Dispelling the Myths of the Black Report: A Memoir

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Before coming to the Black Report itself, perhaps I may remind the gathering of the background to the events at the time. The Conservative Government had come into office in May 1979 committed to establish a firm control of the public finances, to reduce public expenditure and to make room for progressive cuts in the burden of taxation. In the run-up to the election, as shadow spokesman for Health and Social Security, I had secured agreement from my colleagues that spending on the NHS would *not* be cut. Indeed, I gave an election pledge that, if elected, we would stick to the spending plans of our predecessors as set out in the 1978 PESC Report. Although the Treasury tried to secure cuts, I was able to hold the Cabinet to that pledge. As well as maintaining the planned growth in revenue spending, I was able to restore the 30 per cent cuts in capital investment of the preceding Government. What was clear, however, beyond a peradventure was that I could not look to the Treasury for any significant *increases* in NHS spending beyond the growth agreed by Cabinet.

Professor Blume's valuable notes about the origins of the report add a useful dimension to my understanding of what happened. I am told that it was Professor Brian Abel-Smith who, in February 1977, first suggested to Sir Douglas Black that a study should be launched on health inequality, 'analogous to Sir Keith Joseph's initiative on the cycle of deprivation'. This was put to David Ennals, and in March 1977 it was decided to commission a literature survey from a small group drawn from the organisation of the Chief Scientist. Sir Douglas invited Dr Cyril Smith, Secretary of the SSRC, Professor Jerry Morris and Professor Peter Townsend to help him in this task. Later that

month, Mr Ennals, in a public speech, referred to this: 'The first step is to put together what is already known about the problem.'

In the event, it was nearly nine months after the 1979 election that the report reached DHSS officials. My researches confirm Professor Blume's account that serious differences had emerged between the two professors. It is also clear that DHSS officials in touch with the progress of the work were becoming very concerned about some of the methodology being used by the group.

When the report was sent to the department, the files show great dismay by officials. This was because, on the one hand, it appeared to offer little that was new in its analysis of the causes of health inequalities, and, on the other, it proposed measures costing upwards of £2 billion (later estimates put this much higher), with no attempt at assessment of whether the programme proposed could be done or, if done, what it would achieve.

Officials wrote that it was an 'unsurprising' conclusion that there were many factors at work leading to the undoubted inequalities described; that the evidence was in general poorly presented, being piled up piecemeal with any connecting logic hard to discern; that the analysis lacked rigour; that there was much on trends and on international comparisons without much in the way of illumination. A particular criticism was the bias towards areas of *greatest* inequality, with figures taken from opposite ends of the range representing small percentages of the population. Evidence which did not fit the thesis was discounted. 'The group's sympathy for a particular explanation was self-evident.'

Given this provisional assessment by my advisers, I was initially sceptical about publication. There are many minutes by officials on the files arguing about whether to publish or not, and if to publish, how that might be done. By the time they were able to put a clear departmental view to me on this, they had concluded that the balance of the argument lay with publication, but in a way that clearly distanced the department from the recommendations.

Interestingly, the department's medical advisers were rather less dismissive. They drew attention to a number of the minor recommendations about better information, improved statistics, and more research, and argued that there were certainly issues that should be taken up seriously by the department. They warned that the medical profession would certainly expect to see a proper follow-up.

The submission to ministers reached me in May 1980. It reflected the wide-ranging criticisms already rehearsed above and described the report as a mixture of semi-digested data and proposals for massive public expenditure. 'It reads like a policy manifesto from a party who do not expect the responsibilities of office.'

The submission went on to discuss the options about publication, and concluded that publication was inevitable. I was happy to accept that advice. The recommended format was exactly what finally came out – a limited departmental in-house publication, very plain, typescript, with a soft cover. I was recommended to provide a foreword and the files show that this went through several drafts. (For ease of reference, I attach a copy of the foreword as published.[1]) Ministers had, of course, many other preoccupations, notably implementing 'Patients First', and it was not until 8 July that the report with my foreword was ready to go out. We were, however, faced with a timing problem.

I was strongly advised that the report, with its unrealistic proposals for big increases in some social security benefits, should not become embroiled with the controversial social security upratings which were currently before the House. Thus it was that it was not until after the House rose for the summer recess that it was possible to publish the Black Report.

In order to make sure that the report was placed firmly in the public domain, copies were sent to over 100 newspapers, specialist journals and broadcasting media, with a notice that further copies could he obtained from the department. The files record that most newspapers carried this notice as part of their coverage. Copies were placed in the vote office of the House, and in the library. Initially. we underestimated how many copies MPs would require in the first week or two of the recess, and more had to be run off. It may have been this that sparked the accusation that we tried to suppress the Report.

The Report figured in a Commons debate on the first day back after the recess. In my speech opening the debate, I said: 'The Government are right to treat the report with considerable caution. A number of proposals in it warrant careful consideration, and that we are giving them.'[2]

In a speech in Cardiff the following March, after we had done some more research, I was able to answer the question 'Do poor people have less access to the NHS than better-off people?' as follows:

> The Black report thought 'yes', but they did recognise the difficulty of interpreting the data and they made clear that their conclusions were very tentative. Well, my department has looked at a whole lot more evidence. We have compared the total use of the health services, and we have found that people with lower incomes, more of whom are likely to be elderly, tend to receive proportionally more services that the average for the population as a whole.

After a reference to support for this from Collins and Klein of Bath University,[3] I concluded:

> A great deal more study of what is an enormously complex problem is needed before we can be sure of the answers. I am considering what further research should be put in hand. My aim is clear: I want the people of this country to enjoy better health. That is the purpose for which the health service exists, and when I say 'the people', I mean *all* the people.

I attach a copy of the press release for this speech.[4] I also attach a copy of another release,[5] dated July 1981, in which I set out our policy on RAWP as the principal means of redistributing resources in favour of deprived communities – growth in the three most deprived regions at *six* times the rate going to the four Thames regions. This was a significantly faster differential than I had inherited.

I have had to live with a mythology about the Black Report which in some circles lives on today. The report was hailed by the Left as a major signpost for future policy. While it undoubtedly included a number of useful pointers, many of which have influenced subsequent policy decisions, the main thrust of the report was seriously flawed. Its methodology was suspect, and its main recommendations wildly unrealistic.

I was accused of suppressing the report. In fact, I published it in full, sent copies to all the relevant media, made copies available for sale by the department and ordered a reprint when copies ran out.

I was accused of ignoring even the less costly recommendations. In fact, many of these were followed up; research was commissioned and, over the next few years, my successors devised a number of policies to steer resources to deprived communities.

I was accused of not caring about inequalities. True, I have always

been more concerned about poverty and deprivation than about inequality. In contrast to my reaction to Black, I gave full support to the initiative of the London Health Planning Consortium in setting up the Acheson Study Group on Primary Health Care in 1979, and when the report was published in February, 1981, I said: 'Ministers attach the greatest importance to the work of the study group, which they regard as by far the best way of proceeding.' As this report was directed entirely to the problems of primary care in the very deprived areas of inner London, I firmly refute the accusation that I did not care.

NOTES

1. See Appendix A.
2. Hansard, 27 Oct. 1980, Cols. 82/83.
3. E.M. Collins and R. Klein, 'Equity and the NHS: Self-reported Morbidity, Access and Primary Care', *BMJ*, 281 (25 Oct. 1980), pp.1111–15.
4. See Appendix B.
5. See Appendix C.