What needs to happen to reduce health inequalities? Researcher, policy and advocacy perspectives

Dr Kat Smith
Global Public Health Unit
University of Edinburgh
Email: Katherine.Smith@ed.ac.uk

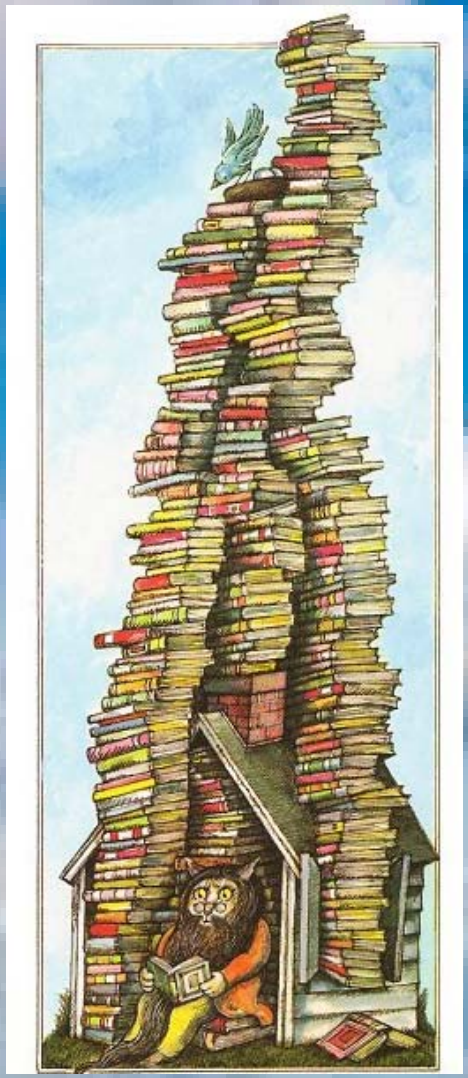
Outline of presentation…

- Perspectives on where we are now with efforts to reduce health inequalities
- Commitments to evidence-based decision-making
- What kinds of policies and interventions do researchers believe are likely to reduce health inequalities in the UK?
- Issues with achieving these kinds of policy changes

Where are we now? Views from different sectors…

Sector	Widely expressed views
Academics	• Still waiting for policies to reflect the available evidence • Still waiting for the research community to develop and promote clear, evidence-informed policy recommendations for reducing health inequalities
Civil servants	• Unsure about progress in reducing health inequalities (especially in England) • Still waiting for researchers to provide clear, evidence-informed recommendations for policy proposals that will reduce health inequalities • Restricted by limited powers (especially in Scotland and Wales)
Politicians	• Embarrassed by lack of progress with reducing health inequalities (especially in the Labour Party, in England) • Wary of health inequalities as a policy issue given lack of evidence-informed 'solutions'
NGOs and other policy-focused PH advocates	• Waiting for solution-orientated research proposals that they can promote • Searching for links between health inequalities and issues / diseases they represent
Practitioners and local decision-makers	• Some sense of local powerlessness and frustration with 'lifestyle drift' at national policy level • Frustration with available research - still waiting for researchers to provide clear, evidence-informed recommendations for policy proposals that will reduce health inequalities at the local level • Very concerned about likely impact of current changes in welfare and economic policy and desperate for research relating to this.

More positively…



Across the interview and focus group data, it is clear that there is widespread, cross-sectoral interest in the evidence relating to health inequalities

Books to the ceiling,
Books to the sky,
My pile of books is a mile high.
How I love them! How I need them!
I'll have a long beard by the time I read them.

Arnold Lobel [1933-1987] children's author

Government policy to be anecdote-based

ALL UK policy decisions are to be based on anecdotal evidence, the government has announced.

After health minister Anna Soubry said "glamorous" cigarette packets caused her to smoke, the government said genuine evidence would be replaced by anecdotes, which are cheaper and more interesting.

They do look pretty amazing

A government spokesman said: "Why waste money on actual research when you can just think of something that happened to you, your uncle Trevor, or someone you met in the pub?

"Some of the anecdotes we've gathered are frankly shocking. Apparently there's a man in Chester who's signing on but gets a new 52" TV and a massive slap-up curry delivered to his house every day. Yes, every day.

"Anecdotes have also been helpful in David Cameron's anti-porn campaign, with one Mumsnet user reporting that her son had stumbled across images of large-breasted milfs after typing 'GCSE revision guides' into Google."

The new policies will include a price increase on fizzy alcoholic drinks, because the bubbles make you more pissed, and a total ban on sitting too close to the TV, which it is

But is our commitment to evidence-based policy holding us back?

Researcher and policy advisor (Scotland): *'The difficulty we've got [with evaluating interventions] is that so **many of the things that are likely to work for health inequalities aren't projects - they're big policies**. So **we're waiting for somebody to implement a policy so we can evaluate it...**'*

Does a focus on evidence pull researchers downstream?

Academic (interviewee): *'[X is a professor] who I like very much. […] S/he did a [prestigious] report and at the launch, s/he started […] off by showing something that* ***must be to do with the nature of British capitalism*** *- it's not plausible really that it's about a single policy decision.* ***And then […] all of his/her recommendations [are at] the micro or meso level*** *- they're all… resilience training or at best how to get good managers […] which is just* ***woefully different*** *from the level of the changes we've seen in the rise of [the problem].'*

The ongoing problem of 'lifestyle drift'

'Lifestyle drift': "the tendency for policy initiatives on tackling health inequalities to start off with a broad recognition of the need to take action on the wider social determinants of health (upstream), but which, in the course of implementation, drift downstream to focus largely on individual lifestyle factors." (Hunter et al, 2009)

"A recurrent slippage occurs as the policy statements move from overarching principles to strategic objectives, with a broad concept of determinants giving way to a narrower focus on individual risk factors." (Graham, 2009)

An alternative/complementary approach to evidence – expert opinion

"What [is] lost in this process [of systematic reviewing] is a huge volume of information. It is assumed that studies, which did not use the favoured methods or had methodological weaknesses, have nothing to contribute. In areas where results are inconsistent it also gives far too much weight to the few articles selected. It requires an act of faith (or folly) to believe that this process produces more reliable conclusions than someone who has studied the field for many years selecting by some complex mental process, which cannot readily be described or duplicated, articles which seem to them particularly important or informative. The most trustworthy conclusions are likely to come from a combination of systematic review and expert opinion (judgement)."
(Kemm, 2006)

There are definitely some problems with this approach to garnering knowledge…

An online survey: what kinds of policies and interventions do researchers believe are likely to reduce health inequalities in the UK?

A bit more info on the survey:

- 99 policy proposals collated from a variety of sources;
- 41 researchers participated in the first (long) part of the survey (mostly academics, but some public sector researchers, mix of genders, disciplinary training, methodological expertise, career stage and length of time in field)
- 92 researchers participated in the second (much shorter) part of the survey

Researchers were asked to consider three statements for each of the policy proposals

1. Based purely on my expert opinion (i.e. not taking into account what is socially, politically or economically feasible) I believe this suggestion would reduce population-level health inequalities in the UK
2. I believe that the ability of this suggestion to reduce health inequalities is strongly supported by available evidence
3. Taking into account the current social, political and economic context, I believe that this is an appropriate policy recommendation for the health inequalities research community to make

Results: Based purely on expert opinion…

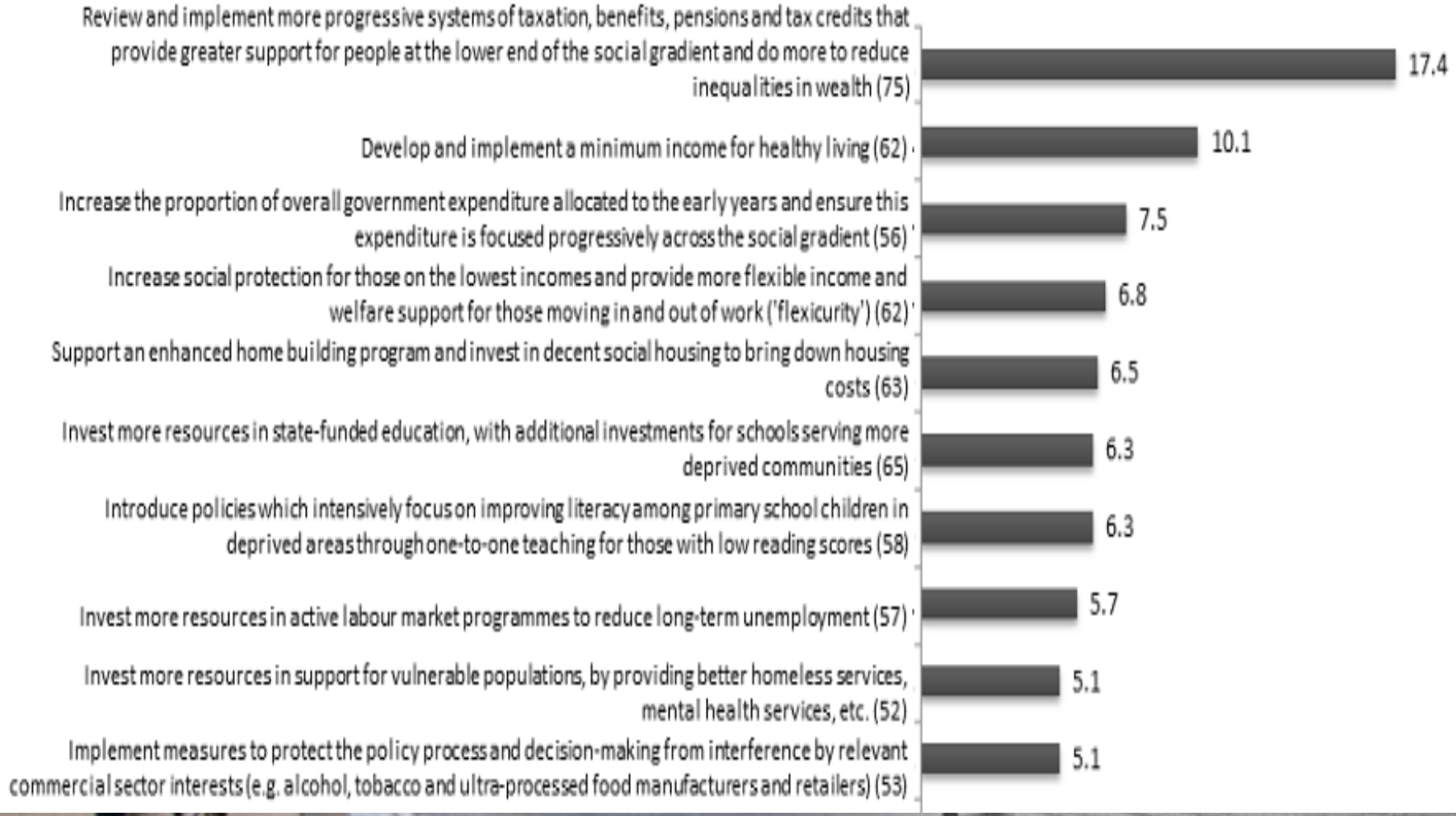
Policy proposal	% disagree or strongly disagree	% agree or strongly agree	Total number who answered this question
Review and implement more progressive systems of taxation, benefits, pensions & tax credits that provide greater support for people at the lower end of the social gradient & do more to reduce inequalities in wealth	5.0	92.5	40
Develop and implement a minimum income for healthy living	7.7	92.3	39
Invest more resources in support for vulnerable populations, by providing better homeless services, mental health services, etc.	00	91.7	36
Invest more resources in active labour market programmes to reduce long-term unemployment	2.5	90.0	40
Invest more resources in primary care health services serving very deprived areas	2.6	89.5	38
Support an enhanced home building program and invest in decent social housing to bring down housing costs	4.9	87.8	41
Increase the national minimum wage	10.0	87.5	40
Reduce speeds in urban areas, starting with the poorest areas (20mph is plenty)	7.5	87.5	40
Increase social protection for those on the lowest incomes and provide more flexible income and welfare support for those moving in and out of work ('flexicurity').	5.1	87.2	39
Increase the proportion of overall government expenditure allocated to the early years and ensure this expenditure is focused progressively across the social gradient.	0	87.2	39

Results: Based on available evidence…

Policy proposal	% disagree or strongly disagree	% agree or strongly agree	Total number who answered this question
Review and implement more progressive systems of taxation, benefits, pensions and tax credits that provide greater support for people at the lower end of the social gradient and do more to reduce inequalities in wealth	5.0	85.0	40
Fluoridate domestic water supplies (where this is not already done)	2.8	77.8	36
Provide stop-smoking services with additional targeting within poorer communities	0	74.3	35
Increase the price of tobacco products via tax increases	8.3	72.2	37
Increase social protection for those on the lowest incomes and provide more flexible income and welfare support for those moving in and out of work ('flexicurity')	5.1	71.8	39
Reduce speeds in urban areas, starting with the poorest areas (20mph is plenty)	10.3	71.8	39
Reduce the availability of tobacco products (both legal and illicit)	5.7	71.4	35
Introduce standardised packaging of tobacco products (i.e. remove branding)	2.9	70.6	34
Maintenance (and improvement) of the NHS in a recognisable form	5.9	70.6	34
Introduce a minimum price for alcohol products via minimum unit pricing	7.5	70.0	40

The results of the second stage of the survey, in which participants were asked to distribute 100 points according to the policy proposals they believed would have most impact on reducing health inequalities

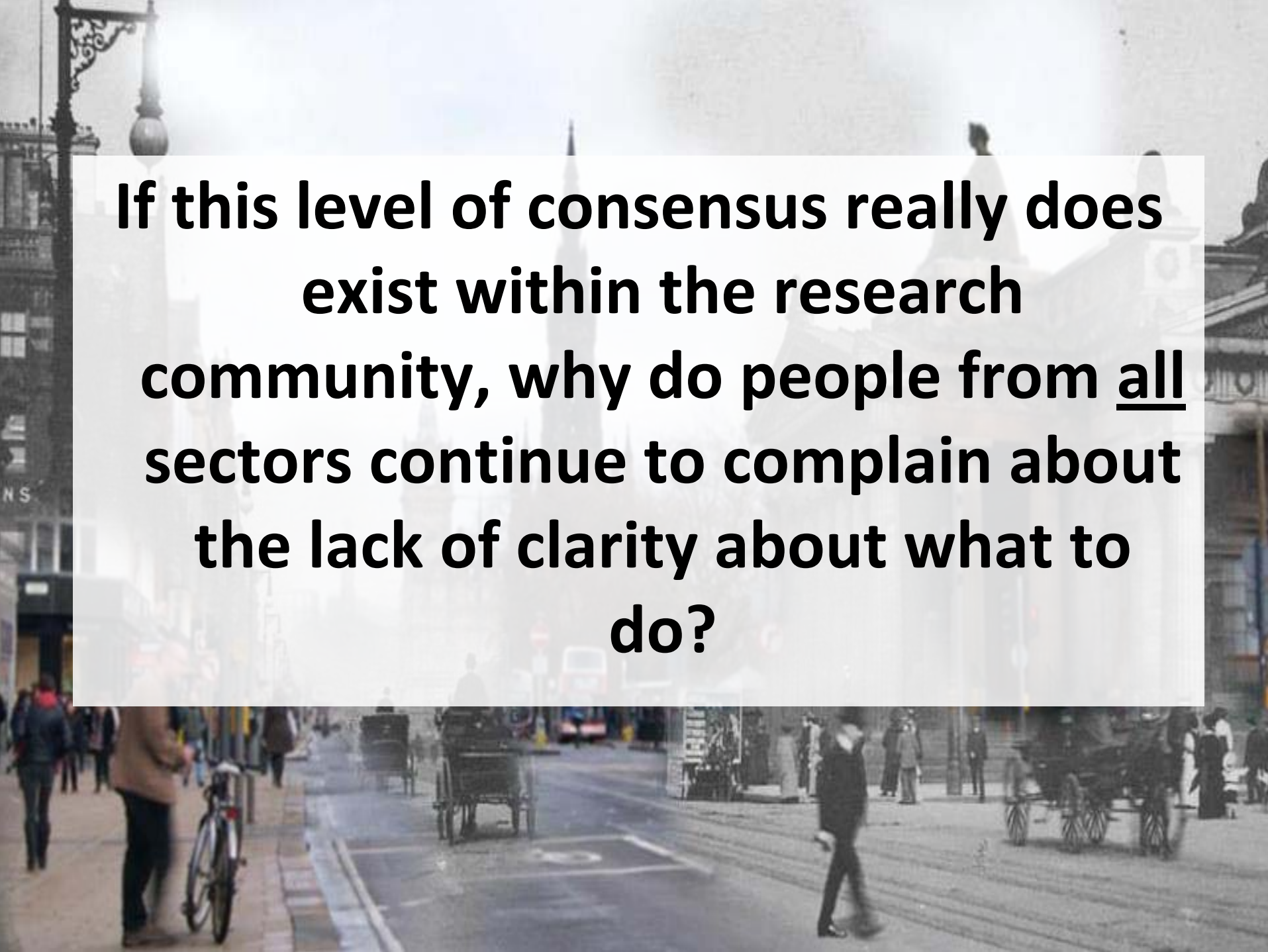
10 Most supported policy proposals



The results of the second stage of the survey, in which participants were asked to distribute 100 points according to the policy proposals they believed would have most impact on reducing health inequalities

Results: Based on available evidence…

Policy proposal	% disagree or strongly disagree	% agree or strongly agree	Total number who answered this question
Review and implement more progressive systems of taxation, benefits, pensions and tax credits that provide greater support for people at the lower end of the social gradient and do more to reduce inequalities in wealth	5.0	85.0	40
Fluoridate domestic water supplies (where this is not already done)	2.8	77.8	36
Provide stop-smoking services with additional targeting within poorer communities	0	74.3	35
Increase the price of tobacco products via tax increases	8.3	72.2	37
Increase social protection for those on the lowest incomes and provide more flexible income and welfare support for those moving in and out of work ('flexicurity')	5.1	71.8	39
Reduce speeds in urban areas, starting with the poorest areas (20mph is plenty)	10.3	71.8	39
Reduce the availability of tobacco products (both legal and illicit)	5.7	71.4	35
Introduce standardised packaging of tobacco products (i.e. remove branding)	2.9	70.6	34
Maintenance (and improvement) of the NHS in a recognisable form	5.9	70.6	34
Introduce a minimum price for alcohol products via minimum unit pricing	7.5	70.0	40



If this level of consensus really does exist within the research community, why do people from <u>all</u> sectors continue to complain about the lack of clarity about what to do?

Upstream policy solutions are difficult to implement:

Policy advisor (Scotland): *'There are some people… who say, well…* ***we can't actually… do structural change or very effective societal intermediary change****, therefore, at the very least, we should ensure that the health service corrects these inequalities.* ***So we can… target primary care, we can change the funding patterns and we can at least ensure that the disease effects of wider inequalities don't manifest themselves as unfairly as they do****. […] Others would say that's a terrible betrayal of our understanding of how these problems arise […] and that would be a justified criticism.'*

Particularly in devolved settings:

Civil servant (Wales): *'There are so many influences at play here, some that* ***we do not have control of because they're not devolved to us****, so things that you might want to do in terms of the* ***taxation system*** *etc, it's beyond our powers so we can't influence those. […] The* ***benefit system*** *[as well] so [there are] some real critical areas that we can't make policy in, so that's a* ***huge limitation for what we're trying to do****.'*

Researchers seem to be reluctant to make specific policy recommendations:

Senior academic: *'Well, obviously reducing income differences [is what is needed to reduce health inequalities].* ***I often shy away from saying how to do*** *it, because, of course, there are social policy experts and… even if you decide you wanted to do it through taxes and benefits, actually to know which benefits are most redistributive… […] So I always say, when people ask me about policy implications, that I think we need to redistribute income but I don't know whether you do that through education policies, through taxes and benefits, through minimum wages… all sorts of things. And I still… take that line because, as I say,* ***it's a technically difficult problem - to know what is the best policy to redistribute****…'*

Lack of coherent advocacy-coalition around health inequalities:

Politician: *'there's **no big lobby** for tackling inequality'.*

Senior academic: *'In tobacco we know what we need to do to a certain extent and there's a lot of consensus around what are the interventions at national, at policy level. So **I think the tobacco control community is very close knit**, both the policy people, the key advocacy groups and researchers and we function very well together. **I don't see that to the same extent in health inequalities**.'*

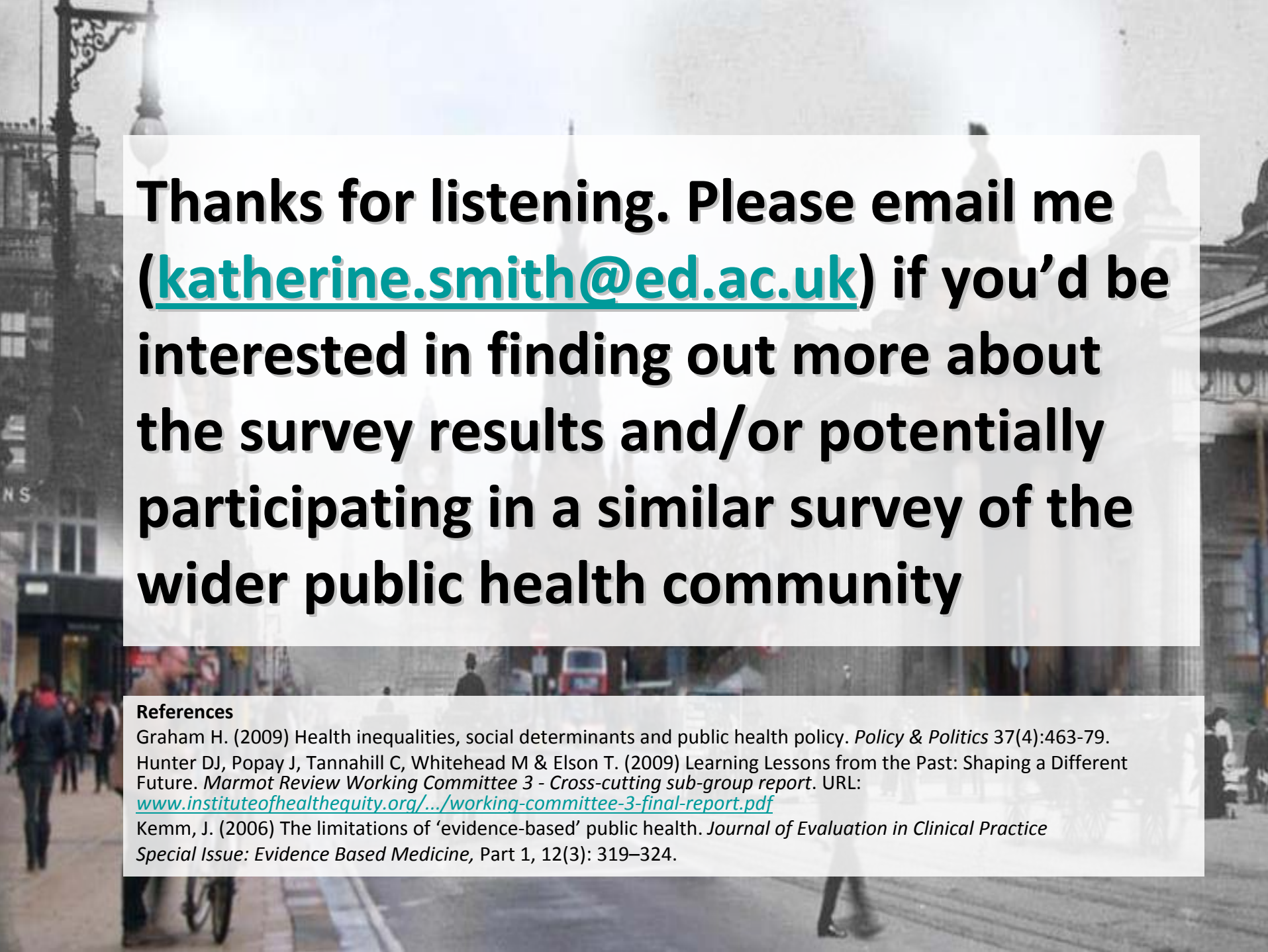
Unclear who is advocating / should advocate for evidence-informed policies to reduce health inequalities…

But researchers are often uncomfortable with this…

Interviewee (public health researcher, public sector, Scotland): *"That's a tricky one. I think that in my personal life, I'm absolutely an advocate;* ***in my work life, I am not paid to be an advocate*** *per se, I am paid to explain the evidence, but I think the evidence is very strongly in favour of particular policy positions and so I think I've got a duty to speak to those policy positions whether or not they're comfortable or whether or not they are the norm in the policy community. So that can often sound like advocacy but it's actually speaking towards the evidence, I hope [laughs]."*

So where does this leave us?

- There appears to be quite a lot of consensus around the kinds of policies that are likely to reduce health inequalities within the research community;
- However, policy recommendations for upstream responses remain vague and un-developed, with some belief it is not the responsibility of HIs researchers to provide 'policy solutions'.
- The research community appears to be divided in terms of what to do next: some think we need more focused, intervention-orientated evidence and some think we need to think bigger (focusing on upstream policy responses) and get better at supporting advocacy for reducing health inequalities.
- Yet it remains unclear who are (or could be) the advocates for evidence-informed policies to reduce health inequalities and it seems clear that many researchers are (understandably) nervous / cautious about taking on this role themselves.



Thanks for listening. Please email me (katherine.smith@ed.ac.uk) if you'd be interested in finding out more about the survey results and/or potentially participating in a similar survey of the wider public health community

References

Graham H. (2009) Health inequalities, social determinants and public health policy. *Policy & Politics* 37(4):463-79.

Hunter DJ, Popay J, Tannahill C, Whitehead M & Elson T. (2009) Learning Lessons from the Past: Shaping a Different Future. *Marmot Review Working Committee 3 - Cross-cutting sub-group report*. URL: *www.instituteofhealthequity.org/.../working-committee-3-final-report.pdf*

Kemm, J. (2006) The limitations of 'evidence-based' public health. *Journal of Evaluation in Clinical Practice Special Issue: Evidence Based Medicine,* Part 1, 12(3): 319–324.