the opposite direction so the desired outcome is not achieved. This may be seen as a key objection to setting outcome targets from a political perspective: it is hard to be sure that they will be attained, even with what appear to be the required resources and policies, and there may be a political price to be paid for failure.

However, the future cannot be predicted and there are no guarantees, and this is surely understood by the general public. For example, a government which manifestly made every effort to reach a stated target for reducing unemployment but failed in the face of an international depression would have to make its case to the electorate, but would be in a very different position to one that was regarded as having done little or nothing about the problem. Precisely because setting a specific target for reducing unemployment to a stated level by a given date will be taken as representing a higher level of political commitment, it is more likely to inject the momentum required to achieve that goal than either stating a broad aspiration to tackle unemployment or announcing a range of interventions. Having specified the societal goal one is aiming at, it is essential to then specify in some detail the ways in which it is to be achieved. High-level outcome targets need to be linked first to a set of intermediate outcomes that would contribute to attaining the desired goals, and critically also to policy. An outcome target that is not linked in concrete terms to what government (and others) are going to do to try to achieve the desired outcome in effect represents no more than a vague aspiration.

So the approach we are suggesting is that 'headline' targets be first set for the outcomes we care most about (and can measure). These should then be

underpinned first with intermediate-level outcome targets and policy goals, e.g. changes in smoking prevalence, alcohol consumption, exercise and nutrition, and the incidence of specific diseases for specific populations. A detailed set of policies aimed at attaining those goals then needs to be set out, with a clear identification of who is to be responsible for delivery on each. The different components and levels envisaged are illustrated in the box below.

Long-term High-Level Outcome Goals

Medium-term Outcome Targets

Medium-term Policy Strategies

National-level Policy and Performance Indicators

Local-level Policies and Performance Indicators

Within this general framework, the distinctive features of health inequalities as a social concern need to be taken into account. One distinctive feature is the long-term and indirect nature of the linkages between many of the factors that affect health - such as income and deprivation, life-style behaviours, and health care - and measured socio-economic health inequalities. The levers available to policy-makers mostly have only indirect effects on health inequality outcomes. This means that the lag between intervention and impact on measured health inequalities will be quite variable, on a spectrum all the way from very short to very long indeed. (To illustrate the point, effective health and safety legislation might have an almost immediate impact. Improving exercise and nutritional intake patterns might have a mixture of short, medium and long-terms effects, and reducing smoking might have an impact on heart disease within 5-10 years but a slower impact on cancer rates.)

For this reason it makes sense for health inequality targets to start with a focus on very long-term objectives. Looking as much as twenty-five years into the future would not be unreasonable. Setting out such long-term objectives would permit more medium-term ones that would be steps along the way to be specified. These could then be accommodated within the framework of a

medium-term strategy. Concretely in the current Irish context, this would mean that the treatment of health inequalities in the revised NAPs/inclusion, which is to cover only a relatively short period, needs to be underpinned by a longer-term strategy and set of goals for the reduction in health inequalities.

As well as the lags involved, it must also be recognised that although much has been learned about the underlying causal processes producing inequalities in health, these are still not very well understood. This means that policy-makers may be particularly unsure about the impact that pulling the various levers available to them will have on health inequalities, even having allowed for the lengthy lag that may be involved. So the impact of feasible interventions is not only often indirect and with a long lag, but their impact on measured health inequalities may also be quite uncertain.
This may make setting outcome targets particularly unpalatable from a political perspective, since even well-designed and resourced policy interventions may not deliver the desired and publicly-adopted outcome. However, the logic of focusing in the first instance on outcomes still stands. Indeed, it has all the more force, since confusing means with ends will be all the more serious where we are not sure which policies will actually be effective.

A parallel may be drawn with the commitment by the British Prime Minister some years ago to 'end child poverty' by 2020. It was quite unclear how child poverty was to be measured and a good deal of effort has had to be invested subsequently to deciding on appropriate indicators, facing the sort of issues we discuss in the health inequalities context in the next section. However, this long-term goal has served as the basis for specifying intermediate targets for 2010 which would allow policy-makers to see whether they are 'on track', and to frame a strategy to tackle child poverty in terms of both those intermediate targets and the overall longer-term ones.
A target to eliminate deep-seated socio-economic problems in a few years will not be credible and thus will not have the desired mobilising effect. This is, if anything, even more true in the case of health inequalities than other societal problems. So in the shorter term, while it may be unrealistic to expect to see a marked impact on health inequalities, as Marmot (2004) puts it 'One does, however, want to see evidence of policies being put into action that might make a difference.' At the same time, one will want to monitor available indicators to see whether health inequalities themselves are moving in the right direction, and it is to the choice of indicators that we now turn.

IDENTIFYING RELEVANT INDICATORS

The specification of targets requires firstly that appropriate social indicators be identified, and secondly that a target level for these indicators be selected to be reached by a given date. From a technical, statistical point of view indicators being used for target-setting need to meet certain standards. For example, they should be robust and statistically validated, they should be measurable in a sufficiently comparable way over time so that trends can be reliably assessed (and if possible in a comparable fashion across countries so that levels and trends can be seen in comparative perspective), and they should be available in a timely fashion so that policy can react.

These technical considerations are very important, as we will illustrate shortly with reference to the current health inequality targets in the Irish national anti-poverty strategy. However, other desiderata also need to be kept to the forefront. Perhaps the most important is that the targets should be framed in terms of indicators that are generally recognised as meaningful, are acceptable to the general public, and capture the core of the social concern involved.

So individual targets should relate to social indicators that have a clear and accepted normative interpretation - there is no ambiguity about which direction represents an improvement. They should be seen generally as valid measures of what they are aiming to reflect, not just by statisticians and other experts but more broadly. Indicators that can be understood only by statisticians and experts will not have the required resonance, whereas everyone can readily grasp the importance of for example being able to get a job or feed and clothe one's family properly, or living a long and healthy life with access to quality health care when needed.

Finally, the set of targets taken together should be generally seen as reflecting the key aspects of the societal problem at hand - in this instance, socio-economic inequalities in health.

The choice of indicators on which to base high-level outcome targets is necessarily constrained by the available information; this is true in any field, but is particularly problematic in focusing on health inequalities.
There are significant problems with the way socio-economic differentials in mortality and morbidity are currently measured in Ireland and substantial gaps in the available information. This can be illustrated by reference to the quantitative indicators underpinning the current targets in the national anti-poverty strategy.

The first quantitative target is to reduce the gap in premature mortality between the lowest and highest socio-economic groups for three categories of cause of death, namely circulatory diseases, cancers and injuries and poisoning. Available measures of socio-economic differentials in mortality by cause of death are based on the combination of data on deaths from the death registration system with data on overall numbers in each socio-economic group from the Census of Population.
These are subject to 'numerator/denominator' biases, especially since the quality of the data on occupation/socio-economic group from the death registers is open to question and the occupational coding employed differs between the two sources.

Furthermore, occupational information about those past retirement age in the death registration data is unsatisfactory as a basis for categorising deaths at that age by socio-economic group, so differentials among older people - where most deaths occur - are particularly poorly measured. The categorisation of women by socio-economic group may also be problematic. The core difficulty is that the two sets of data are not linked, whereas some other countries have sought to link individual deaths with population registers or Census returns to get around these problems.

The target to reduce the gap in low birth weight rates between children from the lowest and highest socio-economic group is monitored using information from the National Perinatal Reporting System. These suffer from the difficulty that a substantial proportion of cases do not have enough information to allow reliable categorisation by socio-economic group, and the quality of the occupational information provided in some other cases may also be open to question.

The other quantitative outcome target in the current strategy relates to the difference in life expectancy between members of the Traveller community and the overall population. Unfortunately, information to allow this to be measured and monitored is not routinely collected at present. This means that baseline data on how great that differential actually was in 2001, the point of departure for the strategy, and the on-going data required to monitor it are not at present available. A large-scale Travellers' Health Study is to be carried out shortly, and this will provide baseline data against which future progress could be monitored if such a study were to be repeated in the future.

As well as such problems with existing indicators, there are major gaps in the coverage of available indicators - among the most obvious being in relation to the health of vulnerable groups such as asylum seekers, refugees and ethnic minority groups. In addition, improved access to quality health services represents part of the strategy to reduce health inequalities and better measures of both access and quality are needed if progress is to monitored effectively.

We discuss the development of data and analyses to underpin health inequality reduction targets and strategy in the next section, but the key issue at this point relates to the way targets are framed using existing information. There are two aspects to this question: are there other indicators that should be used - instead or as well - in framing targets, and could the indicators currently used be employed in a more satisfactory fashion?

There are indicators of health status categorised by socio-economic status available from household surveys, such as the self-assessed health of respondents, whether they regard themselves as having a long-standing or

chronic illness, and their psychological health status. These have been used to study differentials across different population groups and the factors associated with good versus poor levels of self-perceived health, both in Ireland and elsewhere.

This has been particularly valuable in highlighting the strength of the associations between poor self-perceived health and for example unemployment
or material deprivation. However, setting targets in terms of such self-assessed health measures may be problematic,
as measured trends changes in differentials over time could be driven primarily by changes in expectations and the way different people 'frame' their views about
their own health, rather than changes in underlying health.

For the present, and with all their acknowledged limitations, socio-economic mortality differentials appears to be the central indicator available for framing targets for reducing health inequalities in Ireland. This is reinforced by the fact that the EU has assigned priority to the development of an indicator of this type across the member states for inclusion, if possible, among the agreed set of social inclusion indicators. This is usefully complemented by a target based on data about differentials around birth, the other source of data for the general population on which most reliance can currently be placed.

The precise way in which these information sources are employed to frame targets might well be re-examined. For example, an over-arching target for reduction in mortality differentials irrespective of cause might usefully complement the cause-specific ones currently included in the anti-poverty strategy, and infant mortality as well as low birth weight is a key outcome measure. The targets for both premature mortality (for specific causes) and low birth weight are currently set as a 10 per cent reduction in the gap between lowest and

The precise way in which these information sources are employed to frame targets might well be re-examined.

highest socio-economic group by 2007, and this will clearly need to be re-assessed.

We have argued in the previous section that specifying the long-term goal is the first stage in the process, and that a particularly long lag between policy intervention and its impact is to be expected in the case of health inequalities. The implication is that a target for reducing these differentials substantially, for a date significantly further into the future, might be the best starting-point - with staging-points against which trends could be monitored in the shorter-term derived from that. In deciding what constitutes a 'substantial' reduction in these differentials, reference might be made to their measured levels in other countries. It is not realistic to think in terms of eliminating these differentials altogether, but it would be feasible to reach a situation where they were among the lowest in the EU.

Perhaps it is also worth re-thinking the exclusive concentration in target-setting on differentials per se, irrespective of the levels involved. A situation where life expectancy was rising substantially but proportionately for all socio-economic groups - so the gaps between them expressed in relative terms remained unchanged - might well be preferred to one where life expectancy was failing to improve but there was some modest fall in differentials because there was a small increase for the least well-off and a decline for the better-off. The absolute as well as the relative difference in life expectancy between the most and least well-off may well be considered important.

The parallel may be drawn with setting poverty targets, where a long-standing debate about the relevance of relative versus absolute measures of poverty shows little sign of being resolved. One possible approach, put forward in Nolan et al (2002), is to adopt a tiered set of poverty reduction targets, where the aim is to ensure both that real living standards rise for those on low incomes and that the gap between them and the rest of the population narrows.

In the same vein, in the health arena the goal could be first to ensure that life expectancy (and ideally healthy life years) increase significantly over time for lower socio-economic groups, and secondly that the differential in life expectancy (healthy life years) between them and higher socio-economic groups (or the population average) narrows. On the basis of past experience life expectancy for the better-off is likely to continue to improve; so the first

challenge is to ensure that it also improves for the less well-off, while the more ambitious goal is to improve it more quickly for them than for the better-off.

It is of interest in the context of high-level outcome targets to look at the approach taken in Britain. In 2001 the British government pledged to reduce inequalities in health outcomes, as measured by differences across socio-economic groups in infant mortality and life expectancy at birth, by 10 per cent by 2010. Specifically, the targets were to reduce the gap in infant mortality between manual socio-economic groups and the population as a whole, and the gap in life expectancy between the fifth of areas with the worst health and deprivation indicators and the population as a whole.

As well as high-level targets set in terms of outcomes, the framework outlined in the previous section envisages intermediate-level targets being set in terms of both supporting outcomes and policy interventions and performance. In Britain, as well as the high-level targets for reducing health inequalities, a range of supporting outcome targets - such as for conception rates among those aged under 18, for nutrition and obesity rates among children, and for smoking prevalence among manual social classes - has also been adopted. Reaching these targets could make a significant contribution to reducing health inequalities, as well as being important goals in their own right, though it is too early to assess progress in Britain as yet.

This is a real challenge, since if health education and other interventions are simply directed towards the general population they often have greatest impact among those with higher levels of education and earnings.

It must be emphasised, however, that this will only be the case if the improvements achieved for those from lower socio-economic groups are greater than for higher socio-economic groups. This is a real challenge, since if health education and other interventions are simply directed towards the general population they often have greatest impact among those with higher

levels of education and earnings. So specially-designed and targeted interventions will be required if the desired improvements in health are to be achieved but in a way that reduces rather than widens inequalities.

Health system performance can be monitored using available information, though again subject to serious shortcomings, and some quantified targets for improving access and performance have already been set in the context of the health strategy. It is not the aim of this paper to review these performance targets, but it must be emphasised that meaningful quantified and time-related targets for improving access to and quality of health services and reducing socio-economic differentials in access represent a critical element in the target-setting approach being suggested here.

DEVELOPMENT OF DATA AND ANALYSIS

The limitations in the data available on some key indicators of socio-economic health inequalities and the gaps in coverage of the available indicators have been highlighted in the previous section. This goes together with a more fundamental gap, in research about the factors underlying health inequalities, which urgently needs to be filled if efforts to reduce health inequalities are to have any real prospect of succeeding.

Recognition of the importance of information and research for policy design - indeed, for framing targets sensibly in the first place - prompted the 2001 Working Group on NAPS and Health to include among its recommendations that systems to monitor NAPS health targets and indicators should be included within the National Health Information Strategy, and that a programme of research should be set up to support the development of further NAPS health targets and indicators. The 2001 Report set out a monitoring framework which comprised an indicators programme, a research programme, a monitoring system, and a review and evaluation process, and emphasised that each element requires strong links with other government strategies.

The capacity to monitor the NAPS health targets was included among the targets for the National Health Information Strategy as part of the broader health strategy, and the Health Information Quality Authority (HIQUA) has been assigned the task inter alia of working with relevant agencies to ensure the availability of the information necessary to monitor and review those targets. In addition, developing a national data strategy relating to the national anti-poverty strategy is one of the responsibilities of the Office for Social Inclusion. However, as we have seen significant improvements are needed in the indicators being employed and important gaps in coverage

need to be filled. This will involve linkage (at micro-level) of administrative information gathered by various government departments and agencies, which the Central Statistics has been actively pursuing.

Only on this basis will central health inequality indicators such as socio-economic mortality differentials be measured reliably. An in-depth picture of variations in service use across socio-economic groups or income levels could also be seen. In addition, health interview surveys in other countries have demonstrated the potential of large-scale representative household surveys dedicated to capturing variations in health status in detail.

A mechanism to produce and fund a coherent research strategy focused on health inequalities to underpin the development of effective policies, or indeed clear official recognition of the need for such a strategy, have yet to emerge. Such a research programme does not feature in *Making Knowledge Work for Health - A Strategy for Health Research* (Department of Health and Children 2001). While the Health Research Board has funded some relevant research and organisations such as the Institute for Public Health, the ESRI and university researchers have been carrying some out, this is no substitute for a coherent programme on the required scale.

INVOLVING KEY STAKEHOLDERS

As outlined earlier one of the core requirements for targets is that they have to be meaningful, not just in a technical sense for the policy-maker setting them and the statistician monitoring them, but also for the general public and those expected to play a key role in their delivery. The clear implication is that the process of selecting targets itself needs to be a broadly-based one, involving consultation with inter alia those most affected by health inequalities and those who will be involved in the policy interventions designed to reduce them.

(An extensive consultation process was carried out as part of the work of the Working Group on NAPS and Health before the current targets were adopted, as described in one of the background documents to their report entitled *Giving People a Say,* Department of Health and Children 2001.)

Furthermore, the nature of health inequalities themselves makes it essential to adopt a multi-sectoral approach not only across government departments and public agencies but much more broadly, at both national and local level. Inequalities in health reflect deep-seated socio-economic inequalities in society, and improving health services is only part - and in all probability by no means the most important part - of the broad-ranging strategy required to tackle them.

People who experience material disadvantage, poor housing, low educational attainment, unemployment, or homelessness are more likely than others to suffer poor health and die young. This means that a strategy aimed at reducing health inequalities will have to look well beyond health care or even health-affecting behaviours to encompass poverty, housing, the labour market, etc. The wide range of causal factors producing inequalities in health is illustrated by the fact that the 1998 Acheson Report on inequalities in health in the UK, like its path-breaking predecessor the 1980 Black report,

concentrated for the most part on areas of intervention outside of health care. Only 3 of its 39 recommendations dealt with medical care.
The implication is that health inequalities, and targets for reducing them, cannot just be seen as the 'property' of the Department of Health and Children, but nor can it be allowed to 'fall through the cracks' with no clear allocation of responsibility. The Office for Social Inclusion has responsibility for taking the lead in engaging all relevant departments and agencies in the anti-poverty strategy more broadly. However, in the case of health inequalities the need to engage stakeholders within and outside the public sector in framing targets and in the design and implementation of policies to deliver on those targets is, if anything, more fundamental.

The 2001 Working Group on NAPS and Health included among its recommendations that it should be government policy for all relevant sectors to recognise and accept their responsibility for health by developing multi-sectoral working and by having health impact assessments carried out on their policies. The national health strategy has also incorporated health impact assessments in its action plan. The extent to which this type of broad-based approach is implemented and contributing to the promotion of health, and in particular reduction in health inequalities, remains to be seen.

IMPLICATIONS FOR LOCAL DELIVERY

We have emphasised that high-level and supporting targets for the reduction in health inequalities need to be linked to specific policies aimed at achieving those targets, which are concrete and time-delimited, and that responsibility for the delivery of those policy interventions and for meeting the performance targets associated with them has to be clearly assigned. This has to be carried through to local level, where the delivery of services and other interventions actually take place.

There is the very real danger that a high-level outcome target such as reducing socio-economic mortality differentials will appear distant in the extreme from any actions that can be implemented at local level, whether by those working in the health services or others. Engagement of those working 'at the coal face' on the basis simply of such a distant target, apparently unconnected to anything they might do, is unlikely. Thus linkage between national outcome targets, national policy, and local delivery is absolutely critical if the adoption of targets is to have the desired mobilising and energising effect.

This needs to be tackled at a number of levels. The first is that the rationale for the high-level targets themselves needs to be clearly articulated to and understood by those working at local level. Those targets have to be seen as meaningful in a substantive way, rather than merely technical. This means, firstly, that both the broad aims underlying the target-setting and the reasons for the specific choice of targets and indicators adopted (including their limitations) need to be communicated effectively.

Secondly, the relationship between the high-level outcome targets and the range of policy interventions being implemented needs to be communicated. This in turn has to be based on an understanding of the multi-faceted nature of health inequalities and the variety of channels through which they can potentially be influenced.

To be effective, though, they need to be clearly seen by all involved as flowing from a coherent national strategy with meaningful high-level targets.

Finally, the linkage between national policy strategies and what needs to happen at local level - including who is responsible for what - needs to be tightly specified. Time-related objectives with respect to improved delivery of services or other interventions at local level, over a relatively short period, need to be set out - as they would for the rolling-out of any national policy. To be effective, though, they need to be clearly seen by all involved as flowing from a coherent national strategy with meaningful high-level targets.

MONITORING AND EVALUATION

As already noted, one of the recommendations of the 2001 Working Group on NAPS and Health was that systems to monitor national anti-poverty health targets and indicators should be included within the National Health Information Strategy. This does indeed form part of that strategy which is in the course of being implemented in conjunction with the establishment of the Health Information and Quality Authority. Another recommendation, with which it should be linked, is that adequately resourced and supported systems should be put in place to ensure that NAPS health targets and implementation strategies are reviewed and revised.

The need to involve those delivering and receiving services at local level in the initial design of targets has already been emphasised. If this is done it is much more likely that a sense of ownership and identification with the targets will be fostered. However, a feed-back loop is also essential. There must be a channel whereby the views of those delivering services and those in receipt of services and in the communities most affected have a voice in how they are evaluated. Some capacity-building for front-line staff and local communities may well be required to facilitate this input.

The value of involving these stakeholders from the outset, and the need for a partnership approach if this is to be done effectively, was repeatedly emphasised by participants in the recent Combat Poverty conference on target-setting (see www.combatpoverty.ie). There are by now many examples of local projects involving communities and service providers from which lessons can be learned. Both the scale of the challenge in promoting inter-sectoral and inter-agency working, and the need for training and dedicated resources to facilitate partnership, have been highlighted by those involved.

For monitoring and evaluation to be effective, a clear link must be made at the outset between national strategy, policies and what is intended to happen 'on the ground'. A valuable point of reference at the design stage is the approach adopted recently in Britain to the development of targets and strategies to tackle health inequalities, where an impressive effort has been made to go from national high-level targets through supporting outcome targets, national policies, to local responsibilities and initiatives (see for example Department of Health and Children, 2003, 2005).

CONCLUSIONS

Socio-economic inequalities in health are a common feature of even rich countries, and reflect deep-seated structural inequalities in those societies. One of the aims of Irish government policy, as reflected in both anti-poverty and health strategies, is to reduce health inequalities. Expressing this commitment in the form of specific quantified targets represents one part of the wide-ranging multi-sectoral response required if this is to be achieved.

Such targets face problems, particularly since the channels open to government to influence health inequalities are indirect and uncertain and the lag between intervention and impact on measured inequalities may be lengthy. Targets are not an end in themselves or a substitute for co-ordinated, well-designed and well-resourced action. They can however play an important role as part of a framework for a strategy to effectively tackle health inequalities, whereby roles and responsibilities from central to local level are clearly set out.

This paper has suggested an approach to target-setting aimed at enhancing the prospect that they will indeed play such a positive role in the new NAP/Inclusion currently being prepared.

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Notes

Notes

To inform public policy on setting targets to reduce poverty and health inequalities, Combat Poverty commissioned Professor Brian Nolan of the Economic and Social Research Institute (ESRI) to write a paper that would propose an approach to setting, monitoring and reviewing such targets.

The paper begins by describing the targets relating to health inequalities adopted in the current National Action Plan Against Poverty and Social Exclusion (NAP/Inclusion), and where they fit in relation to the official strategy for health and the health services. It then steps back to discuss more generally the role that such targets can play, and some principles that can usefully be taken into account in setting them.

A general approach to setting targets for the reduction of health inequalities respecting these principles, but also reflecting the need to link targets to policy, is suggested. The ways in which targets can be used for monitoring and evaluation, the mechanisms for involving key stakeholders – including people experiencing poverty – in this process and the implications for local delivery of services are then discussed.

The author makes the case that targets are not an end in themselves or a substitute for co-ordinated, well-designed and well-resourced action. They can, however, play an important role as part of a strategic framework to effectively tackle health inequalities, whereby roles and responsibilities from central to local level are clearly set out. This paper has suggested a joined-up approach to target-setting aimed at enhancing the prospect that they will play a positive role in the NAP/Inclusion process.

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working for a poverty-free Ireland