Researchers, Campaigners and Corporations: Who is working to shape policy responses to health inequalities in the UK and the EU and what kinds of ideas and evidence are they promoting?

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Context: The ongoing struggle to reduce health inequalities

“Has the English strategy to reduce health inequalities failed? The importance of this question cannot easily be overstated. The explicit and sustained commitment of recent Labour governments to reduce health inequalities was historically and internationally unique [...]. Their policy initiatives built on decades of public health research, and more often than not were based on empirical evidence which had been collected and summarized by leading public health experts. Labour stayed in power for an exceptional 13 years, and in Western democracies it is difficult to imagine a longer window of opportunity for tackling health inequalities. If this did not work, what will?” (Mackenbach, 2010)
The puzzle: What explains this lack of progress?

Suggestions made by interviewees, focus group participants and recent academic commentaries:

(i) **Insufficient knowledge** about what works in reducing health inequalities (limited learning from policies and interventions that have been implemented);

(ii) Sufficient knowledge but a **failure to enact/implement policies** to reduce health inequalities that reflect the available evidence;

(iii) **Lack of a public mandate** for necessary policies and **dearth of advocacy** to achieve required support;

(iv) Health inequalities researchers were **out-lobbied**;

(v) **Career-interest of researchers** – dependency on the continuation of the ‘health inequalities research industry’. 
We haven’t yet asked:

*Who* (beyond the research community) is trying to influence the policies impacting on health inequalities and *what ideas* are they promoting?
Perhaps because of public health’s instrumentalist view of policy

- Rational, linear theories of policy change
- EBM
- EBP
- Bad Science, Geek Manifesto, etc

Public health commitments to evidence-based policy

Acceptance that research and policy are political

- Theories of policy change (political science)
- Ethics
- Public participation
- Public health successes (e.g. tobacco control)
Research funding and data sources

• Funding: ESRC Funded Projects (ES/K001728/1 and PTA-037-27-0181) and various small grants from the University of Edinburgh.

• This presentation draws on the following data sources:
  • Various literature reviews;
  • 15 focus group discussions with researchers, policymakers and NGOs concerning the future of health inequalities research, which included debates about the role of advocacy in research and policy;
  • 130 interviews with relevant actors (public health researchers, policymakers and advocates);
  • A two-stage online survey of health inequalities researchers;
  • A mixed-methods analysis of submissions to consultations on health inequalities in the EU and UK.
Findings – Part 1:

What kinds of policies and interventions do researchers believe are likely to reduce health inequalities in the UK? Does there appear to be any consensus about what ought to be being advocated?
The long-standing consensus on the multifaceted nature of Hls:

A bit more info on the survey:

• 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
Results: Based purely on expert opinion...

<table>
<thead>
<tr>
<th>Policy proposal</th>
<th>% disagree or strongly disagree</th>
<th>% agree or strongly agree</th>
<th>Total number who answered this question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and implement more progressive systems of taxation, benefits, pensions &amp; tax credits that provide greater support for people at the lower end of the social gradient &amp; do more to reduce inequalities in wealth</td>
<td>5.0</td>
<td>92.5</td>
<td>40</td>
</tr>
<tr>
<td>Develop and implement a minimum income for healthy living</td>
<td>7.7</td>
<td>92.3</td>
<td>39</td>
</tr>
<tr>
<td>Invest more resources in support for vulnerable populations, by providing better homeless services, mental health services, etc.</td>
<td>0.0</td>
<td>91.7</td>
<td>36</td>
</tr>
<tr>
<td>Invest more resources in active labour market programmes to reduce long-term unemployment</td>
<td>2.5</td>
<td>90.0</td>
<td>40</td>
</tr>
<tr>
<td>Invest more resources in primary care health services serving very deprived areas</td>
<td>2.6</td>
<td>89.5</td>
<td>38</td>
</tr>
<tr>
<td>Support an enhanced home building program and invest in decent social housing to bring down housing costs</td>
<td>4.9</td>
<td>87.8</td>
<td>41</td>
</tr>
<tr>
<td>Increase the national minimum wage</td>
<td>10.0</td>
<td>87.5</td>
<td>40</td>
</tr>
<tr>
<td>Reduce speeds in urban areas, starting with the poorest areas (20mph is plenty)</td>
<td>7.5</td>
<td>87.5</td>
<td>40</td>
</tr>
<tr>
<td>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').</td>
<td>5.1</td>
<td>87.2</td>
<td>39</td>
</tr>
<tr>
<td>Increase the proportion of overall government expenditure allocated to the early years and ensure this expenditure is focused progressively across the social gradient.</td>
<td>0</td>
<td>87.2</td>
<td>39</td>
</tr>
</tbody>
</table>
Results: Based on available evidence...

<table>
<thead>
<tr>
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<tr>
<td>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</td>
<td>5.0</td>
<td>85.0</td>
<td>40</td>
</tr>
<tr>
<td>Fluoridate domestic water supplies (where this is not already done)</td>
<td>2.8</td>
<td>77.8</td>
<td>36</td>
</tr>
<tr>
<td>Provide stop-smoking services with additional targeting within poorer communities</td>
<td>0</td>
<td>74.3</td>
<td>35</td>
</tr>
<tr>
<td>Increase the price of tobacco products via tax increases</td>
<td>8.3</td>
<td>72.2</td>
<td>37</td>
</tr>
<tr>
<td>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')</td>
<td>5.1</td>
<td>71.8</td>
<td>39</td>
</tr>
<tr>
<td>Reduce speeds in urban areas, starting with the poorest areas (20mph is plenty)</td>
<td>10.3</td>
<td>71.8</td>
<td>39</td>
</tr>
<tr>
<td>Reduce the availability of tobacco products (both legal and illicit)</td>
<td>5.7</td>
<td>71.4</td>
<td>35</td>
</tr>
<tr>
<td>Introduce standardised packaging of tobacco products (i.e. remove branding)</td>
<td>2.9</td>
<td>70.6</td>
<td>34</td>
</tr>
<tr>
<td>Maintenance (and improvement) of the NHS in a recognisable form</td>
<td>5.9</td>
<td>70.6</td>
<td>34</td>
</tr>
<tr>
<td>Introduce a minimum price for alcohol products via minimum unit pricing</td>
<td>7.5</td>
<td>70.0</td>
<td>40</td>
</tr>
</tbody>
</table>
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:

- 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 (75)
- Develop and implement a minimum income for healthy living (62)
- Increase the proportion of overall government expenditure allocated to the early years and ensure this expenditure is focused progressively across the social gradient (56)
- 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) (62)
- Support an enhanced home building program and invest in decent social housing to bring down housing costs (63)
- Invest more resources in state-funded education, with additional investments for schools serving more deprived communities (65)
- Introduce policies which intensively focus on improving literacy among primary school children in deprived areas through one-to-one teaching for those with low reading scores (58)
- Invest more resources in active labour market programmes to reduce long-term unemployment (57)
- Invest more resources in support for vulnerable populations, by providing better homelessness services, mental health services, etc. (52)
- Implement measures to protect the policy process and decision-making from interference by relevant commercial sector interests (e.g. alcohol, tobacco and ultra-processed food manufacturers and retailers) (53)
- Invest more resources in primary care health services serving very deprived areas (52)
- Increase the national minimum wage (49)
- Maintenance (and improvement) of the NHS in a recognisable form (39)
- Introduce a minimum price for alcohol products via minimum unit pricing (37)
- Increase the price of tobacco products via tax increases (34)
- Reduce the availability of tobacco products (both legal and illicit) (34)
- Provide stop-smoking services with additional targeting within poorer communities (28)
- Reduce speeds in urban areas, starting with the poorest areas (20mph is plenty) (31)
- Introduce standardised packaging of tobacco products (i.e. remove branding) (26)
- Fluoridate domestic water supplies (where this is not already done) (25)
If this level of consensus really does exist within the research community, why isn’t there a clearer coalition to promote these kinds of solutions?
Findings – Part 2:

A perceived absence of advocacy and advocates within health inequalities debates...
Advocacy and lobbying recognised as important by actors, across sectors:

Senior academic (interviewee): “[T]hat sort of public advocacy role is actually really, really important, because actually it makes subsequent discussions about the need for interventions or the need to put money into inequalities, it sort of makes that slightly easier. [...] it’s like sort of campaigning in advance of some other intervention - you need some sort of preparation on the ground,”

Senior civil servant, Wales (interviewee): “I think that it’s hard for... a public health community with relatively limited resources [...] I mean the BMA estimated two years ago the alcohol industry was spending £800 million on advertising in the UK on alcohol and you look at Carling Cup, Heineken Cup, in Wales Brains was a local brewery that sponsored the Welsh rugby team, and you see what’s happening with the Olympics, with McDonalds and Coca Cola and then you realise that the resources that we have at our command just don’t stack up against these big beasts.”
The lack of organisations advocating to reduce health inequalities:

Academic (interviewee): “There’s not a kind of central advocacy organisation in the way you might imagine in other areas…”

Politician (interviewee): ‘Whatever efforts there are from Pickett and Wilkinson’s, is it The Inequality Trust?’

Interviewer (KS): ‘The Equality Trust, yeah.’

Politician: ‘The Equality Trust is going to be tiny compared to the lobbying by the food industry, alcohol and tobacco. It’s always going to be way behind.’

Senior academic: ‘There are organisations like the Institute of Health, Michael Marmot’s thing, I’ve forgotten what you call it, just recently set up, but also the one, Richard Wilkinson’s organisation, The Equality Trust is it?’
The recognition of limited advocacy & coalitions w/in health inequalities:

Senior academic (interviewee): “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 & researchers & we function very well together. I don’t see that to the same extent in health inequalities.”

Senior academic (focus group participant): “I still think that there’s a reluctance to recognise that public health is essentially a political discipline [...] I do think it’s indefensible that advocacy isn’t a core public health competence. And again I don’t think it’s a coincidence that lots of the pressure for advocacy being integrated into the public health curriculum has come from people like Simon Chapman (in tobacco control) who’ve long argued that why is it that we’re prepared to go on and make media appearance without any training, but will sit down and rehearse a conference paper that’s going to be listened to by 20 people? [...] Lots of what we’ve been talking about [today] is how do we build an advocacy coalition for public health and health inequalities?”
### Table 2: To what extent is public health advocacy evident in health inequalities and tobacco control?

<table>
<thead>
<tr>
<th>Feature (adapted from Chapman, 2007)</th>
<th>Evident in health inequalities?</th>
<th>Evident in tobacco control?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clarity about public health objectives</td>
<td>✗</td>
<td>✓</td>
</tr>
<tr>
<td>Place and maintain issues on public and political agendas</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Reframe issues to the benefit of public health</td>
<td>✗</td>
<td>✓</td>
</tr>
<tr>
<td>Discredit opponents of public health objectives</td>
<td>✗</td>
<td>✓</td>
</tr>
<tr>
<td>Engage relevant actors beyond research &amp; policy</td>
<td>✗</td>
<td>✓</td>
</tr>
<tr>
<td>Employ evidence accurately but persuasively, developing analogies, metaphors, etc</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Be strategic and opportunist</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

Key: ✗ = almost no evidence of feature within data; ✓ = some evidence of feature within data; ✓✓ = lots of evidence of feature within data.
Findings – Part 3:

Who is trying to influence policy responses to health inequalities (beyond researchers) and what evidence and ideas are they promoting? An analysis of submissions to EU and UK policy consultations...
The policy consultations:

• We analysed the submissions made to 2 policy consultations focusing on health inequalities which both took place in 2009:
  • ‘EU Action to Reduce Health Inequalities’; and
  • The first phase of the ‘Strategic Review of Health Inequalities in England post 2010’ (usually known as ‘the Marmot review’).

• Although summary reports were produced and made available by the teams organising the consultations, neither the European Commission nor the Marmot team published the full responses and our analysis appears to be the first attempt to openly, collectively assess them.

• To access the documents, we contacted the Commission and the Marmot review team explaining the purpose of the research and requesting copies of all responses. Once certain identifying information had been removed for data protection reasons, we were sent 100 responses from the Marmot review, and 147 responses from the EU consultation. Each was assigned a unique identifier.

• 11 responses were excluded from the Marmot consultation, and 10 from the EU consultation, either because they were not ‘tailored’ responses or because the response was from an individual or where the respondent could not be identified (details removed for data protection reasons).
Why do organisations respond to policy consultations?

Frequent suggestions from interviewees working in advocacy/lobbying organisations:

- Because consultations are perceived to occasionally make a difference to ensuing policy decisions;

- Because there aren’t many other actors who will be working to promote a particular view / idea so it’s important to ensure this is put forward (can serve as a point of reference);

- To enhance awareness and policy credibility of the organisation as a policy actor.
Who responded to EU consultation?

- EU, international & EU member states: 2.20%
- Political parties: 3.60%
- Private sector: 9.50%
- Professional, research and research funding: 27.70%
- Public sector: 26.30%
- Voluntary sector: 30.70%

Percentage of responses included in analysis
Who responded to UK consultation?

![Bar chart showing the percentage of responses included in analysis for different organisation types.]

- **EU, international and EU member states (including national UK):** 12.70%
- **Private sector:** 7.60%
- **Professional, research and research funding:** 26.60%
- **Public sector:** 30.40%
- **Voluntary sector:** 22.80%
What did respondents suggest were the causes of health inequalities?

**UK consultation - specified causes of HIs**

- None specified / unclear: 22.80%
- Other: 25.30%
- Healthcare: 22.80%
- Health Education and Promotion: 30.40%
- Living and working environments: 36.70%
- Political, economic and social structure: 60.80%
Responses RE causes generally map on to ‘Rainbow model’ of health determinants

Whereas responses RE solutions appear to invert the ‘Rainbow model’...

Health Determinants Model

What did respondents put forward as suggested policy responses to HIs?

UK consultation - suggested responses to HIs

- None specified / unclear: 3.80%
- Other: 40.50%
- Improving policy process: 21.50%
- Targeting particular groups: 45.60%
- Improving data, information & research: 35.40%
- Healthcare & pharmaceutical interventions: 50.00%
- Health Education and Promotion: 46.80%
- Living and working environments: 53.20%
- Political, economic and social structure: 31.60%

Percentage of submissions which emphasised this solution
Why does there appear to a consistent mismatch between identified causes & recommended responses?

1. **Upstream policy responses are not deemed practical/feasible:**
   King’s Fund consultation response (Marmot): “The principles of social justice are an admirable long-term approach to address the social determinants of health; however, the political reality is that many politicians will not agree with this approach."

2. **Dominance/application of medical ‘hierarchies of evidence’:**
   MRC consultation response (Marmot): “[W]e recommend that systematic reviews (where relevant up-to-date reviews are unavailable in the published literature) are commissioned to underpin the key recommendations."

3. **Actors want to feel they can make a difference:**
   Senior academic (interviewee): “I can see why some colleagues in public health and health inequalities do smoking research, do lifestyle interventions - not because they’re evil, it’s because they want to make that difference...”

4. **Actors may have vested interest in maintaining a ‘health’ focus:**
   Faculty of Public Health consultation response (Marmot): "In general, we agree with the focus on addressing inequalities in income and resources given the impact they can have on health inequalities. However, it is important that the review does not try to tackle other inequalities and begin to stray too far away from a focus on health..."
Preliminary conclusions

• There is widespread & increasing support for notion advocacy is needed to achieve the kinds of political, policy and social changes many public health researchers have argued are necessary to reduce health inequalities;

• Represents a shift away from (flawed) perceptions of policymaking as rational and linear and an increasing acceptance of more political accounts of policymaking;

• However, there are no clear ‘advocacy coalitions’ within health inequalities policy debates and there has been very little analysis of who (beyond) researchers are involved in these debates: our analysis of policy consultation responses suggests many other sectors have an interest in this area and could usefully be further examined.

• Both the majority of researchers and other kinds of actors engaging in health inequalities policy debates seem to support the idea that there are political, structural and economic causes of health inequalities but the potential solutions they are putting forward do not mirror this assessment.

• Rather, solutions often focus on more downstream interventions, including health promotion and healthcare related interventions (though, in the UK, there is also support for welfare-state related interventions, particularly amongst the public sector and groups representing health professionals).