Better benefits for health: plan to implement the central recommendation of the Acheson report

Douglas Black, J N Morris, Cyril Smith, Peter Townsend

The Old Forge, Whitchurch on Thames, Reading RG8 7EN
Douglas Black, *past president, Royal College of Physicians*

Health Promotion Research Unit, London School of Hygiene and Tropical Medicine, London WC1E 7HT
J N Morris, *emeritus professor of public health*

Cornwall Gardens, London SW7 4AE
Cyril Smith, *past secretary, Economic and Social Research Council*

London School of Economics and Political Science, London WC2A 2AE
Peter Townsend, *visiting professor of international social policy*

Correspondence to: Professor Townsend

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Call for a plan to implement the message of the Acheson report

As authors of the Black report, we welcome the report of the independent inquiry into inequalities in health by the scientific advisory group under the chairmanship of Sir Donald Acheson.[1 2] In particular, we welcome the attention given in the report to the increasing problems caused since the late 1970s by the rapidly widening gap in living standards. We also welcome recommendation number 3 (among the 39 principal recommendations) which specifies the need for policies to "reduce income inequalities and improve the living standards of households in receipt of social security benefits."[1] The report specifies that benefits in cash or in kind must be increased to reduce "poverty in women of childbearing age, expectant mothers, young children and older people." Nine other recommendations (numbers 8, 13, 20, 21, 22, 27, 31, 35, 36) were explicitly linked to recommendation 3, reinforcing the call for integrated action to alleviate unemployment and the deprived condition of many ethnic minority groups, elderly and disabled people, and families with children; and increase benefit levels and real living standards. Another 10 recommendations are concerned with meeting material needs in schools, housing, the environment, transport, and diet. These priorities reflect those expressed in our 1980 report. We said then: "We have tried to confine ourselves to matters which are practicable now, in political, economic and administrative terms, and which will, nonetheless, properly maintained, exert a long-term structural effect .... We have continued to feel it right to give priority to young children and mothers, disabled people and measures concerned with prevention .... Above all, the abolition of child poverty should be adopted as a national goal."[2]

Although the cost of implementing our recommendations was not as high as was claimed by Patrick Jenkin, who was secretary of state at the time, affordability was a key issue then as now. History shows that governments can introduce radical changes but, when they occur, they are ordinarily built on precedents and are divided into a succession of steps. To be influential, scientific advice has to be pitched in a practicable and manageable, as well as desirable, form. What matters most in 1999 is that the government changes the direction of trends that increase poverty and inequality. This change depends on mobilising popular support for a number of principal measures and on introducing new institutions at the same time as strengthening existing ones. There exists overwhelming evidence of support from national opinion surveys for the kind of measures presented in table 1.[3]

Summary points

- The 1998 Acheson report echoes the findings of the 1980 Black report that the gap in inequalities in health has been steadily increasing and that differences in material deprivation are a major cause of the increase
- The likely effects on inequalities in health of the chief policies implemented in the 1980s and 1990s still need to be estimated so that strategies to improve health can be improved
- The level of benefit that is minimally sufficient to maintain health and effective working and social capacity among different types of families needs to be defined and related to a programme to improve benefits
- A staged programme of the action needing to be taken by different government departments needs to be specified by the government

Affordable reduction of inequalities of health

We believe that it is possible and desirable, following the publication during the past two decades of the evidence reviewed by Acheson and his colleagues, to reach a scientific and popular consensus about the necessary combination of measures required to tackle this problem. The Acheson group, unlike ourselves, was expected to keep "within the broad framework of the government's overall financial strategy."[1] This included the chancellor's strict limits on public expenditure. Accordingly, policies to improve benefits were not specified and costed. However, the group expressed the same priorities as we did in 1980. In table 1 we have reproduced the principal recommendations made in our report with estimates of cost made

at the time by Margaret Thatcher's government,[4] and we have updated these estimates to the late 1990s with information supplied by the Department of Health in a written answer to a parliamentary question in late 1998.[5] Although an exact estimate of current costs would depend on allowing for different sources of potential revenue as well as changes in the population affected, these estimated costs may provide a useful basis for agreement on how the measures required to implement the Acheson report might be reached.

In 1980 there were, in theory, many alternative options available to help solve the United Kingdom's divisive problem of the widening gap in living standards. The Black working group recommended a combination of measures, most of which could have been introduced through existing legislation, which had a great deal of public support, and which would have made a substantial and measurable initial difference in meeting what was then, and is even more so now, a huge national problem.

We believe that policy recommendations should routinely be costed. This was done in the Black report. As table 1 shows, in relation to national measures of gross domestic product, or even the current cost of social security, the extra resources needed were not unachievable. In today's terms important advances could be made for less than 2% of the gross domestic product or about one tenth of the expenditure on social security. The total amount is of an order illustrated by the chancellor's decisions in 1997-8 to introduce the windfall tax (which should generate £5bn ($8bn) between 1997 and 2002) and to change tax allowances and National Insurance contributions. Another indicator is the £2.5bn surplus of contributions overpayments in the National Insurance Fund in 1997-8, which will rise to £7bn in 2000-1.

Table 1 Annual estimated cost of meeting the principal recommendations of the Black report on inequalities in health

Recommendation	1982[4] (£m)	1982 costs in 1996 prices[5] (£m)
10 Free milk for children under 5	300	700
12 Expansion of day care for children under 5	550*	1250
23 Special programmes in 10 areas with highest mortality	65	150
24 Child benefit increased to 5.5% of average gross male earnings	950†	2200
25 Age related child benefit	1275‡	2900
26 Maternity grant increased to £100	60	140
27 Infant care allowance	440§	1000
28 Free school meals for all children (net extra cost)	640¶	1460
29 Comprehensive disablement allowance	1175**	2700
Total annual cost	5455	12 500
Total cost (as % of gross domestic product)	2.2	1.7‡
Total cost (as % of social security budget)	13	11.7‡

*An initial capital cost of about £300-£400m would also be required.
†Cost of raising child benefit to £7.57/week.
‡Assuming average increase of £3/week for children aged 5-15.
§The cost of a benefit of £5.85/week if half of the 2.9 million women at home looking after children had a child under age 5.
¶Assuming 70% uptake.
**As estimated by the Disability Alliance in 1981.
‡As percentage of 1996 figure.

Table 2 Number of people (children, when data available) in millions living below given standards of income, excluding people who are self employed.[13] Data adjusted according to the retail price index

Standard	1979	1993-4	1994-5	1995-6
Below lowest tenth of 1979 median income	2.8	3.0	2.9	3.0
Below half of 1979 average household income	4.5 (1.2)	4.35	4.25	4.4 (1.3)
Below half of contemporary average household income	4.5 (1.2)	11.6	12.1	12.2 (3.9)

Policies causing standards of living to diverge

The task ahead is daunting but must be accepted. One problem, which has not been examined by successive governments during the past two decades, is the effect of specific policies on trends in the inequalities of living standards and, hence, health. The biggest influences on structural trends need to be identified and explained. In the United Kingdom these influences include the abolition of the link between social security benefits and earnings, restraints on the value of child benefit, abolition of lone parent allowances, abolition of the earnings related addition to incapacity benefit (which enabled people who were disabled before reaching pensionable age to draw early on their entitlement to the State Earnings Related Pension Scheme), and the substitution of means tested benefits for universal social insurance and non-contributory benefits for particular population categories such as disabled people.

We estimate conservatively that but for changes in entitlement to social security benefits the poorest 20% of the population would today have about £5bn (20%) more in aggregate disposable income, that the ratio between the richest and poorest 20% would be reduced, and that poverty by European standards would be reduced by more than one third.

The problem of poverty is larger than is often represented.[6–12] Even narrowly drawn government statistics, for example the annual Department of Social Security reports on households with below average income, reveal a serious divergence of living standards in the 1980s and 1990s.[13] Thus, in the 1990s the number of adults and children with incomes below the low income standards set for 1979 has remained as high as, or even higher than, in 1979 (table 2). This represents an "absolute" standstill or deterioration in their living standards. The latest report shows that in 1979 1.2 million children were living in households with incomes below half of the national income after housing costs but, despite a big increase in living standards nationally and among wealthy people in the intervening 17 years, there were 1.3 million children below that standard in 1996-7.[13] If instead we look at the "relative" situation and take average household income as it was in both 1979 and 1996-7 then the number of children in households earning less than half that average grew from 1.2 million to 3.9 million.

Denying even half of the average household living standards to so many children is bound to impair both health and access to education, gravely diminishing the stock of national skills. The widening gap has recreated and worsened the problem of two nations: we must do whatever is required to banish it.

The problem is growing. The latest national survey data show that the poorest 20% of households (more than 11 million people), who depend for 80% of their income on benefits, had an average disposable weekly income of only £86 a week (at 1997-8 prices) in the financial year 1994-5 and, three years later, £87.[14] The richest 20% of households had an average of £707 in disposable weekly income in 1994-5, and this increased to £753 a week in 1997-8. Table 8.3 of these data shows

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Differences in material deprivation are one cause of the increase in health inequalities

that the richest 20% had 8.2 times the income of the poorest 20% in 1994-5 and 8.6 times their income in 1997-8.[14] Late into the 1990s the gap in disposable income continues to widen.

The part played by successive policies in redirecting income trends has not been examined in reports on public health, almost as if there were no connection between government measures and changes in the structure of society. These links must be shown. The Acheson report has made a start, pointing out that while average household income has grown by 40% in real terms during the past two decades it has grown much faster among the richest in the population. "For the poorest tenth, average income increased by only 10 per cent (before housing costs) or fell by 8 per cent (after them)."[1] However, this statement is not precise; it needs clarification and an account of the exact contributions made to the trend in different years by policy changes. Indeed, a brief paragraph on income distribution early in the report which is intended to set the socioeconomic scene seems to contradict this statement. This paragraph describes increases in "median real household disposable income before housing costs," and shows that "the bottom decile point rose by 62 per cent from £74 per week to £119 per week."[1] But this covers the years 1961 to 1994. This was a time when, as the report later states, there was a movement towards greater equality—in the 1960s and 1970s—followed by a "reversal" of this trend.

These two periods of recent British history, roughly dividing the 1980s and 1990s from the 1960s and 1970s, must be distinguished. A computerised simulation of the national distribution of income, whereby the effect of different recent and prospective policies can be more exactly described and conclusions drawn, could be sponsored by the government and undertaken by the Office for National Statistics.

Adequacy of benefit

The second problem to be neglected by successive governments is the adequacy of benefit. Defining a poverty line has become increasingly important both internationally and scientifically. A breakthrough occurred in 1995 with the agreement to issue a declaration and programme of action after the world summit on social development, which had been convened by the United Nations. The declaration was signed by 117 countries, and individual nation states committed themselves to the preparation of national plans to eradicate poverty by applying two standardised measures of "absolute" and "overall" poverty.[15] In the United Kingdom, a national opinion poll carried out in late 1997 found that 20% of the population perceived themselves as living in "absolute" poverty.[16] The people surveyed gave estimates of income need which, when aligned with the composition of their households, showed that they considered that income support levels were generally from 25% to 50% too low. Expert statistical and scientific work on household income needs, some of it recent, broadly confirms this scale of shortfall.[7–12 17] The combination of scientific investigation and democratically representative opinion polling provides forceful evidence of the severity of this national crisis.

Concerted radical action to improve health

In the 1998 budget the chancellor announced a welcome increase in the rate of child benefit together with improvements in income support rates for children, to take effect from April 1999. However, the increase in child benefit applies only to the eldest or only child in the family and, since the real value of the benefit had fallen, it primarily represents a catching up exercise. If the chancellor decides to tax the benefit, a move that has been suggested but for which there is little support,[18 19] the benefit may be withdrawn from higher income households later and converted into a means tested benefit. In 1999 the government will also replace the family credit with the working families tax credit, which is designed to increase the level of benefit as well as the numbers entitled to it. This credit is also means tested and is intended to increase by about half a million the number of low income families receiving such a credit. On the basis of written answers to parliamentary questions, investigations into the minimum necessary family income, and after protracted research some observers have concluded that the new credit "will not provide Low Cost Allowance level incomes to two-parent families."[17] On all the available evidence, means tested benefits are poor in coverage, costly to administer, do not encourage savings, and are generally inadequate in meeting needs, as well as being unpopular.

The Acheson group argues for policies that "increase the income of the poorest," and shows how important it is to raise benefit levels, restore the earnings link to national insurance and other non-means tested benefits, and introduce more progressive taxation.[1] These general recommendations have to be turned into exact operational elements of a bold and integrated national plan.

Social exclusion and poverty

How might an effective antipoverty programme be related to the government's strategy to reduce social exclusion? In its third report to the prime minister in September 1998 the Social Exclusion Unit proposed a broad programme for "tackling poor neighbourhoods."[20] A "new deal for communities" will begin in 17 districts, with more areas able to join the programme later. There will be funds to develop and implement community based plans covering everything from jobs and crime to health and housing. Ten government departments will be involved. Their assignments are to get more people into work; improve the social management of neighbourhoods and housing; reduce antisocial behaviour; develop schools and youth facilities; improve access to shops, financial services, and information technology; and make the government work better.

The strategy is imaginative and undoubtedly obliges different departments and specialists to work together. However, some observers believe that the strategy is tilted too far towards the long term and that more urgent structural action needs to be taken to begin to remedy some of the worst problems of poverty. These problems need to be dealt with immediately.

The work of the unit is distinct from that concerned with poverty. The unit's approach is interdepartmental, pump priming, and experimental. The department is preoccupied with antisocial behaviour and access to services, jobs, and other opportunities rather than with the scope and adequacy of benefits and other influences on the distribution of income.

A single paragraph in the command paper discusses social security. "Problems with the benefit system are being addressed by welfare reform, the Working Families Tax Credit, and the minimum wage … . The relationship between housing policy and housing benefit is being reviewed." Poor pensioners are to be helped by "boosting income support levels to provide a guaranteed minimum income," getting more pensioners to apply for benefit, and by making annual payments towards their winter fuel bills.[20] The Acheson report confirms that a more ambitious programme is necessary. Alternative strategies to reduce poverty, especially those not involving additions to means tested programmes, have not yet been discussed.

Conclusion

We have argued for public recognition of the central message of both the 1998 Acheson report and the 1980 Black report on inequalities in health—that is, the need to increase benefits for poor people, especially families with children. In conjunction with other recent reviews of income and health,[21–25]—including those formally sponsored by the royal colleges of general practitioners, nursing, and physicians; the Faculty of Public Health Medicine; Action in International Medicine; and the *BMJ*,[26]—we call for acknowledgment of the harmful effects on the distribution of income and, therefore, on health of particular policies (such as the abandonment of the link between earnings and benefits, cuts or reductions in benefits for some vulnerable groups, and the inadequate level of child benefit). We also recommend that:

- Future policy proposals that affect income should be accompanied by estimates of their effects on the structural distribution of income and their likely general effects on health, and
- Priority should be given by the government to the annual determination of what are "adequate" levels of benefit (this could be incorporated into the poverty audit announced on 17 February 1999 by the secretary of state for social security).

We propose that a government report should be prepared that defines the minimum income and benefit needs for differently constituted families as the basis of a phased programme designed to increase benefits accordingly. This should be the government's top priority. This would represent a necessary step towards implementing the recommendations of the Black and Acheson groups; making improvements in child benefit, lone parent benefit, incapacity and disability living allowance benefits; and improving the basic state retirement pension.

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