



# **Lay understandings of health inequalities and potential policy responses - comparing data from a national survey and three citizens' juries**

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# Outline:

- Background - what kinds of policy responses to health inequalities in the UK do researchers promote?
- How does this compare to public understandings of health inequalities?

- Part 1: Meta-ethnography (literature review)
- Part 2: National survey (Opinium and Sarah Weakley)
- Part 3: Citizens' Juries

(Team: Kat Smith, Rosie Anderson, Gillian Fergie, Becky Hewer, Sarah Hill, Oliver Escobar, Alex Wright & Sarah Weakley)

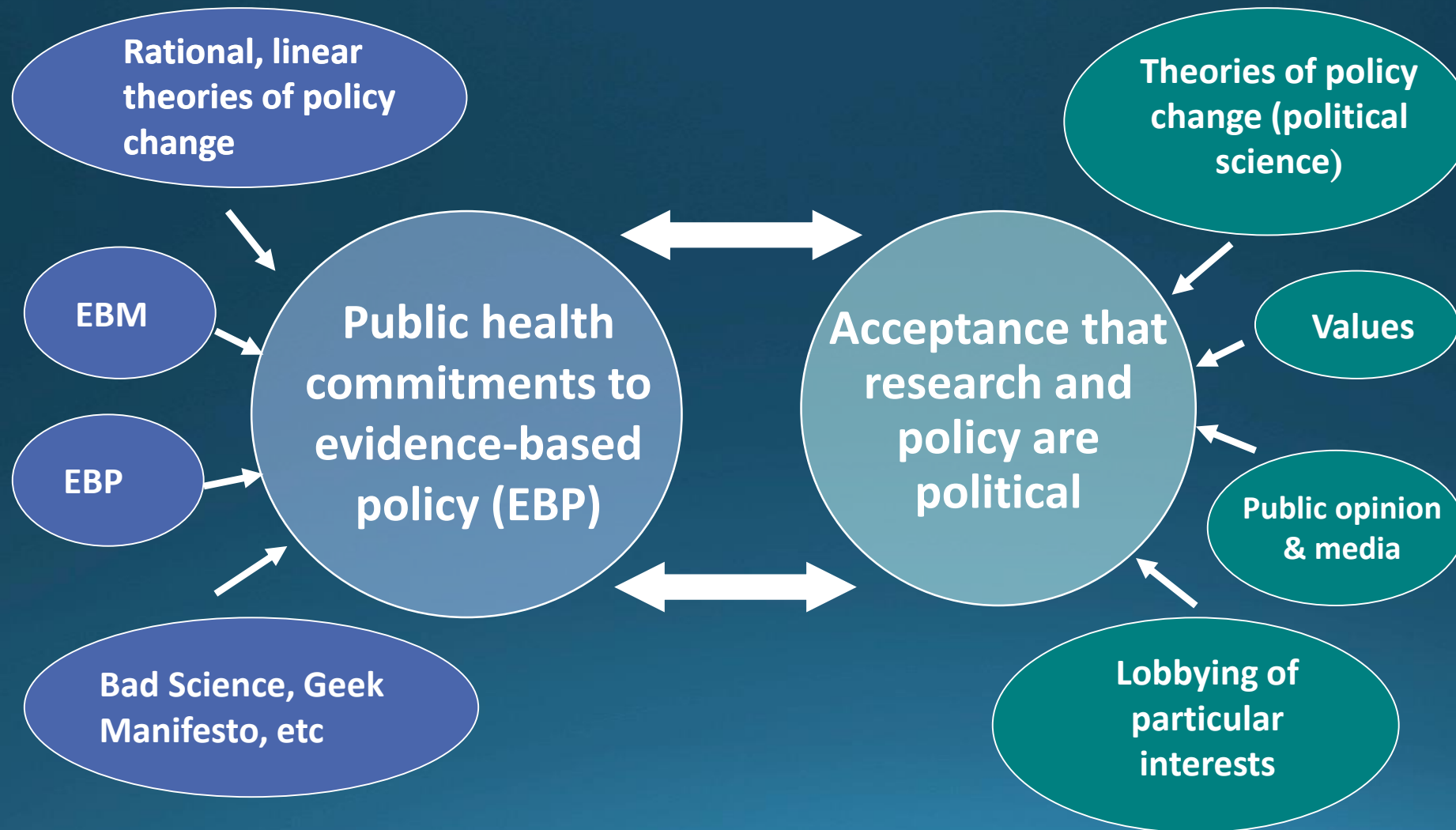
- Preliminary conclusions

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# Moving beyond 'politics' as the obstacle to EBP





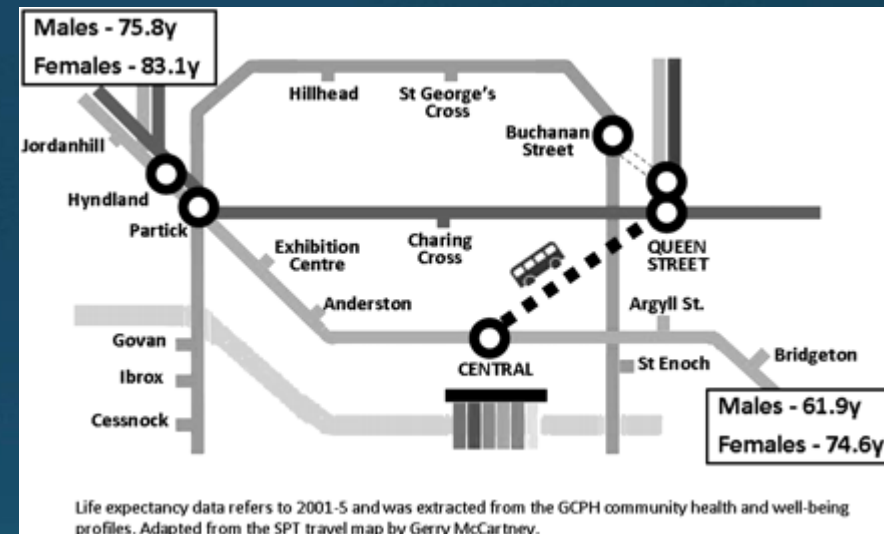
Calls for advocacy to achieve the necessary public mandate to tackle health inequalities...



“[W]e need more advocacy to make sure that elected governments have a democratic mandate to make the necessary policy changes. Reducing health inequalities requires large-scale policy change in many fields, and this change will have to be articulated in political party programmes.” (Mackenbach, 2011: pp573-4)

# Illustrative public engagement examples

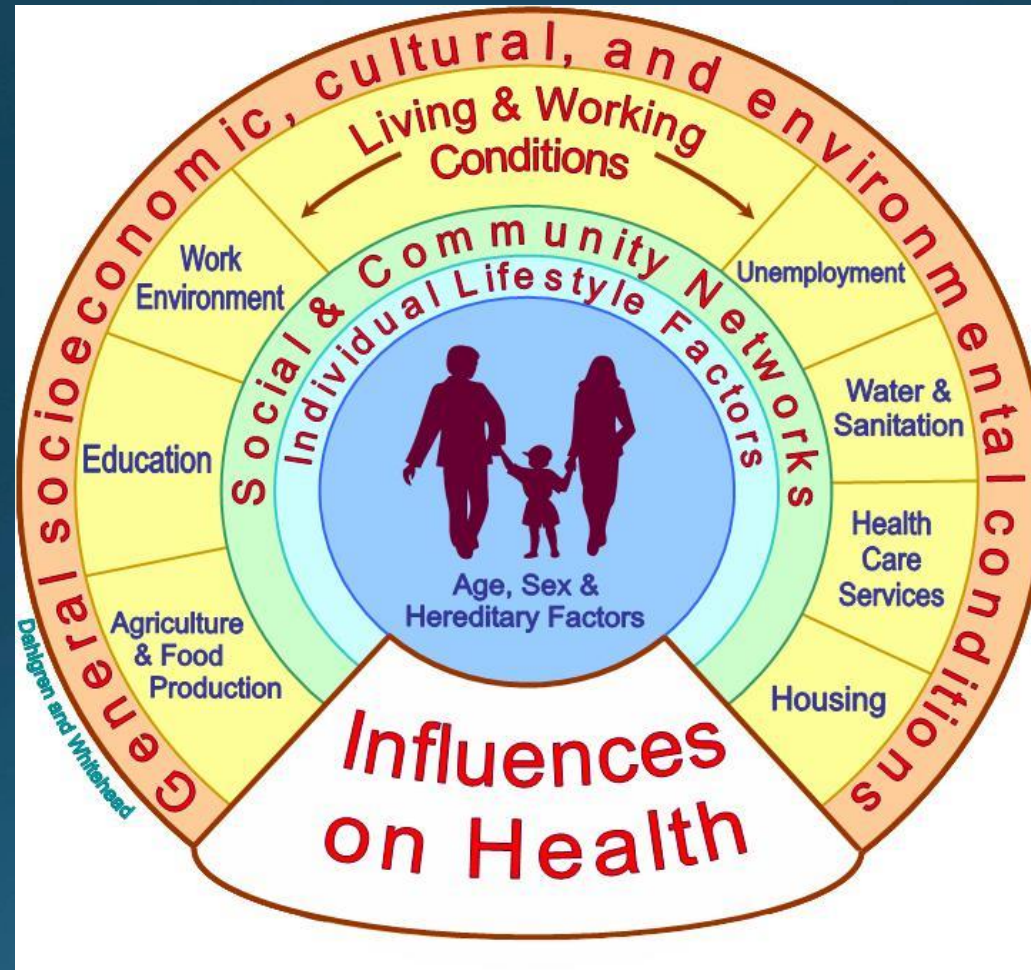
PUBLIC HEALTH LEAGUE									
	Team	P	W	D	L	F	A	GD	Pts
C 1	Chelsea	18	46	786	83	86	426	14	114
2	Tottenham	19	59	904	80	85	653	7	114
3	Crystal Palace	17	62	968	80	84	526	9	105
4	Man Utd	20	60	920	80	84	560	9	103
5	West Ham	19	57	1060	79	83	620	7	100
6	QPR	21	50	936	79	84	631	9	97
7	Arsenal	22	54	1025	78	83	849	5	89
8	Aston Villa	19	64	1062	78	82	691	8	80
9	Southampton	22	65	1053	78	83	726	8	73
10	Leicester	24	57	1078	77	82	573	8	72
11	Swansea	24	56	1065	78	82	562	12	66
12	Burnley	20	65	1297	78	82	698	10	57
13	West Brom	23	66	1112	77	81	791	8	52
14	Newcastle	24	60	1110	78	82	828	12	47
15	Stoke	19	67	1198	77	81	996	10	38
16	Sunderland	23	69	1203	77	81	1071	10	33
17	Hull	29	60	1210	77	81	837	12	31
R 18	Man City	24	63	1280	76	80	852	9	30
R 19	Everton	23	67	1206	76	81	810	10	29
R 20	Liverpool	23	67	1206	76	81	810	10	29



Gerry McCartney: <http://jech.bmj.com/content/65/1/94.full>

Clare Bamba:  
<https://www.dur.ac.uk/research/news/thoughtleadership/?itemno=24790>

So what kinds of policy responses have health inequalities researchers been promoting?



Dahlgren and Whitehead's (1991) 'Rainbow model' of the determinants of health



# 2010 Marmot Review:



“Reducing health inequalities will require action on six policy objectives:

- Give every child the best start in life
- Enable all children young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention”



# An online survey of health inequalities researchers...

- 99 policy proposals collated from a variety of (academic) sources (Marmot Review, academic articles, interviews);
- 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

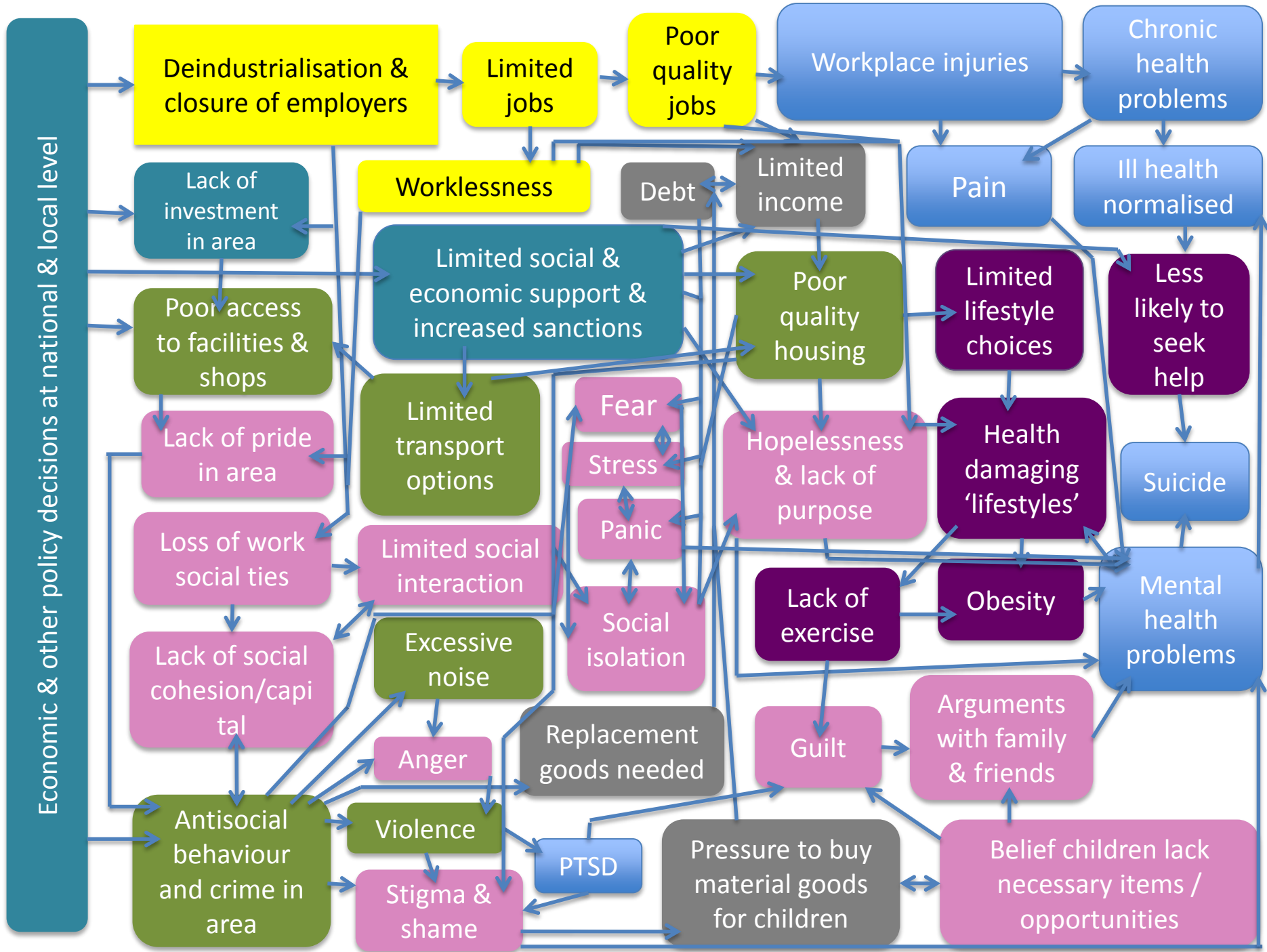
# Top Five Policy proposals for reducing health inequalities from researchers in Survey Part 2

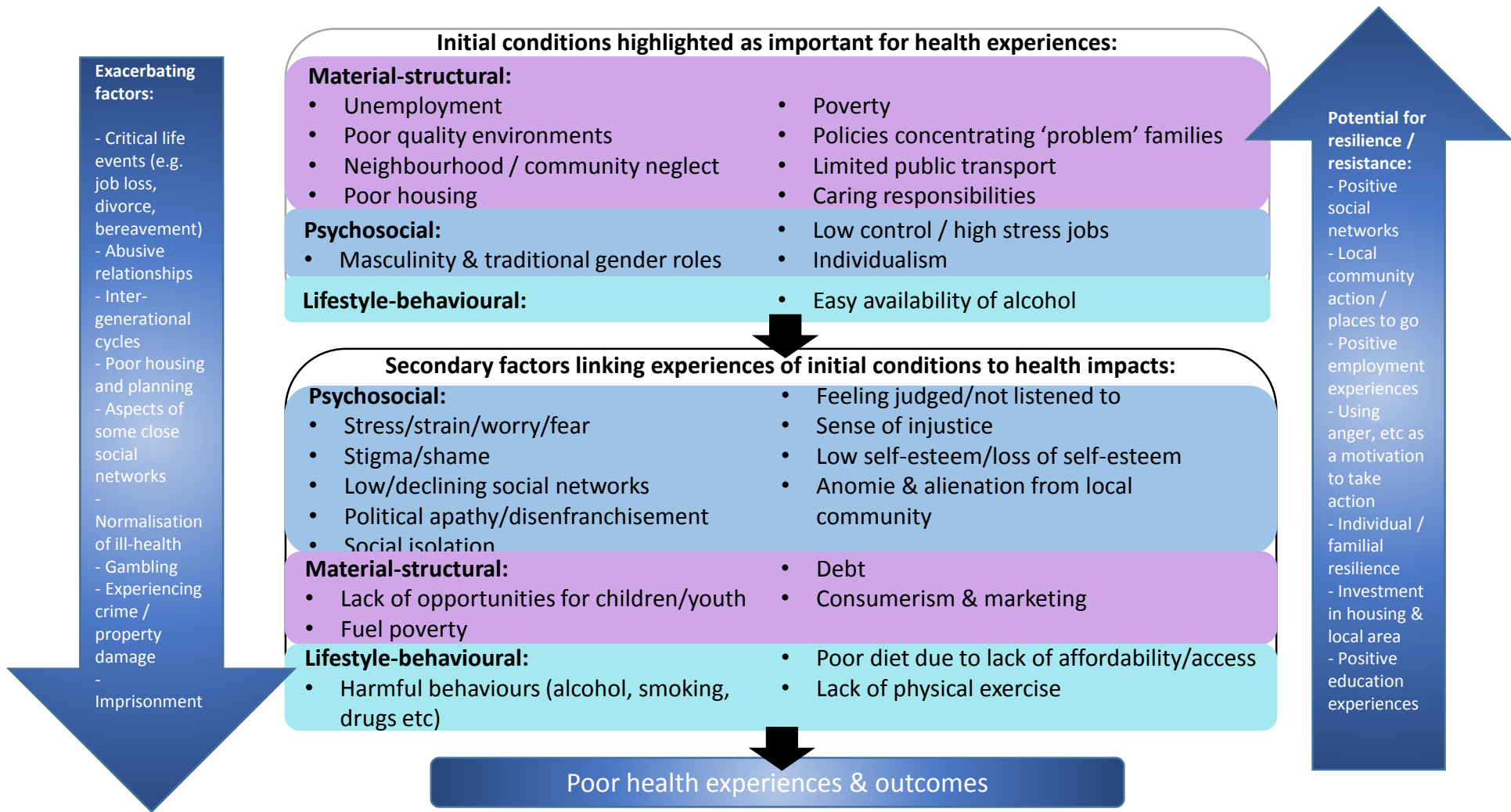
1. Review and implement more progressive systems of taxation, benefits, pensions and tax credits that provide greater support for people at the lower end of the social gradient and do more to reduce inequalities in wealth
2. Develop and implement a minimum income for healthy living
3. Increase the proportion of overall government expenditure allocated to the early years and ensure this expenditure is focused progressively across the social gradient
4. 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. Support an enhanced home building program and invest in decent social housing to bring down housing costs

# So how does this compare to what the public think about health inequalities? Part 1 - a meta-ethnography review of existing evidence....

- Evidence is very limited (we only identified 17 studies, written up across 20 publications, that explored lay understandings of health inequalities in an in-depth way, which weren't disease / risk factor specific).
- We did not identify any studies asking people what kind of policy interventions they would support to reduce health inequalities.
- Some overlap of methodological variation and differences in findings.
- All of the in-depth qualitative studies find public explanations of the link between socioeconomic deprivation / poorer neighbourhoods and poorer health support researchers' concerns with the social determinants of health.







# The devastating impacts of large-scale industrial closures

*“Well the first link to go was the mines. But that was ok after a while, it was devastating for the miners. That was ok really because then some of ’em could get work here. In the steelworks. Some people moved away but a lot of ’em came back as well. A lot of the miners came back and the second chain, the second link in the chain was British Steel. When it was announced it was closing. And to me that was a death knell in the town. And everybody stood still, oh my god. And it was like, if that chain was broken and it was flung away and everybody just, they just didn’t know what to do, none of us really.”* ('Martha' quoted in Walkerdine 2010: p.111)



# The no-pay, low-pay cycle

‘This was not employment that was based on terms and conditions, formal or informal, or which was notable for the fair or compassionate treatment of workers (for example, paid sick leave was rarely available). They worked for employers who were as quick to fire as they were to hire. [...] They are more likely to encounter work that generates ill health and face a stronger likelihood of speedy expulsion back to unemployment when they suffer ill health.’

(MacDonald and Shildrick 2013: p.151)

# The consistency with which unhealthy commodities were described...

<i>Lifestyle-behaviour</i>	<i>Illustrative quotation</i>
<b>Drugs and alcohol</b>	<p>‘Both older adults and younger people linked the absence of facilities for young people to problems with vandalism, anti-social behaviour and the likelihood of turning to <i>‘drugs and alcohol, because there’s f**k all’’</i> (Parry, Mathers et al. 2007: p.128)</p>
<b>Smoking</b>	<p>‘For many of the mothers who were caring on a full-time basis for children, smoking a cigarette emerged as their only luxury and their only leisure activity. It was a moment of self-caring which, unlike a cup of tea or coffee, needed no preparation. For women caring in poverty, a packet of cigarettes, additionally, can be their only item of personal expenditure.’ (Graham 1987: p.55)</p>
<b>Unhealthy diet</b>	<p><i>‘[P]eople are always going to buy cakes, it’s just the pills of life. They eat cakes and biscuits and sweets and so on, that taste nice so they make you think of different things’</i> (female resident of an inner city estate in Greater Glasgow, quoted in Davidson, Mitchell et al. 2008: p.176)</p>

## A paradox?

- While the public, particularly those experiencing socioeconomic disadvantage, provide very sophisticated accounts of how socioeconomic factors shape their health, they are reluctant to explicitly acknowledge health inequalities. Why?
- Attempt to resist stigma, shame and assert a sense of control over destiny of self (and family and friends)?



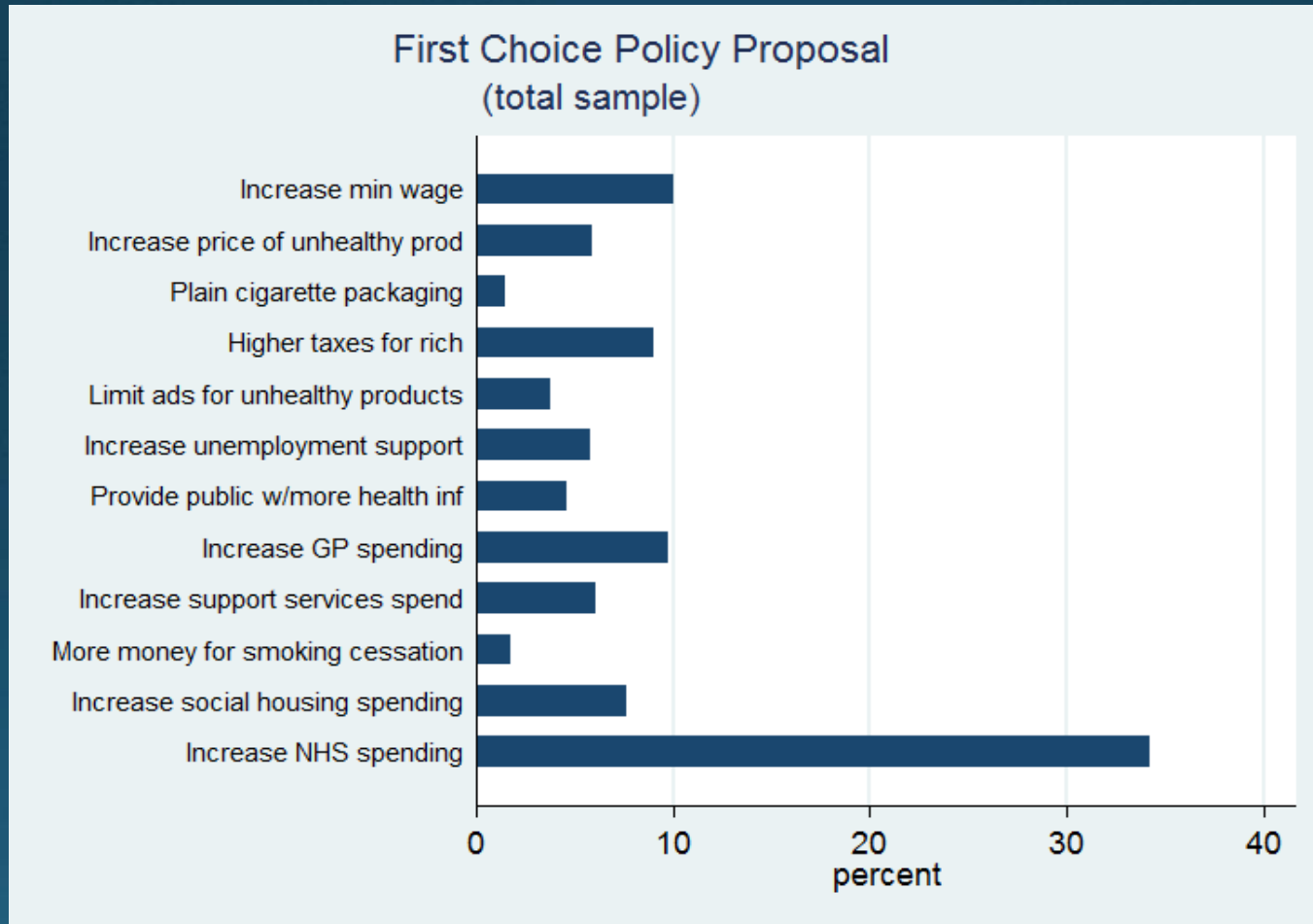
This means we need to think very carefully about the impact of public engagement around health inequalities:

*'Nearly every day I'm picking this paper up, I'm reading about the life expectancy wae me and [compared to] maybe staying doon in London... they're absolutely kicking you every way they can, like. And if you're in a poor area, you'll always be in a poor area... Naebody's gonna try and help you oot it, but if you're in an affluent area, to hell wae the rest....'* ('John' quoted in Mackenzie et al. 2016: p8)

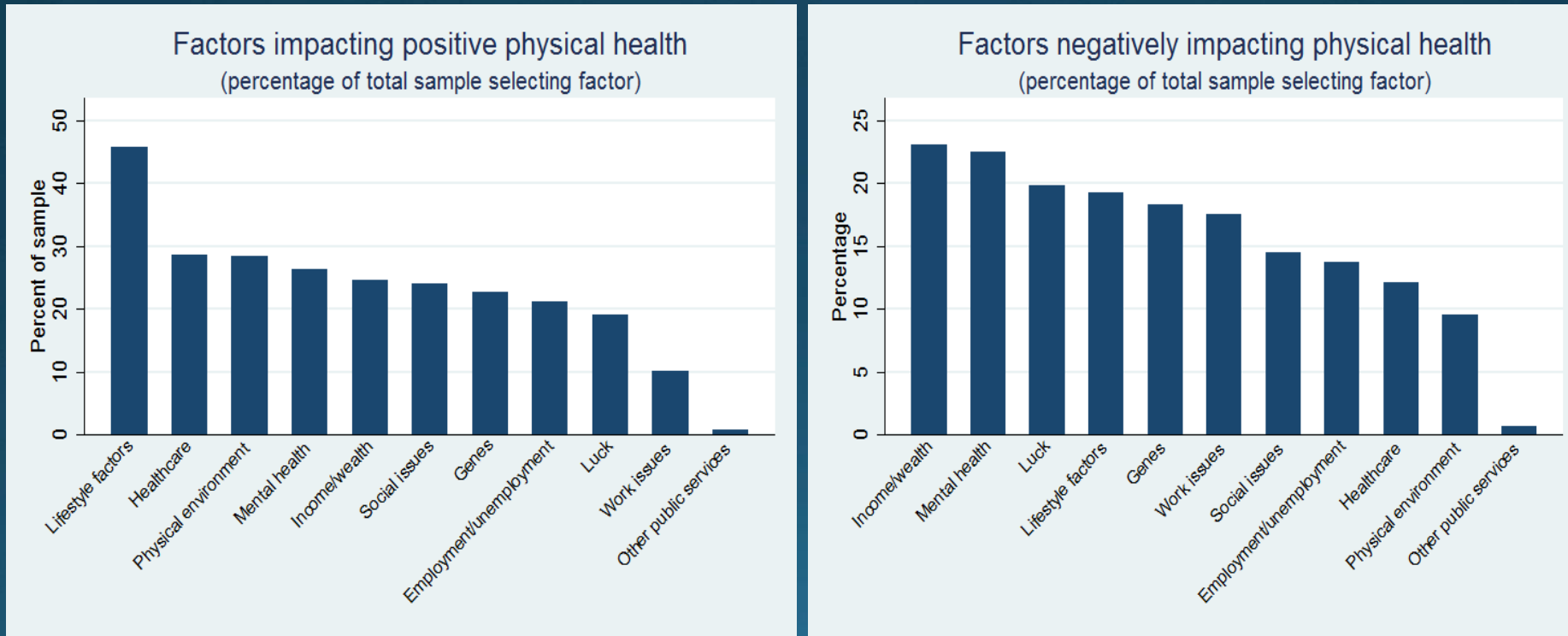
# What do the public think about health inequalities? Part 2 - a national survey...

- We designed an online survey which Opinium administered to 1,540 nationally representative respondents and 50 'top up' respondents for Glasgow, Manchester and Liverpool in August 2016.
- Results suggest that ~70% of people are aware richer people live longer but most people do not seem to think poorer people are more likely to experience key NCDs (heart disease and cancer), mental ill health or accidents.
- The results were surprisingly similar to a survey undertaken in 1997, described by Macintyre et al (2005). This suggests public recognition of health inequalities has not increased since 1997.

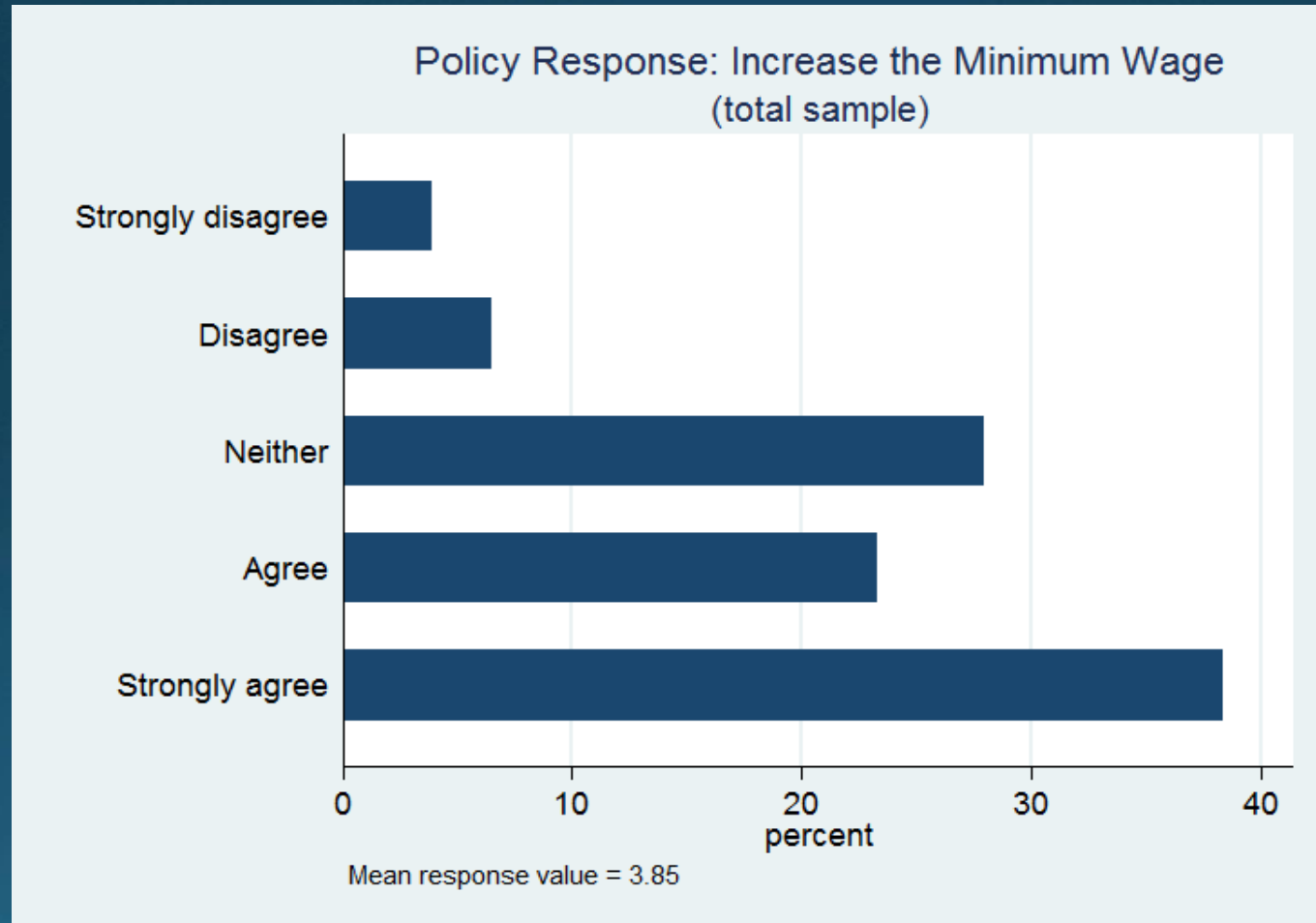
Also suggested that most people think healthcare is the key solution to health inequalities



# But survey shows people are aware that healthcare isn't the biggest influence on their own health....

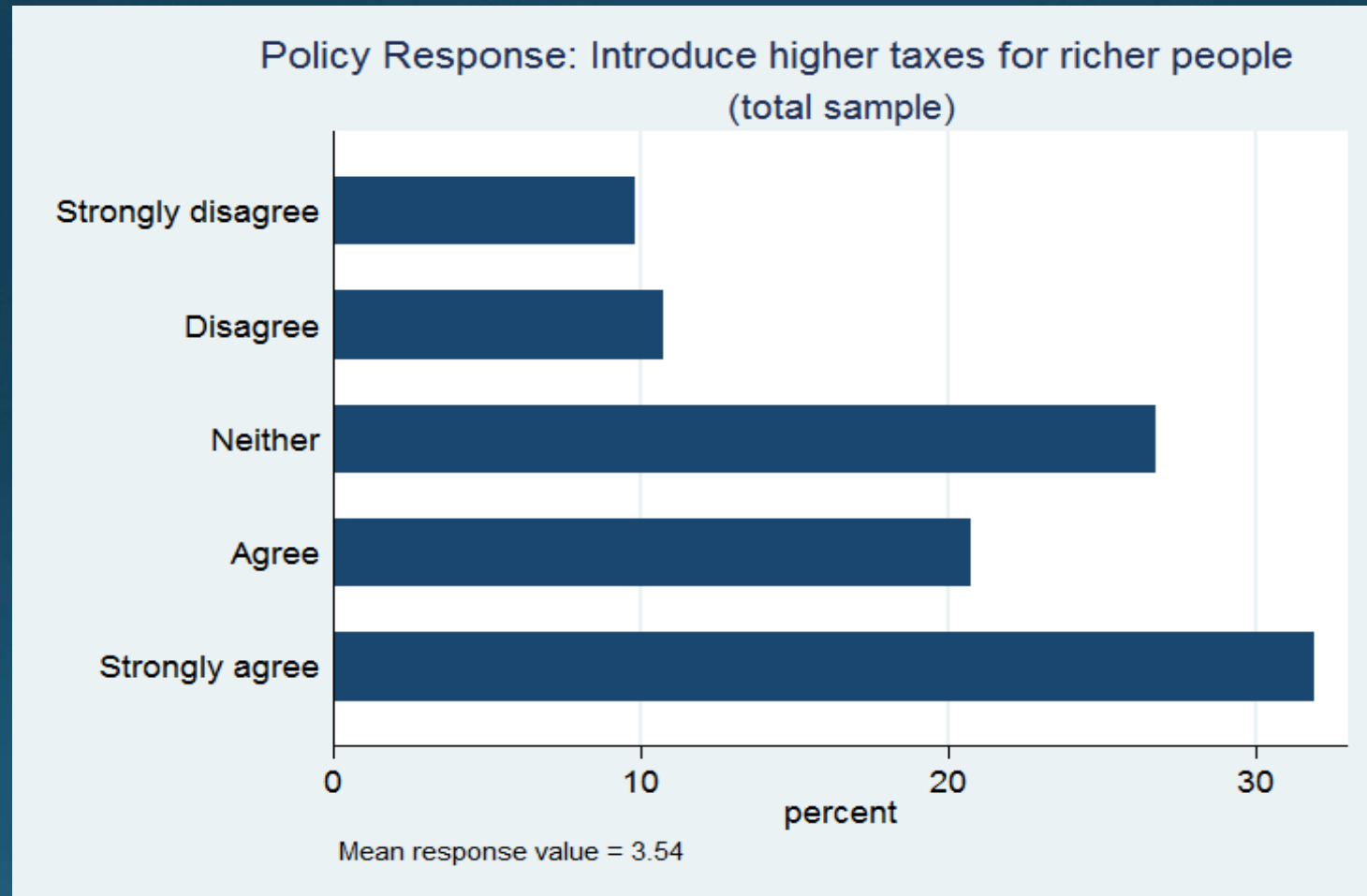


And most people supported all of the research-informed policy proposals included in the survey, e.g.:





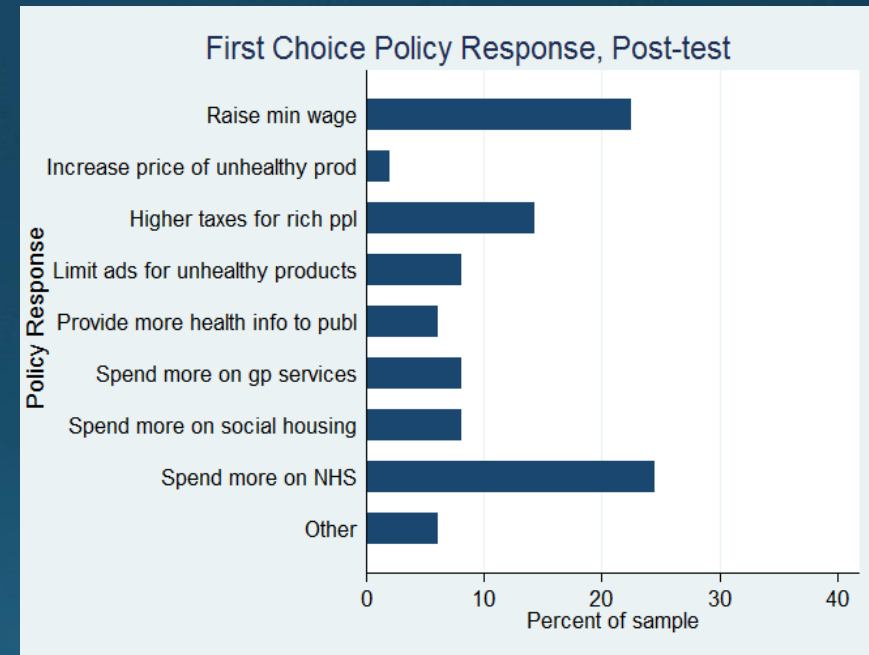
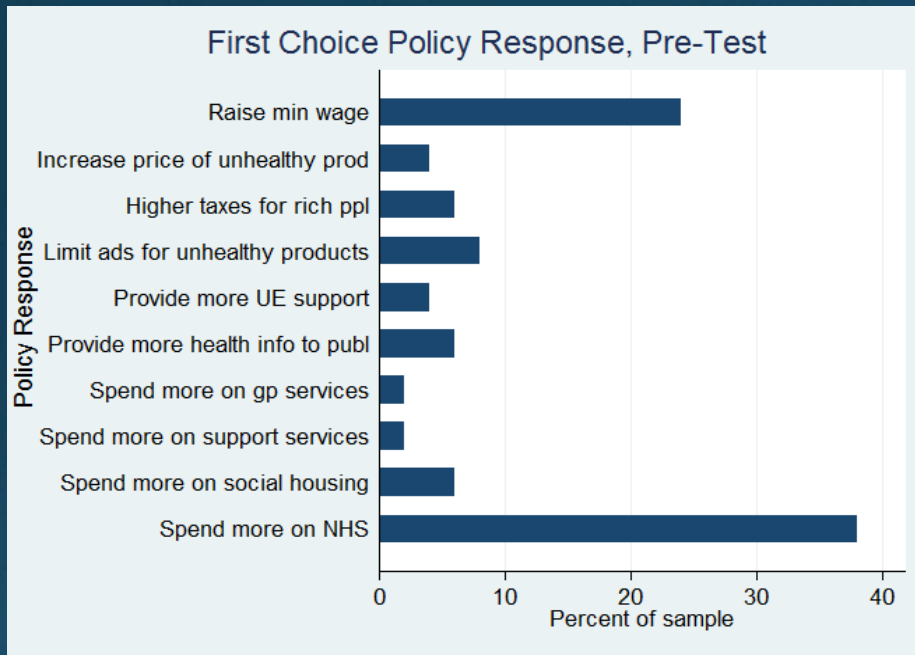
Even policy proposals that researchers and policymakers seem to assume are not supported:



# What do the public think about health inequalities? Part 3 – citizens' juries...

- We undertook three two-day citizens' juries in July 2016 in Glasgow, Manchester and Liverpool.
- The full sample includes 56 respondents for all 3 waves: 20 respondents in Glasgow, 19 in Liverpool, and 17 in Manchester.
- We asked participants to complete the same questionnaire as survey participants before, during and after the jury and asked them to participate in a collective voting exercise.
- The results suggest that this kind of approach to discussing health inequalities increased participants' recognition of health inequalities and their associated sense of unfairness.
- The level of support among participants for more economic (redistributive) policy responses also increased over time (individually) and (more noticeably) in collective voting...

# First choice policy response pre and post citizens' jury engagement



# Collective voting:

## Glasgow:

1. Close the tax loopholes [participants' own suggestion]
- 2=. Increase national minimum wage
- 2=. Introduce higher taxes for (\*very) rich people [\*participants' own addition]
3. Reduce the price of healthy products [participants' own suggestion]
4. Provide more support for people seeking jobs

## Manchester:

- 1=. Introduce higher taxes for rich people
- 1=. Spend more on the NHS
- 2=. Close corporate tax loopholes [participants' own suggestion]
- 2=. Increase the national minimum wage
3. Invest more money in social housing

## Liverpool:

1. Spend more money on the NHS
2. Increase the national minimum wage
3. Provide more support for people seeking jobs
- 4=. Spend more on GP services
- 4=. Ban zero hour contracts

# Preliminary conclusions

- Increasing recognition among His researchers that efforts to promote EBP were based on a flawed (technocratic and elitist) approach and that greater public engagement is needed
- But our initial approaches have been outward facing (disseminating information and raising awareness), rather than listening or discussing potential responses.
- This is problematic since existing research evidence suggests:
  - This approach does not appear to have increased public recognition of health inequalities
  - People (especially those experiencing socioeconomic disadvantage) already have a good understanding of factors impacting on their health
  - But they are often reluctant to explicitly acknowledge health inequalities for other reasons (stigma, shame, disempowerment, etc), a tension that efforts to publicly highlight health inequalities might exacerbate
- Focusing on public support for research-informed solutions to health inequalities (in survey and CJs) challenges research and policy perception of lack of public mandate
- Employing a deliberative approach to engaging members of the public in discussions about health inequalities seems to increase participants': (i) willingness to acknowledge the problem of health inequalities; (ii) sense of health inequalities being unfair; (iii) support for research-informed policy responses (though over-expectation of NHS role remains)



# References

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