Cross-government co-ordination to improve health and reduce inequalities

Summary of a private roundtable

Introduction

Supporting good public health is an important aim for any government. Not just because people value it highly, for themselves and their communities, but also because it is important for the economy. A country's population health influences economic activity, productivity and health-related government spending – shaping GDP and the government's fiscal pressures.

Historically, the UK has enjoyed continual overall improvements in population health. In England, in the century before 2010, average life expectancy increased consistently by nearly three years every decade. But the last decade has seen a substantial shift in these trends. Life expectancy has been stagnating since 2011, and declined in 2020 as a result of Covid.[1]

The UK also has large and growing health inequalities. The gap in male life expectancy at birth between England's poorest and richest areas widened by 8% between 2011–13 and 2018–20, amounting to nearly a decade's difference by 2020.[2] The equivalent gap is nearly 14 years for Scotland,[3] eight years for Wales[4] and seven years for Northern Ireland.[5]

The idea of co-ordinating cross-government policy to improve health and tackle health inequalities is not new. Research has attributed rising health inequalities to changes in the "building blocks" of health – from housing to jobs, to access to education and healthy food.[6] Implementing policies to tackle these root causes of preventable ill-health, and targeting these factors to improve health outcomes, requires action right across government. Every government department has the power to improve at least one.

But no government since the 2000s has implemented a sustained cross-government programme to tackle health inequalities. Boris Johnson's government came closest, with its Levelling Up strategy committing to action – but a promised health disparities white paper was shelved after Sajid Javid's resignation as health secretary and the subsequent collapse of the administration. The lack of effective cross-government co-ordination to tackle health inequalities is an example of what commentator and Institute for Government senior fellow Sam Freedman calls the "policy paradox":[7] we know that it's a good idea, for the nation's health and long-term finances, so why aren't we doing it?

Now is an important time to answer that question. Preventing population ill-health is a political priority crucial for both Keir Starmer's 'health mission' should Labour get into government and Rishi Sunak's pledge to reduce NHS waiting lists.

Whoever is in power, worsening population health is set to be one of the big challenges of the next decade. With an existing high burden of disease, an ageing population and worsening population health – across multiple fronts, from mental wellbeing to diabetes – ill-health is already set to create a high and increasing fiscal pressure on government.

The Office for Budget Responsibility has called the rise in health-related working-age economic inactivity over the last three years a "significant risk" to fiscal sustainability, estimating it has added £15.7 billion to annual borrowing through foregone tax and additional welfare spending over this period.[8] Obesity alone is estimated to cost the government £6.5 billion each year.[9,10]

The run-up to and aftermath of a (probable) 2024 election is an opportunity for the current government and any would-be Labour administration to begin work on a more strategic, co-ordinated approach that has the momentum, consensus and stability to persist in the long term – with the machinery of government to match. Done right, there is a window to break with the disruptive institutional and political churn that has been a feature of public health policy in the last decade and more.[11] Institute for Government work shows that long-term policy programmes are most likely to succeed when introduced at a salient political moment – including when new or returned governments take office or when opposition parties seek to move new issues into political focus.[12] In July 2023, it appears that both factors apply.

But introducing an effective cross-government programme to improve health and reduce inequalities is a lot easier to announce than to do. Those in government cannot simply agree that stagnating life expectancy and high inequalities are a problem – that is self-evident. Ministers and civil servants need to know how to make progress in the context of complex social and economic processes which generate these outcomes if they want to seriously prioritise addressing them.

In June 2023, the Institute for Government and the Health Foundation jointly organised a roundtable bringing together experts and officials with experience working in cross-government roles. As part of a programme of work making the case for a whole-government response to improve health, the Health Foundation funded this session to discuss the barriers to more effective cross-government co-ordination, and the opportunities for government to take a more ambitious approach to improving health and reducing inequalities. This short paper summarises the lessons learned from that discussion.

What are the barriers to cross-government co-ordination?

Institute for Government research has found that government often struggles to co-ordinate policy programmes that are inherently cross-cutting – that is, not sitting neatly within one department's jurisdiction.[13] Roundtable participants agreed this was true of health inequalities. While recognising the work of individuals in the Office for Health Improvement and Disparities (OHID) – set up in 2021 after the abolition of Public Health England – participants noted its limited power to co-ordinate policy. It sits within the Department of Health and Social Care (DHSC) where the NHS takes up most resource and capacity. As one participant explained:

> ***"The NHS is a monolithic institution and so politically important that it always has to be the priority. It's difficult to reconcile that with [OHID's] wider responsibilities."***

Another participant emphasised that "OHID's institutional strength and ability to influence across government is limited". This impedes progress because many of the policy levers to improve health sit within other departments. Taking obesity as an example, responsibility for key policies is held by the Treasury (via fiscal measures), the digital and culture department (advertising regulations) and Defra (regulating producers and retailers). DHSC needs to persuade these departments to act, often in conflict with their own priorities. This means that achieving consistent cross-government action on obesity has so far proved impossible.[14] This has been made even harder by institutional and official churn, as one participant described:

> ***"Expertise flew out of [Public Health England] and it's dissolving over time as people are leaving."***

But participants emphasised that the biggest barrier to more effective co-ordination was that improving health and reducing health inequalities have not been a priority, in No. 10 or in departments. The group agreed that the above barriers would be surmountable if ministers were particularly passionate about the agenda, or if the prime minister made it a priority. One participant argued that moving public health policy closer to ministers through OHID was potentially a very good idea, but "on the proviso that ministers care; the problem is it's moved closer to ministers who don't care". They noted that this only makes it more likely that good officials leave.

The group raised a few reasons for this lack of political buy-in. One was that DHSC and its agencies did not always "play the Whitehall game" by persuading departments that its policy interests were of wider benefit. Given that departments often see public health priorities as conflicting with their own, one participant noted that:

> ***"People interested in health are not that good at saying 'How can we solve your problems?', rather than 'How can you solve ours?'."***

It is also the case that many public health policies are politically thorny. Again looking at obesity, a fear of being seen as "nanny statist" has held back policy, even as polling shows that a majority of the public support interventions like restricting advertising for unhealthy foods and extending the sugar tax.[15] Roundtable participants also highlighted the impact of the pandemic, arguing that while it revealed the UK's vulnerability to ill-health, the legacy of the lockdowns has left politicians "even more nervous about being more assertive".

A whole-government approach

Participants argued that the government should build an approach to tackling health inequalities akin to that adopted to climate change – rightly prioritised as a complex, long-term issue requiring a whole-government response. The discussion sought to explore how government could achieve this on two fronts: first, building consensus around a whole-government approach to health; and second, designing the structures, systems and processes to deliver that agenda.

How could government build consensus around a cross-government health agenda?

Attendees noted that if a policy area is a government's "one big thing", less consensus is needed and it can "bash things out of the way to get there". But a perpetual challenge for government is prioritisation: there are so many policy challenges which could be that "one big thing". In this context, participants agreed that precisely what makes policy to improve health and reduce health inequalities so difficult to co-ordinate – its intersectional, systemic nature – is also the biggest potential strength of the agenda. There are countless opportunities for government to improve health and address inequalities through cross-government policy packages that align with other political priorities, such as policies aimed at delivering better housing or better work.

Participants agreed that, for progress to be made here, policy makers will need to shift their perception of this as just a "health" issue, and instead recognise that poor health outcomes are both a downstream consequence of wider social and economic policy, and an upstream cause of problems with which other departments grapple. For instance, improving health and reducing health inequalities could be a core component of a strategy for tackling economic stagnation, or reducing regional inequalities as intended in the Levelling Up strategy.

> ***"[Government should get better at saying] 'This is in your interests'… Reducing health inequalities can have a powerful impact but it's not always how departments will approach it because they're thinking about what they know about."***

Participants also agreed that much more could be done to boost public engagement, to help build consensus on the need for government to act, in turn attracting greater scrutiny on progress. They noted a lack of clear measures and concepts on which to hang a public campaign or new policy, in contrast to issues like gender inequalities and climate change:

> ***"You can't imagine getting 100,000 people marching on Westminster to improve health inequalities… We don't have a 'gender pay gap' health equivalent, or an emissions health equivalent."***

But attendees instead pointed to the power of individual stories for capturing the public's attention and making health inequalities' intersectional causes and impacts more visible.

> ***"When people are exposed to the consequences – like mould in homes or food poverty – that does generate outrage. The right reporting can bring more public demand for change."***

As a local example of where this has worked well, participants pointed to the Wigan Deal where local communities, businesses and the government worked together to navigate local services cuts, adopting a shared mission to design cross-cutting services to improve local health and care. The council was able to reduce the services budget while improving

outcomes, and local communities felt shared ownership over those services, telling "their own story about what the deal meant for them", and for Wigan as a place.[16]

Here, government can also learn from external stakeholders already developing framings for health inequalities that are better at reaching the public. The Health Foundation is already making progress in this area, bringing together a Health Equals coalition of 28 member organisations to shape a new public conversation around the 'building blocks' of health.[17] And with FrameWorks UK has also jointly produced a 'toolkit' outlining the most effective ways of communicating with the public about tackling these drivers of population ill-health.[18]

These are important ways to explore how to set a whole-government health agenda. However, participants noted that the policy programme is not just set once. Institutional and structural reform (explored below) can help create some stability for a policy agenda, but the political argument for consensus around their purpose, value and direction has to be refought and re-legitimised, particularly after an election but also each time a new health secretary or public health minister takes office.

What does government need to effectively deliver a cross-government health agenda?

What does the centre of government need?

An honest broker

Participants agreed that the government needs an institutional "honest broker" across the many departments which need to work together to tackle health inequalities: HMT, DHSC, DWP, Defra, DLUHC, DBT, DfT, DfE, DCMS and the Home Office. This could be a special unit to challenge business as usual in departments and lead focused progress on improving health and tackling health inequalities from the centre of government.

Or it could be a cabinet committee to drive decision making, allocate responsibilities and mediate conflicts between departments. Past Institute for Government research has found that the most successful cabinet committees are usually chaired by the prime minister or another very senior minister, have high-level senior attendance by ministers, meet regularly, have high-powered and well-resourced secretariats, and include officials with deep expertise where relevant.[19]

Drawing on their experience, participants discussed how machinery-of-government changes can risk just "moving deckchairs", but done right can "really internalise and pull apart ways of thinking". A good example was Tony Blair's Rough Sleepers Unit, which, led by former deputy director of the homelessness charity Shelter, Louise Casey, reduced the number of rough sleepers by two thirds in just two years.[20]

The group agreed that special units work best when set up with a short-term, clear remit, as past Institute for Government research has recommended.[21] The aim should be to mainstream work back into business as usual within departments after they have achieved their initial objectives. One participant said:

> ***"Government often reaches for [special units] when stuff is hard. They have the most impact when they're a task-and-finish unit, but it works less well when they linger on indefinitely."***

A robust strategy

Participants were clear that effective cross-government co-ordination to improve health and reduce health inequalities requires a clear, robust strategy. One participant described a good strategy as an "anchor" for policy. The government's net zero strategy was regularly referenced as an example of this, while recognising that the clarity and simplicity afforded by carbon budgets as a measure of progress were not available to those working on health inequalities.

Rather than "a shopping list of policies that might work", as one previous Institute for Government interviewee described the UK's obesity strategies,[22] a serious strategy provides what health academic Harry Rutter calls a "20-year vision, five-year strategy, one-year plan".[23] This means stating credible long- and medium-term goals, identifying the key contingencies for meeting them, and designing a clear path forward for policy, backed up by robust analysis.

Monitoring and evaluation against well-designed targets

Drawing on a presentation from Professor Clare Bambra exploring preliminary findings from upcoming work in partnership with the Health Foundation, participants discussed how government should use targets to reduce UK health inequalities.

The group agreed that well-designed targets, including both long-term and interim targets, can be crucial for driving progress and structuring delivery. One participant with experience working in the Prime Minister's Delivery Unit (PMDU) said:

> ***"I believe in targets… If ministers and permanent secretaries have to account for delivery, it does galvanise attention."***

As a striking example, over the period from 2000 to 2010 under the English Health Inequalities strategy, government was able to reduce the infant mortality rate in England's most deprived local authorities by a quarter, and reduce the gap between those areas and the rest of England by a third.[24] As one participant said: "It's very hard to argue with that."

However, participants raised three risks of targets, which policy makers must account for in their design. First, choosing the right metrics is important. While life expectancy is an excellent standardised indicator, participants highlighted that it is lagged (the effects of new measures take time to be felt) and so cannot reflect the real-time impacts of policy; for this, further interim metrics measuring the social determinants of health are needed.

Second, one participant highlighted the tension between the benefits of interim targets in creating discrete goals for policy (and the associated ability to evaluate progress quantitatively), versus the fact that health inequalities are systemic and ultimately indivisible. As they put it:

> ***"There's no cross-cutting issue in people's lives; it's just their life."***

As such, the government needs to negotiate the balance of designing effective interim targets which give policy makers manageable medium-term goals, while keeping a clear eye on how these are interacting and affecting health inequalities as a whole, as they are experienced in people's lives.

Third and finally, one participant raised concerns that targets set at a national level can "look brilliant from the centre [of government]" but disrupt useful existing work happening within local authorities. The group agreed that the best way to mitigate this is to allow latitude for

local authorities to decide how they will achieve targets in their own areas. It is also important to ensure that the people responsible for delivering health inequalities policies – the pathway to meeting these targets – are included in the design process. Past Institute for Government work agrees, concluding that the UK policy making system persistently struggles with delivery problems, which haven't been adequately considered in the policy design process.[25]

Accountability

Roundtable participants agreed that a robust strategy with well-designed targets needs strong accountability mechanisms baked in to ensure progress stays on track. There are different options for how this could work:

- **Legal accountability:** parliament passes a new law obligating the government to make specified progress against health inequalities targets (akin to the Climate Change Act 2008).
- **An independent institution:** like the Climate Change Committee, the government creates a new independent institution to monitor progress against health inequalities targets, advise if the government is on track, and make recommendations for adjustments where needed.
- **An annual report to parliament:** the government appoints a watchdog with a statutory duty to report annually to parliament on progress against health inequalities targets.

Resources

The "elephant in the room", as one participant described it, is that any large-scale projects on improving health and reducing health inequalities will need investment:

> ***"The next government will be time poor and cash poor, so the challenge is… Can the government manage short- and long-term [priorities] simultaneously? There is already a massive burden of illness that needs to be dealt with at the same time as longer-term improvements in health."***

Participants agreed that, inevitably, a serious programme to tackle this would be expensive, but ultimately argued that the government "can't afford not to", and should balance these costs against the long-term economic benefits of improving health and reducing inequalities (both in reducing health care costs and increasing economic activity and productivity).[26]

One participant, commenting on how "health inequalities are massively caused by bad wages and huge mental stress from work", suggested that government could consider requiring businesses to take a more active role in reducing health inequalities:

> ***"To what extent can you bring business in to grapple with offloading costs which they're responsible for?"***

What do departments need to deliver a cross-government health programme?

Beyond strengthening co-ordination from the centre of government, participants had three key ideas for how departments could work together better to improve health and reduce health inequalities.

Collaborating in areas of shared interest

Participants praised past instances where driven civil servants have fostered cross-government work in an area which had not been an express ministerial priority. For instance, one

participant described how a dynamic director-general really "pushed forwards" a cross-government response to an independent review which broke "down institutional barriers". Participants also outlined how some officials have set up their own unofficial cross-departmental groups to inform long-term thinking in areas of mutual interest, with eight departments represented at director level in one example. Another attendee described the crucial role of a strong cabinet secretary to bring departments together, giving the example of cross-government working on anti-microbial resistance:

> ***"You had Jeremy Heywood bringing civil service leaders together, saying: 'We can do something about this.' People put heart and soul into it… [discussing] what policy options were and engaging ministers."***

One participant also recommended that departments fund joint work where relevant; if, for instance, the Home Office was interested in producing some research on mental health within the immigration system, but couldn't find the budget for it internally, this could be a project that DHSC funds and both departments benefit from.

Thinking beyond the department

Participants suggested that departments should seek to facilitate a more "permeable" culture, thinking and learning more from beyond each department's immediate scope.

Participants emphasised the opportunities for departments to learn from the devolved nations' approach to health inequalities. Where the devolved nations have adopted different policies – for instance, the commissioner-led preventative public health programme under the Well-being of Future Generations (Wales) Act 2015 – these provide "natural experiments" which the wider UK government should seek to learn from. Participants noted that to make the most use of this opportunity, the UK and devolved governments should work together to ensure that the comparable data needed to evaluate these policies is collected and available for researchers to analyse.

Participants also highlighted the difference between devolved nations' single accounting officer performance appraisal system, and the UK government's multiple accounting officers (one in each department), which they suggested encouraged siloed thinking – and incentives. One participant suggested that departments could include a lateral element to civil servants' performance appraisal, encouraging officials to develop their knowledge and connections to policy issues adjacent to their departmental remit.

After a presentation from Dr John Ford and Heidi Lynch exploring preliminary findings from upcoming work in partnership with the Health Foundation, the group discussed the advantages and disadvantages of health impact assessments. Some participants argued that such assessments could play a useful role in institutionalising a place for health inequalities in policy conversations beyond DHSC. Drawing on their experience using them, one participant said:

> ***"You had to crowbar people into thinking about health inequalities. [Impact assessments] ask the question and challenge people."***

The presenters and participants agreed, though, that they weren't a "magic wand". One participant made the point that impact assessments are only as good as our measures of health policy impact. There are inherent uncertainties in predicting the interaction effects of policies which are aimed at changing systemic factors. Drawing on experience using impact

assessments in the PMDU, another participant suggested that health impact assessments would be most meaningful when informed by those who would be delivering policy.

Another highlighted the trade-offs of expanding health impact assessments into other departments, expecting they would be unpopular with ministers:

> ***"My challenge is… you're increasing the regulatory burden on policy, making ministers' lives harder, and the return on investment is after the ministerial term [has ended]."***

Developing robust evidence

Throughout the discussion, participants affirmed the need for robust evidence to design, monitor and evaluate policy. They made four recommendations for how departments could improve their use of evidence in future:

1. Use the Office for National Statistics (ONS) effectively: draw on "the particular role of the ONS as an independent central body to collect and collate data".
2. Work with industry to secure safe access to industry data (for example through more initiatives like the Food Data Transparency Partnership).
3. Engage with analysts and researchers early for policy evaluation: "design that upfront".
4. Invest more in building the evidence base for health prevention policy. Prevention research, including vaccines, accounted for less than 6% of total funding for health research in 2018 (the last year for which there is full data available).[27]

What role should local authorities play in delivering a cross-government health agenda?

Local authorities play a crucial role in improving health and tackling health inequalities. They shape local environments and deliver public services, both of which have a major impact on how people experience the social determinants of health.[28]

As such, while participants agreed that government should lead a national strategy for health from the centre, they argued that local authorities should have a voice at the table for designing policy, and should be given the latitude to decide how centralised policy will be precisely delivered in their area, according to their local priorities. As one participant recommended:

> ***"You have to give local communities more say and input into how things are delivered."***

Participants argued that central government has "lots to learn from regional and local systems" for managing health inequalities. One participant suggested that government could revive a network of local health inequalities support teams, which fed lessons from local experiences back into central government:

> ***"[There used to be] support teams, which were all about local knowledge and bringing that together with a national health inequalities support system. You could roll those out. They were cheap as chips [but really valuable]."***

Conclusion

Stagnating health outcomes, and large and widening health inequalities, will be one of the big policy challenges facing the next government, whatever its political composition. Preventing population ill-health has to be a political priority for both Rishi Sunak and Keir Starmer if they are to meet their respective pledges to reduce pressure on the NHS. If the next government is serious about tackling health inequalities, this roundtable has raised a set of tests for policy makers in designing their approach, summarised here:

On ambition:

- Does the government adopt a whole-government approach to improving health, where the scale and scope of the agenda match the scale and scope of the problem?
- Does the government have a robust strategy, with credible long- and medium-term goals, the key contingencies for meeting them, and a clear, evidence-based path forward for policy?
- Does the strategy set clear, well-designed health inequalities targets, with interim targets centred on improving outcomes in the 'building blocks' of health, like housing, jobs, education and healthy food?
- Does the government have a compelling communications strategy for the programme, which is realistic about challenges but emphasises the intersectional social and economic benefits of reducing health inequalities?

On accountability:

- Has the government planned how policies are going to be monitored and evaluated, making effective use of the ONS and external analysts where appropriate?
- Does the strategy have strong accountability mechanisms to keep it on track?

On delivery:

- Is there an 'honest broker' to bring departments together, co-ordinating and driving joint progress on reducing health inequalities?
- Has the government committed enough resources for effective policy programmes which will meet the strategy's targets?
- Are departments and officials encouraged and empowered to collaborate?
- Is central government leading and co-ordinating the agenda, but including latitude for local authorities to adapt it to their own contexts?

Poor health and high and rising UK health inequalities have been a persistent policy problem over the last decade. Health experts argue that improving outcomes requires co-ordinated action right across government to improve outcomes in the building blocks of health. So the question policy makers are asking now needs to grow beyond "Why hasn't this been done before?" to "How do we make it happen now?" This discussion has sought to give the next government answers to both.

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