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Understanding lay perspectives on socioeconomic health inequalities in Britain: a meta-ethnography

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Abstract The links between socioeconomic circumstances and health have been extensively studied in Britain but surprisingly few studies consider lay perspectives. This is problematic given popular efforts to reduce health inequalities appear to be based on assumption that public understanding is limited (this is evident in efforts to raise awareness of both ‘upstream’ causes of health inequalities and health-damaging behaviours). The results of this meta-ethnography, involving 17 qualitative studies, fundamentally challenge this assumption. We show, first, that people who are living with socioeconomic disadvantage already have a good understanding of the links between socioeconomic hardship and ill-health. Indeed, participants’ accounts closely mirror the research consensus that material-structural factors represent ‘upstream’ determinants of health, while ‘psychosocial’ factors provide important explanatory pathways connecting material circumstances to health outcomes. Despite this, people living in disadvantaged circumstances are often reluctant to explicitly acknowledge health inequalities, a finding that we suggest can be understood as an attempt to resist the stigma and shame of poverty and poor health and to (re)assert individual agency and control. This suggests that work to increase public awareness of health inequalities may unintentionally exacerbate experiences of stigma and shame, meaning alternative approaches to engaging communities in health inequalities discussions are required.

Keywords: inequalities/social inequalities in health status, experience of illness, lay epidemiology, poverty, meta analysis, systematic reviews

Introduction

A large, cross-disciplinary body of research demonstrates the significant association between socioeconomic disadvantage and poor health experiences in Britain (Marmot 2010, Smith *et al.* 2016). This continually growing literature has informed an explicit recognition that socioeconomic health inequalities are socially produced; meaning they are considered by many researchers and policymakers to be avoidable, unfair and unjust (Whitehead 2007); all of which inspires a desire to intervene (Garthwaite *et al.* 2016). Yet, while post-1997 policy initiatives have seen Britain labelled as a global leader in policy efforts to reduce health inequalities (Mackenbach 2011), most indicators suggest either that health inequalities have continued to widen (see Mackenbach 2011) or that progress has been extremely limited (Bambra 2012).

There is some agreement (Garthwaite *et al.* 2016) that this failure reflects a policy preoccupation with trying to change people’s behaviours (improving diets, reducing alcohol intake,

etc.), while available evidence highlights the importance of 'upstream' (material, structural) determinants and suggests that efforts to change people's behaviours often exacerbate health inequalities (Whitehead 2007). Mackenbach (2011) argues that the dissonance between research and policy at least partially reflects the fact that policymakers did not believe they had a public mandate for the kinds of 'upstream' policies that research evidence suggests is required. In her interviews policy actors, the lead author of this article previously reached similar conclusions but noted that it was unclear how policy actors were assessing public opinion about health inequalities since they themselves often commented on the lack of evidence on this topic (Smith, 2013). In this context, the lead author (Smith, 2013) criticised health inequalities researchers for not sufficiently incorporating community voices in their research and for seeking to effect change (on the public's behalf) via an elitist approach that involves directing messages towards what Weiss (1990: 9) calls the 'ubiquitous benevolent despot, the decision maker', rather than via more democratic approaches. More seriously, Heath (2007: 1301) has charged researchers with participating in the creation of a health inequalities 'industry' in which affluent researchers 'piggyback' on the distress of the poor as 'a substitute for difficult political effort – opium for the intellectual masses'.

Where researchers do attempt to engage the public in debates about health inequalities in Britain, such efforts appear to be disseminative in nature, broad in scale and informed, at least to some degree, by an assumption that public understanding is limited. Innovative and creative examples include Bamba's (2015) football 'league-tables' of inequalities between urban centres in England and McCartney's (2011) metro map of health inequalities in Glasgow. The limited survey based-research (which is only included in our meta-ethnography where it was accompanied by more in-depth, qualitative data) provides support for such efforts, finding that the British public tend to under-estimate the extent of health inequalities (Macintyre *et al.* 2005) and downplay material, structural and environmental causes of poor health (Blaxter 1997, Popay *et al.* 2003a, 2003b). However, as this meta-ethnography demonstrates, sociological studies provide a rather different perspective on public understandings of health inequalities.

Drawing on 17 in-depth, qualitative studies this review asks three, linked questions (which were developed on the back of earlier scoping reviews that simply asked what studies tell us about lay understandings of health inequalities (Smith 2013)). The first two questions were our guiding analytical questions, which we asked of each study included in the meta-ethnography: (i) how do people living in Britain understand the links between socioeconomic circumstances and health?; and (ii) to what extent do people acknowledge the existence of health inequalities in Britain? The third question, which we explore towards the end of the paper, emerges out of the analysis we present and this is to ask what the implications of these findings are for health inequalities research and public engagement. In sum, the findings demonstrate the value of sociological enquiry in this area, challenging: (i) the need for further descriptive research, analysing the 'problem' of health inequalities (since there appears to be a strong consensus between epidemiological and lay perspectives about the causes of health inequalities); and (ii) the merit, ethics and impact of efforts to raise public awareness of health inequalities (given the risks of exacerbating shame and stigma). Instead, we outline some alternative approaches to research and engagement.

Methods

Our aim was to identify all published, qualitative studies exploring how people living in Britain understand the links between socioeconomic circumstances and health and/or

acknowledge/speak about health inequalities. We conducted a systematic search of seven academic databases (ASSIA, EBSco, which included EconLit and CINAHL Plus, Embase, which included PsychINFO and Medline, IBSS, PubMed, Sociological Abstracts and Web of Science). The main search string, which was developed iteratively and refined following feedback from colleagues, combined the names of methodological approaches deemed likely to capture lay perspectives with terms relating to socioeconomic disadvantage and health, as follows: ('focus group*' OR interview* OR deliberative OR survey OR ethnograph*) AND (disadvantage* OR poverty OR depriv* OR poor OR inequ*) AND (health OR suicid* OR depress* OR anxi* OR cancer OR cardiovascular OR 'heart disease' OR stroke OR diabetes). We also tried to limit searches to studies written in English, published in peer-reviewed sources and focusing on the UK or sub-regions in the period from 1997 onwards (i.e. the point at which tackling health inequalities became a clear policy priority). We did not include studies that had a specific focus on a particular behavioural risk factor (e.g. diet or smoking) or illness (e.g. cancer), although we had included these studies in an earlier, rather broader scoping review, since we wanted to capture people's broad accounts of the links between socioeconomic circumstances and health. The specific approaches to searching varied by database, depending on available options (e.g. where databases had geographical options as filter, we used those but, in other cases, we added relevant terms to the search string). Between them, these searches resulted in 24,876 hits, each of which was assessed for relevance (using title and, where necessary, abstract) by KS, a process which was cross-checked by RA.

This preliminary analysis identified 36 articles which were downloaded and read in full by KS, who identified 10 as meriting inclusion in the review. RA again cross-checked this process and identified a further two papers for inclusion. KS checked the reference lists of these 12 articles for further relevant publications and used citation tracking tools to help identify newer articles. This process garnered an additional seven relevant publications. We then checked our results against a recent international review of qualitative research on health inequalities (Elliott *et al.* 2016) which identified one additional publication (Bolam *et al.* 2006) linked to a study that was already included. This resulted in the inclusion of 20 publications in total, which covered 17 distinct studies (three studies had been written up twice and in all three cases we opted to analyse the publications collectively, since there were significant overlaps across the papers). Where authors had written non-peer reviewed and peer-reviewed publications from the same study, we only included the peer-reviewed publication since these were the ones we were most easily able to access and share.

Informed by, Noblit and Hare's (1988) 'meta-ethnography' approach to reviewing qualitative studies, we only included in-depth, sociological studies. We also decided to restrict our geographical focus to the UK, in light of Noblit and Hare's (1988) caution regarding the appropriateness of considering studies across contrasting cultural settings. A rapid review of the international evidence base on this topic, conducted by Elliott *et al.* (2016), suggests that the literature in this area is, in any case, dominated by UK studies and that those undertaken elsewhere vary greatly in contextual setting (Australia, Bangladesh, Ireland, Japan, New Zealand, Sweden and the USA). Table 1, which summarises the geographical location and methodological approach of the 17 studies, shows that most included studies were based on interviews or focus groups, with a smaller number using other qualitative methods and only two studies (one of which was written up as two publications) employing a mixed methods approach (Popay *et al.* 2003a, 2003b, Vassilev *et al.* 2014). Table 1 summarises the geographical focus of included studies (since no studies focused on Northern Ireland, our review focus became Britain).

The earliest included study was published in 2001 (Cattell 2001) and the most recent in 2016 (Mackenzie *et al.* 2017 - first published online in 2016). This means that, over our

Table 1 *Summary of methodological approach & geographical focus of included studies*

<i>Main methodological approach</i>	<i>Number of studies</i>	<i>Geographical focus</i>	<i>Number of studies</i>
Qualitative interviews (some with prompts, supplementary methods)	8	England	9 (1 South-East, 2 Midlands, 2 North-West, 3 North-East, 1 Southern)
Focus groups	4	Scotland	5
Other (ethnographic, photovoice, etc.)	3	Wales	1
Mixed methods (survey combined with in-depth interviews)	2	Multiple sites in Britain	2
Total	17	Total	17

20-year search period (1997–2016), we identified an average of less than one study per year, affirming the low level of research on this topic (Elliott *et al.* 2016). An overview of all 17 studies is provided in Table 2. Given the difficulty of searching for a relatively broad set of criteria (and the multiple potential search terms), it is possible that we missed some relevant studies (our choice of databases means we are particularly likely to have missed book chapters, PhD theses and grey literature). Nonetheless, the reference mining and citation tracking we undertook helped address some of these limitations and demonstrated that many included studies cited each other, suggesting that we had managed to identify the most relevant peer-reviewed studies.

We chose not to assess the quality of included studies and instead relied on peer-review as a marker of sufficient quality for inclusion. This decision reflects existing critiques of applying quality appraisal check-lists to qualitative studies (e.g. Barbour 2001) and because of a concern, when experimenting with applying Critical appraisal skills programme (CASP) (Public Health Resource Unit 2015), that studies we deemed to be high-quality were receiving low scores due to a lack of methodological information (rather than because of definitive flaws).

Having identified the 17 studies (20 publications) summarised in Table 2, we worked to synthesise the findings, using an approach informed by Noblit and Hare’s (1988) guidance on undertaking meta-ethnography. This involved KS chronologically reading each of the publications several times to gain an in-depth understanding of the key findings regarding our two, linked questions. This initial analysis led us to conclude that, of the three types of synthesis associated with meta-ethnography, a ‘line of argument’ approach was most appropriate. As Noblit and Hare (1988: 62) put it, ‘A line of argument synthesis is essentially about inference: What can we say of the whole [...] based on selective studies of the parts?’ In other words, our original aim was to ascertain how people living in Britain, particularly those in disadvantaged circumstances, understand health inequalities, based on our interpretation of 17 in-depth studies exploring how specific communities and groups within Britain understand health inequalities.

Our intention had been that we would then identify all relevant examples of what meta-ethnographers refer to as ‘first order constructs’ (participants’ accounts and interpretations of their experiences) and ‘second order constructs’ (authors’ views and interpretations of participants’ accounts). However, like Atkins and colleagues (2008), we immediately found ourselves struggling to distinguish between the two since the amount of original data included in most of the studies was so limited that the author(s)’ decision to include these particular small sections (over others) meant we felt these extracts were more akin to ‘second order’ constructs. Reflecting this, we decided to focus only on identifying second order constructs (treating the small

Table 2 A summary of included studies, focusing on geographical context, methods, data sources and study aims

Reference	Geographical focus/ context	Methods and data sources	Study aim(s)
1. (Mackenzie <i>et al.</i> 2017)	Cumnock & Kilmarnock, towns in deindustrialised areas of Scotland	Interviews with 20 people, mixed generations.	To explore understandings of the causes of (ill) health in local communities.
2. (Garnham 2015)	Clydebank, Scotland (post-industrial town)	Mixed methods case study, drawing on photovoice projects, oral history interviews, existing written histories and secondary source quantitative data (total number of participants unclear).	To explore the utility of Swidler's concepts of <i>cultured capacities</i> and <i>strategies of action</i> in mapping pathways through which area-based, multiple deprivation and inequality impact upon resources for health and health inequalities.
3. (Rind and Jones 2015)	Ex-mining communities in North East England	Four focus groups involving 19 participants (in total).	To unpack how broader societal and environmental changes associated with industrial decline affect beliefs and attitudes towards physical activity in ex-mining communities.
4. (Vassilev <i>et al.</i> 2014)	Northwest England	300 participants drawn from register of diabetes and heart disease patients from GP practices in North West England. Cross sectional survey with 35 nested qualitative interviews.	To explore the meanings and experiences of social status of people living with a long-term condition with particular reference to employment status.
5. (MacDonald and Shildrick 2013)	Teesside, north east England	Biographical interviews undertaken with 186 young adults living in some of the poorest neighbourhoods in Teesside.	To examine how experiences of health, wellbeing and bereavement interact with processes of youth transition and social exclusion for young adults living in some of England's poorest neighbourhoods.
6. (Watson and Douglas 2012)	A deprived inner-city neighbourhood in Aberdeen, Scotland. The area is Aberdeen's second most deprived area	A qualitative community-based participatory research study conducted using photovoice (PV), with young people (aged 12–19) attending a youth project. This involved giving participants	To investigate how young people living in socially and economically disadvantaged circumstances in Aberdeen viewed and experienced their local neighbourhood and its impact on their mental well-being.

(continued)

Table 2 (continued)

<i>Reference</i>	<i>Geographical focus/ context</i>	<i>Methods and data sources</i>	<i>Study aim(s)</i>
	according to employment and health statistics and is within the bottom 10% of the most deprived postcode areas of Scotland.	disposable cameras and asking them to take photographs of things that made them feel happy and healthy, and those that made them feel unhappy or unhealthy. After cameras were returned, in-depth individual interviews were conducted which focused on discussing 10 of the photographs that they had taken and picked. 13 cameras were distributed, 11 were returned and nine interviews were subsequently (two girls and seven boys).	
7. (Walkerdine 2010)	A town (pseudonym 'Steeltown') in the valleys of South Wales, following the closure of steelworks in 2002.	Psychosocial (long, unstructured) interviews with community members	To explore the place of affect in community relations with respect to trauma following the closure of a steelworks for a working-class community.
8. (Roberts 2009)	Easington, North East England (one of the most deprived areas in England outside London)	Anthropological (personal, reflexive) account written by a local GP	To explore the relationship between institutionalised inequalities in wealth and opportunities, and emotional health, in a disadvantaged community in north-east England.
9. (Dolan 2007)	North-East Coventry, Midlands, England: one relatively disadvantaged and one relatively advantaged community	Interviews with 22 men (11 from each community), all working class regardless of ward of residence, age ranges 21 to 60, average age 40. All participants were interviewed twice.	To explore the various ways in which social capital is experienced by men in varying community contexts, including by analysing participants' perceptions of the impact of social networks and communities on their health

(continued)

Table 2 (continued)

<i>Reference</i>	<i>Geographical focus/ context</i>	<i>Methods and data sources</i>	<i>Study aim(s)</i>
10. (Parry <i>et al.</i> 2007)	West Midlands, England	Focus groups in three areas within the West Midlands, involving 16-early-20 year olds and older residents (over 60). Each group of participants met twice. Photographs taken by participants in between the focus groups were used as prompts for discussion in second focus groups. Total number of participants unclear.	To illustrate how residents of disadvantaged communities believe where they live influences their health.
11. (Davidson <i>et al.</i> 2006, 2008*)	Scotland and the North of England, January 1999-February 2000.	14 focus group discussions, involving 76 participants from Scotland and Northern England. Pre-existing groups of people within the same social networks (e.g. community centre groups and work colleagues) recruited to each focus group, with a wide range of socioeconomic circumstances across the sample.	To examine lay perceptions of societal and health inequalities.
12. (Bolam <i>et al.</i> 2004, 2006)	Two inner city locales in an unnamed Southern English city (population of approximately 380,000), September 1999-December 2000.	Semi-structured interviews with 30 participants and two follow-up focus groups with a self-selecting sample of interviewees. Participants were selected to ensure diversity across the sample and included 14 men, 16 women, 20-62 years old and from a mixture of ethnicities and social classes.	<p>2004 publication: To explore the individualisation of class identity and health in a southern English city.</p> <p>2006 publication: To describe accounts of health, well-being and place-identity in the two contrasting locales, to advance psychosocial explanations of geographical inequalities in health.</p>

(continued)

Table 2 (continued)

Reference	Geographical focus/ context	Methods and data sources	Study aim(s)
13. (Airey 2003)	A deprived neighbourhood in Edinburgh, Scotland	The larger study (a PhD) drew on interviews with 24 women aged 45–59 (12 each from two neighbourhoods in Edinburgh with contrasting socioeconomic and health profiles). This paper draws only on the data from the more deprived neighbourhood.	To explore how contextual and compositional features of place may interact to influence well-being.
14. (Burningham and Thrush. 2003)	Three sites: Possilpark in North Glasgow; Cefn Mawr in North Wales, where people live very close to a chemical factory; and Bromley-by-Bow in East London, where people live very close to major roads.	Focus groups of between 3 and 10 people, with 68 people participating in total, across the three sites:— Possilpark: older people on state pension, unemployed young men, parents SEG D & E and disabled people. —Cefn Mawr: unemployed men with families to support, lone mothers, parents SEG D & E and one-to-one interviews with people with long-term illness. —Bromley-by-Bow: Bangladeshi women, lone mothers and older people on state pension. A survey of a random sample of 777 people living in the four areas followed by 51 in-depth interviews. This sub-set of people was selected purposively to ensure social diversity. Of these, 19 were asked to take part in a 2nd interview focusing on health inequalities, of whom 12	To examine how people living in disadvantaged communities talk about and experience environmental inequalities
15. (Popay <i>et al.</i> 2003a, Popay <i>et al.</i> 2003b*)	Two localities in Salford and two in Lancaster (one relatively disadvantaged and one relatively advantaged in each), North West England		To explore lay understandings of health inequalities

(continued)

Table 2 (continued)

<i>Reference</i>	<i>Geographical focus/ context</i>	<i>Methods and data sources</i>	<i>Study aim(s)</i>
16. (Backett-Milburn <i>et al.</i> 2003)	Two contrasting but contiguous areas in a large Scottish city, one relatively advantaged and one relatively disadvantaged.	were from the relatively deprived study localities and seven from the relatively affluent. Two rounds of semi-structured interviews, using child friendly prompts and to techniques (e.g. photos, drawings and vignettes) with 35 children aged 9–12 living in the two contrasting areas (20 from the more affluent area and 15 from the more deprived area to lower due to recruitment issues). 30 parents also interviewed.	To understand the socioeconomic and cultural contexts of children's lifestyles and the production of inequalities in health
17. (Cattel 2001)	Two deprived areas in East/North East London, Keir Hardie and Cathall.	In-depth interviews with residents in two deprived areas. Areas were selected on the grounds of similar deprivation, and 'dissimilar opportunities for participation', using secondary analysis of official statistics and local data as well as information from practitioners and agencies in four East London	To explore the dynamics between poverty and exclusion, including by considering the links between neighbourhood, health, well-being, social networks, social capital and social processes.

(continued)

Table 2 (continued)

Reference	Geographical focus/ context	Methods and data sources	Study aim(s)
		boroughs. In each neighbourhood to interviews were conducted with 35 to 37 residents and with approximately 15 people whose work takes them into the neighbourhood (final total unclear). Potential interviewees were selected on the basis of participant observation, snowballing and via key contacts. Efforts were made to reflect the demographics of the neighbourhood, and to include the less active, less confident, as well as more participatory individuals. Problems of access resulted in a higher proportion of female interviewees than male. Teenagers were excluded.	

extracts of original data that most publications included as ‘second-order’ by virtue of the authors’ decision to include them).

Having made this decision, we first identified all potentially relevant second order constructs relating to our two, linked questions. We then considered how the second order constructs identified in each study could be translated to those in others, a process which involved grouping similar constructs into broad interpretative categories and, where necessary, iteratively editing the wording of these categories to enable very similar constructs to be merged. In practical terms, this translation process was initially undertaken on hardcopies of the publications (in note form), before employing tables created in Word. In addition, for constructs categorised as relevant to lay explanations of the links between socioeconomic circumstances and health, KS produced a hand-drawn diagram illustrating the links between constructs *within* each study. KS also worked to combine these diagrams and, while the end result was deemed too complex to be of use to readers, it played an important role in our analysis, providing a source against which to check emerging findings. RA then read each study once to cross-check KS’s analysis, at which point a small number of studies were identified as making brief mentions of second order constructs KS had not identified.

Findings

This analysis allowed us to produce Table 3, which: (i) takes a temporal approach to order our overarching interpretative categories of second order constructs, from initial socioeconomic circumstances, through health experiences, to potential for change; (ii) provides readers with some quantifiable evidence regarding the number of studies in which we identified specific second order constructs (within each interpretative category, constructs identified in the greatest number of studies are listed first and those that appeared in the fewest, last); and (iii) uses colour-shading to thematically cluster the constructs according to broad sets of popular, research-informed theories for explaining health inequalities (informed by Bartley 2004 and Smith *et al.* 2016). In producing this table, we focused first on (i), then (ii), with the thematic colour-shading representing the final stage. Since Table 3 is complex, we developed Figure 1 as a simplified, visual summary of the tabulated information.

Taken together, the included studies demonstrate that people in Britain, or more specifically people in Britain experiencing socioeconomic deprivation (who were the main focus of all of the included studies), have a complex and dynamic understanding of the ways in which socioeconomic circumstances impact on health (see Figure 1 and also Parry *et al.* 2007). In this section, we begin, by discussing what the studies reveal about lay understandings of the relationship between socioeconomic circumstances and health, before moving on to consider factors and experiences that emerged as potential agents of change (either ‘amplifying’ health impacts or providing some form of ‘resilience’ or resistance). These two sections build directly on Table 3 and Figure 1. In the final sub-section, we go beyond Table 3 to consider how and why participants resisted ideas about the existence of health inequalities (despite their evident understanding of the impact of socioeconomic circumstances on health).

Lay understandings of the ways in which socioeconomic circumstances impact on health

Our decision to distinguish between ‘initial conditions’ and ‘secondary factors’ in Table 3 reflects a consistent pattern across the studies in which authors and their participants described initial conditions to which they attributed both direct health impacts and indirect health impacts (as we describe below, with reference to housing).

Table 3 Author(s)' interpretation of participants' accounts of socioeconomic health inequalities

Interpretative category		Interpretations put forward by original author(s) (2 nd order constructs)	Relevant studies
#Temporal sequence of socioeconomic – health links	Initial conditions highlighted by authors as factors participants suggested were potential contributors to socioeconomic health inequalities	1. Unemployment is pervasive so there is a lack of opportunities for renewed employment	1-5,7-11, 14, 15, 17 [13 studies]
		2. The local neighbourhood/community has been neglected by those with power and resources (e.g. by local councils and other public services)	1,2,6-11,14,16,17 [11 studies]
		3. The local environment is plagued by problems, including polluted environments (e.g. passive smoke, traffic and industrial fumes), crime, risky work environments and lack of clean, safe places for children to play/young people to go.	2, 3, 6, 10, 11, 12, 14, 15, 16, 18 [10 studies]
		4. The available housing is inadequate/poor quality (e.g. damp housing and high rise housing)	2, 10, 11, 12, 14, 15, 17, 18 [8 studies]
		5. Familial/individual income/resources are inadequate to live well (accounts of poverty and deprivation)	2, 4, 6, 12, 15, 17, 18 [7 studies]
		6. Local policies concentrate problem families/individuals (e.g. those with substance abuse problems or those involved in antisocial behaviour or criminal activity) in particular areas	2, 9, 10, 13, 15, 17 [6 studies]
		7. Available jobs are low control, high stress	3, 5, 8, 18 [4 studies]
		8. People experience a sense of individualism (i.e. people feel expected to take responsibility for themselves and their situation and/or expect the same of others)	1-3, 12 [4 studies]
		9. Public transport is limited	10 [1 study]
		10. Alcohol is easily available	8 [1 study]
Secondary factors highlighted by authors as linking respondents' accounts of their experiences to socioeconomic deprivation to health impacts		1. Stress/strain/worry/fear (including fear and/or experiences of crime, anti-social behaviour, violence and racism and fear of negative interventions by public services, e.g. sanctioning benefits)	2, 5-18 [15 studies]
		2. Stigma of living/being in particular (less affluent) places/groups, which were perceived to be looked down on by others, or of not being able to provide adequately for families, specifically identified as a source of psychosocial stress by some authors [2 and 13].	1, 2, 4, 6, 10-17 [12 studies]
		3. Low/declining social capital and networks (including feeling unsafe, distrustful and suspicious of others in community/neighbourhood) often linked to changes in working patterns, housing, health status or changes in people living in area	1-4, 7, 9-11, 13, 15, 17 [11 studies]
		4. Health damaging lifestyle behaviours as a form of escapism (e.g. drinking alcohol, drug use, comfort foods and smoking), especially when other options perceived to be very limited and/or participants were experiencing physical or psychological pain	1, 2, 5, 8-11, 15, 16 [9 studies]
		5. Sense of apathy, political disenfranchisement/not being represented/cared for by mainstream political parties/governments	1-3, 5-7, 10, 11, 17 [9 studies]
		6. Individual experiences of social isolation	4, 5, 8, 10, 13, 15, 17 [7 studies]
		7. Sense of injustice, powerlessness, fatalism and lack of hope	1-3, 5, 10, 14, 17 [7 studies]
		8. Poor diets and hunger resulting from poverty and/or lack of healthy food being available for reasonable prices locally	1, 8, 10-12 [5 studies]
		9. Low self-esteem/loss of self-esteem (e.g. as a result of unemployment)	1, 2, 5, 16, 17 [5 studies]
		10. Fuel poverty	1, 12, 14, 18 [4 studies]

(continued)

Table 3 (continued)

<i>Interpretative category</i>	<i>Interpretations put forward by original author(s) (2nd order constructs)</i>	<i>Relevant studies</i>
Direct health impacts of socioeconomic deprivation	11. Debt	12, 15, 17 [3 studies]
	12. Anomie and alienation from local community	2, 15, 17 [3 studies]
	13. Tight social networks in which some issues could not be spoken about	7, 8, 17
	14. Consumerism and marketing, increasing pressure to buy particular products/brands, including unhealthy products	8, 11, 12 [3 studies]
	15. Lack of physical exercise	1, 3 [2 studies]
	1. Depression linked to poverty, lack of sense of hope, stress, social isolation, feelings of rejection/shame (e.g. following loss of jobs, unsuccessful applications for jobs or simply from the stigma of being unemployed or living in certain areas), historical abuse and poor housing/environment	1, 4-13, 15-18 [15 studies]
	2. Aches, pains, lethargy, dizziness and other physical pains, often linked to stress	1, 2, 5, 8, 9, 17, 18 [6 studies]
	3. Injuries, ill-health and childhood deaths linked to poor work and home environments	3, 10, 12, 16, 18 [5 studies]
	4. Minor ailments (e.g. respiratory problems, viruses, colds, flu, eczema), often linked to damp housing and poor quality environments and, less often, lack of self-care [18]	2, 10, 11, 18 [4 studies]
	5. Injuries and deaths occurring as a result of experiences of violence and accidents	5, 8, 9 [3 studies]
	6. Difficulties accessing treatments for health problems (e.g. facing longer waiting times if you are from certain areas/backgrounds or experiencing mental health problems which impede accessing treatments for other health issues)	8, 11, 15 [3 studies]
	7. General ill-health linked to not eating (e.g. parents going without meals to feed children), unemployment and lack of purpose	1, 17 [2 studies]
	8. Panic attacks linked to poor employment experiences	5 [1 study]
	1. Poor mental health attributed to poverty via multiple pathways (e.g. social isolation, lack of exercise, fear of crime and anti-social behaviour, stress and fear, unhealthy lifestyle-behaviours, perceived lack of opportunities, shame and relative sense of inferiority/unfairness)	1, 2, 6, 11-13 [6 studies]
Less-direct / longer term / cumulative health impacts	2. Chronic conditions generally and premature aging linked to poor environmental conditions in home and/or at work and poor diet	11, 12, 14, 15, 18 [5 studies]
	3. Cardiovascular health problems linked to stress, overwork, poor housing/environments and social isolation	4, 7, 17, 18 [4 studies]
	4. Depression linked to suicidality	5, 9 [2 studies]
	5. Earlier experiences of ill-health/trauma used to explain later experiences of ill-health/disease	17, 18 [2 studies]
	6. Respiratory diseases linked to smoking and poor environmental conditions	11, 18 [2 studies]
	7. Some diseases linked to longer-term neglect and poverty (e.g. tuberculosis and kidney disease)	18 [1 study]
Potential for change	1. Positive social networks (families, friends and colleagues) and associated support	3-7, 9, 15-17 [9 studies]
	2. Local community action, groups and 'places to go' (e.g. self-help groups, tenants' groups, toy libraries, courses, neighbourhood festivals, etc)	6, 7, 10, 15-17 [6 studies]
	3. Finding a job / positive employment experience	5, 7, 17 [3 studies]

(continued)

Table 3 (continued)

<i>Interpretative category</i>	<i>Interpretations put forward by original author(s) (2nd order constructs)</i>	<i>Relevant studies</i>
becoming employed, changing employment)	4. Deprivation/sense of injustice/anger and critical life events identified as motivating factor for some participants in their accounts of engaging in local initiatives and groups acting as a 'spur to social action'	5, 7, 17 [3 studies]
	5. Individual/familial resilience	15, 16 [2 studies]
Potential for worsening circumstances / exacerbating factors (e.g. losing jobs, family breakdown)	6. Investment in housing and local area, including green spaces	3, 6 [2 studies]
	7. Positive education experiences	10 [1 study]
	1. A disconnect between jobs/opportunities and perceptions of masculinity/traditional gender roles	1-5, 7, 8, 9 [8 studies]
	2. Feeling under suspicion (e.g. in shops), judged (e.g. by potential employers), not respected and/or not included in decisions (e.g. politically and in schools)	1, 4-6, 9, 10, 16 [7 studies]
	3. Critical life events such as bereavement, family breakdowns, chronic illness diagnosis and becoming unemployed	4, 5, 7, 15, 17 [5 studies]
	4. Abusive relationships	4, 8, 17 [3 studies]
	5. Negative aspects of close social networks	4, 7, 17 [3 studies]
	6. Normalisation of ill-health	5, 18 [2 studies]
	7. Imprisonment for crime	5 [1 study]
	8. High levels of caring responsibilities	5 [1 study]

Colour coding key:

<i>Research informed theoretical clusters developed to explain health inequalities</i>		<i>Type of health outcome</i>
Material-structural	Lifestyle-behavioural	Physical health
Psychosocial		Mental health

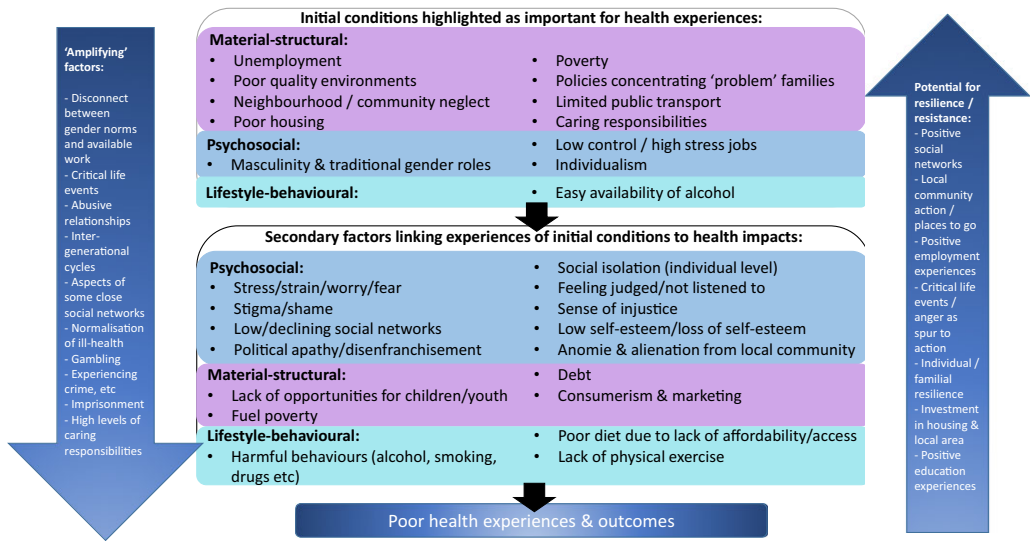


Figure 1 *Simplified overview of participants' accounts of socioeconomic health inequalities*

Of the various initial conditions identified as important in studies, employment opportunities and experiences seemed to play the most fundamental role in people's lives, with multiple implications for health. Reflecting this importance, accounts of the closure of major community employers were often emotive, as the following extract, taken from an interview with a woman living in the Welsh valleys, illustrates:

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 steel-works. 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. ('Martha' quoted in Walkerdine 2010: p.111)

Where communities experience multiple large employer closures, these changes not only threaten people's livelihoods and incomes but also particular ways of life, and the impacts tend to be multiplicative (Garnham 2015, Mackenzie *et al.* 2017, Rind and Jones 2015, Roberts 2009, Walkerdine 2010). Many older participants, for example, spoke with nostalgia about the days in which large employers were at their height, emphasising the strong social ties that this way of life facilitated – the 'buzz of people' (Terry, oral history participant, quoted in Garnham 2015) – as well as employers' investment in local facilities, such as sporting amenities and parks (e.g. Rind and Jones 2015).

When large-scale employers closed, participants reflected that this triggered a breakdown of social connections and the emergence of a collective sense of hopelessness. The resulting worklessness reduced community wealth, increased stress and lowered living standards (e.g. Garnham, 2015). At a more individual level, participants who had lost jobs reported feeling that they had experienced a consequential decline in their perceived social status, 'daily meaning' and structure, as well as material income (Vassilev *et al.* 2014).

When combined with an increasingly minimal and heavily regulated welfare support system (evident in the more recent studies), several participants described feeling pushed into jobs that they considered to be damaging for their mental health, with 'call centre' work singled out as a particularly pernicious example by a GP working in Easington (Roberts 2009). As Macdonald and Shildrick note, when reflecting on the employment opportunities experienced by many of their young participants:

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 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 2013:151)

Many of the participants and study authors attributed this situation to the political and economic decisions of local and national policy actors and this then contributed to a sense that these communities were being treated unfairly, to the benefit of others (Cattel 2001, Garnham 2015, Mackenzie *et al.* 2017, Rind and Jones 2015, Roberts 2009, Walkerdine 2010). This informed a common perception that those in positions of power had deliberately neglected certain areas (or, at the very least, given preferential treatment to affluent areas):

In all of the focus groups, there was a perception of neglect and that 'authorities' did not listen to or understand residents' needs [...]. We did not prompt discussion on inequalities or seek comparisons with other areas. However, among young people in all three areas there was explicit recognition that 'other' areas were better than where they lived. Participants questioned the fairness of this. (Parry *et al.* 2007:130)

Complaints of poor quality, limited, local shops and facilities (e.g. play parks), combined with limited transport options, were linked by participants to low exercise (Backett-Milburn *et al.* 2003) and poor diets (Popay *et al.* 2003b). While poor quality housing (high rise flats, in particular) was linked to feelings of hopelessness, depression, social isolation and/or a sense of being uncared for (Bolam *et al.* 2004, Cattel 2001, Davidson *et al.* 2008, Garnham 2015, Parry *et al.* 2007, Popay *et al.* 2003b, Watson and Douglas 2012). Participants explained that both the direct, negative emotional and physical consequences of poor quality living environments, and the difficulties facing those attempting to improve conditions, contributed directly to experiences of depression:

If you open your door and it's full of rubbish and what have you, it makes you feel depressed, you know. ('Margaret', low SES participant living in Greater Glasgow, quoted in Davidson *et al.* 2008: 174)

The amount of times I've been so depressed because of the way the house is has been unbelievable, that's their fault. I begged for help, they never gave me it. ('Jane', low SES participant living in Greater Glasgow, quoted in Davidson *et al.* 2008: 176)

Poor housing was also identified as a source of shame and stigma, leading to feelings of being unsafe and contributing to arguments within the household (Parry *et al.* 2007) and an unwillingness to have friends and family over (Davidson *et al.* 2008), while additionally contributing to some forms of chronic ill-health (Bolam *et al.* 2004, Davidson *et al.* 2008).

All of the initial conditions mentioned so far have a connection to income but, interestingly, few participants explicitly linked income to health. Rather, people tended to focus on a wide range of material and financial resources that combined to contribute to poor living and working environments, stress and anxiety and which were exacerbated when debt was involved (Watson and Douglas 2012). These experiences informed people's sense of not having many choices/options available (Bolam *et al.* 2004) and feelings of stigma and guilt (e.g. not being able to afford to provide treats for children or, in some cases, to provide adequate food and clothing) (Parry *et al.* 2007). In one study, a participant called 'John' reflected that, prior to the introduction of the minimum wage, he had been told by one of his bosses that he was earning less than the security dogs he worked alongside (Mackenzie *et al.* 2017). His account illustrates how low wages can contribute directly to low self-esteem and fuel people's sense of injustice. Reflecting this, Vassilev and colleagues' (2014) study of 300 GP patients with long-term conditions found that access to material resources (particularly income and wealth) played a central role in the way that people assessed their social status.

Across the studies, as Figure 1 highlights, participants commonly referred to key psychosocial pathways as important explanations for the ways in which they felt the initial (largely material-structural) conditions they lived and worked in impacted on their health. The most common psychosocial pathway linking socioeconomic deprivation to poor mental health outcomes was stress (Backett-Milburn *et al.* 2003, Bolam *et al.* 2004, Cattell 2001, Davidson *et al.* 2006, 2008, Garnham 2015, MacDonald and Shildrick 2013, Parry *et al.* 2007, Popay *et al.* 2003a, 2003b, Roberts 2009, Walkerdine 2010, Watson and Douglas 2012). Stress was described in ways that suggested it contributed directly to depression, anxiety, panic attacks and anger and indirectly to social isolation (e.g. via family arguments) and poor decision-making (e.g. around managing limited finances or consumption of harmful products).

While stress was the most frequent psychosocial experience to be mentioned, 'fear' appeared to be one of the most damaging and often related to previous negative social interactions, including, for example, being the subject of violence (including racial, gender-based, sexual and drug and alcohol fuelled violence), other criminal acts (Cattell 2001, MacDonald and Shildrick 2013, Parry *et al.* 2007, Roberts 2009, Watson and Douglas 2012) or, more broadly, disrespect or discrimination. This, in turn, could lead to people feeling uncared for (Burningham and Thrush. 2003, Watson and Douglas 2012) and, in some cases, keen to avoid interactions with the public services intended to provide a basic ('safety net') level of support (Garnham 2015).

Other important psychosocial factors identified in the studies include shame and stigma (Cattell 2001, Davidson *et al.* 2006, 2008, Garnham 2015, Mackenzie *et al.* 2017, Parry *et al.* 2007, Popay *et al.* 2003a, 2003b, Watson and Douglas 2012) and, in fewer studies, 'anger' (Cattell 2001, MacDonald and Shildrick 2013). These feelings were, in turn, commonly connected to concerns about feeling 'judged', 'disrespected' and labelled as 'poor' (Watson and Douglas 2012, Vassilev *et al.* 2014). In most cases, these experiences were described in ways that suggest they interacted with one another, with negative consequences for health. Shame, stigma and fear, for example, were described as directly impacting on mental health but also combining to fuel unhealthy behavioural responses, including a perceived need to spend money on items that could not really be afforded (e.g. to ensure children looked 'smart enough' so that neighbours would not report them to social services for neglect – Cattell 2001). It is worth noting, however, that anger and a sense of injustice were occasionally referred to in ways that suggested these experiences could be positive for health (e.g. in instances where it had caused participants to work collectively to try to challenge the source of the perceived problem (Cattell 2001, Davidson *et al.* 2008)).

The other frequently mentioned pathway linking people's living and working conditions to their health was 'lifestyle behaviours', with health-damaging behaviours often being described by participants and authors in ways which suggested they were a rational (even inevitable) response to difficult circumstances, coping mechanisms or forms of escapism:

[I]t is possible to theorise the attraction of heroin, at least in part, as a form of self-medication to numb psychic pain and ameliorate 'ill-being'. (MacDonald and Shildrick 2013: 150)

[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' (female resident of an inner city estate in Greater Glasgow, quoted in Davidson *et al.* 2008: 176)

Such an account was used by one of Dolan's (2007) interviewees to explain why local initiatives to reduce drug-related crime were unlikely to work without efforts to change the wider circumstances, particularly in terms of employment:

Like when they come in an say, 'Right we're going to clear you of drugs'. OK. That's great. But we say what are you going to replace it with? If you take something away, you have to replace it with something else. Work isn't here, so you can't replace it with work.' (Bob, 39, resident of a non-affluent area in Coventry, quoted in Dolan, 2007: 487).

In the context of both these kinds of within-study accounts of policy failures and the research consensus that post-1997 policy efforts to reduce health inequalities in Britain have failed, the following sub-section focuses on considering what studies suggested about the potential to alter the impacts of material and structural circumstances on health.

Factors with the potential to 'amplify' or provide 'resilience' to negative health impacts

The wide arrows to left and right of Figure 1 capture factors that were described as either 'amplifying' the negative health impacts of difficult socioeconomic circumstances (left-hand arrow, Figure 1) or providing a sense of resilience or resistance (right-hand arrow, Figure 1). Categorising second-order constructs as one or the other was not necessarily clear-cut with, for example, critical life events and anger being described in ways which suggested that they could sometimes serve to increase people's sense of hopelessness and, potentially, their use of alcohol and drugs, but, at other times, provide triggers for people to change damaging patterns (e.g. Macdonald and Shildrick 2013). Likewise, as Figure 1 illustrates, while most studies suggested that strong social networks (where available) provide some resilience to factors that might otherwise impact negatively on health, a small number of cases highlighted how tightly-knit networks of people sharing experiences/circumstances could exacerbate negative experiences or may make it harder to ask each another for help (e.g. shared bereavement or limited resources – see Cattel 2001).

It is clear that many of the factors identified as having the potential to change the way in which people's living and working conditions impact on their health (for better or worse) are difficult (in some cases impossible) to change at an individual level or even, perhaps, a single policy level. Participants' accounts also support the idea that negative experiences can be cumulative, making it increasingly difficult over the lifecourse for people living in deprived circumstances to respond positively to the complex web of negative influences captured in Figure 1. 'Health selection', in which poor health limits a person's income (e.g. via the jobs that it is possible to do) played a role in this, with some participants attributing their exit from the labour market to ill-health (MacDonald and Shildrick 2013).

To what extent do people explicitly acknowledge socioeconomic health inequalities?

The above accounts suggest that lay understandings of the multiple and intersected ways in which socioeconomic circumstances impact on health is closely aligned to research-informed theories of health inequalities researchers (Bartley 2004, Marmot 2010, Smith *et al.* 2016), highlighting the importance of both material and structural conditions and psychosocial pathways. Yet, across the seven studies that explicitly considered what people thought about 'health inequalities', participants repeatedly resisted their existence. With the odd exception in three studies (Davidson *et al.* 2008, Mackenzie *et al.* 2017, Parry *et al.* 2007), participants seemed more comfortable discussing socioeconomic inequalities than health inequalities (Backett-Milburn *et al.* 2003, Cattel 2001, Parry *et al.* 2007). More commonly, participants denied the existence of health inequalities or acknowledged them only with reluctance (Airey 2003, Backett-Milburn *et al.* 2003a, Bolam *et al.* 2004, Davidson *et al.* 2006, 2008, Popay *et al.* 2003).

This appears to represent something of a paradox (though one that occurred *within* several studies, rather than between different studies, so a paradox we explored but not one for which we employed meta-ethnography's 'refutational' analysis, since that focuses on exploring contradictions *between* studies): participants appeared to understand the multiple, complex pathways between socioeconomic circumstance and health and yet deny (or resist) the logical consequence of these unequal experiences. The studies provide a variety of explanations for this apparent paradox, all of which relate to experiences of stigma and shame. First, participants were concerned and on occasion angered by negative images of the place they regarded as home (Airey 2003, Burningham and Thrush. 2003, Parry *et al.* 2007), sometimes interpreting potentially derogatory labels associated with their place of residence, as attacks on themselves as residents (as 'scum' as one of Parry *et al.* (2007) participants put it). Some participants believed that the stigma associated with living in particular areas directly limited their employment opportunities (e.g. Parry *et al.* 2007), while others discussed health impacts relating to the 'shame' of living in a particular area:

'I live in Whitecrook and Whitecrook's got a very bad name. It embarrasses my wife tae have tae live there, y'know. She feels embarrassed if she tells people or people have tae come tae the house. It's a shame. It affects her mentally. It affects me tae a slight extent but not as bad, I think the wife's more affected by it.' (Owen, photovoice participant in Garnham, 2015: 328)

These accounts reflect Bush *et al.* (2001) observation that the stigma attached to particular places is perceived to easily transfer to particular communities, stimulating efforts to resist such 'labelling'. Participants' reluctance to openly acknowledge the existence of socioeconomic health inequalities might therefore be understood as part of a set of strategies intended to limit the sense of stigma, shame and injustice associated with living in particular places or communities. While not exploring this point in detail, almost all of the study authors that explored this issue concluded that, in denying the existence of health inequalities, participants were resisting the suggestion that premature ill-health and death was in some way inevitable for people like them (Airey 2003, Backett-Milburn *et al.* 2003, Bolam *et al.* 2004, Popay *et al.* 2003a, Watson and Douglas 2012). Indeed, some studies found that the specific idea of socioeconomic health inequalities could itself become a source of stress for people living in poorer areas (Davidson *et al.* 2008, Mackenzie *et al.* 2017). Hence, media coverage of health inequalities seemed to contribute to people's sense of injustice and stigmatisation:

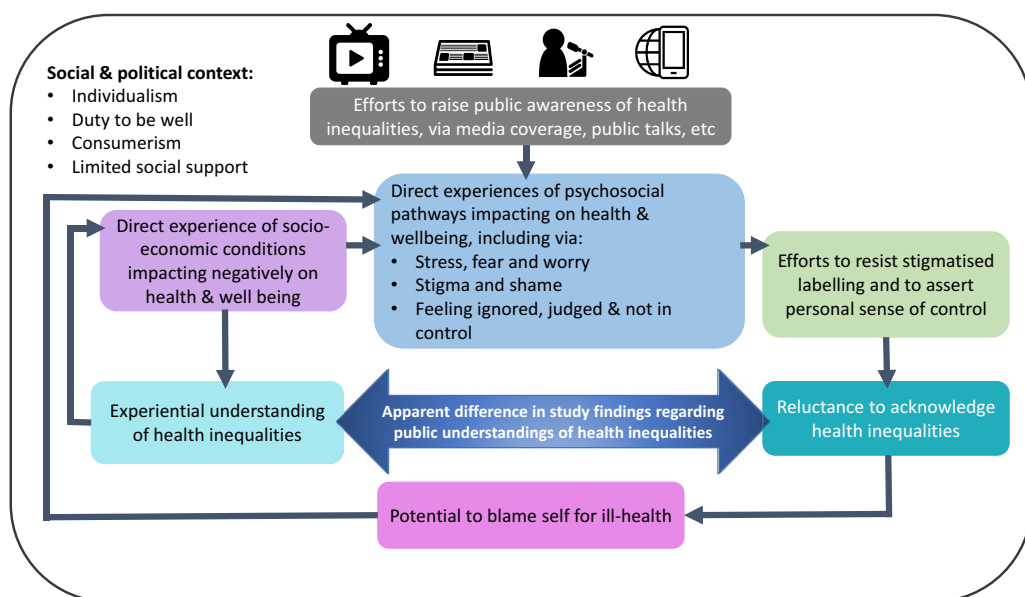


Figure 2 The potentially damaging impact of efforts to raise public awareness of health inequalities due to feelings of stigma, shame and lacking control

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... Nae-body'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.* 2017: 8)

In contrast, as Figure 2 summarises, assuming individual responsibility for one's health status appeared to increase people's sense of control (something, it is important to remember, that was already being challenged in multiple ways). This means that efforts to increase public awareness of health inequalities (e.g. via mass media coverage of the issue) may have the unintentional impact of further stigmatising and shaming the communities in which poor health is most prevalent (i.e. exacerbating some key psychosocial contributors to ill-health) and, potentially, reinforcing a reluctance to acknowledge these inequalities. Reflecting on the quote above, from 'John' in Mackenzie *et al.* (2017), this seems especially likely where messages about health inequalities focus on the extent of health differences between particular areas or groups without being connected to any sense that these differences are being (or could be) substantially reduced.

As Figure 2 illustrates, the worrying (though logical) consequence of this was that participants often seemed to end up blaming themselves for their own poor health:

Author (interviewer): 'Do you think that living here has affected your health either positively or negatively?'

Mary (interviewee): 'No, I don't think that's, I think my health problems are just my health problems [diabetes and angina] and that's it, I think, I think that the diabetes was because of my weight, and the heart condition was a combination of the diet and possibly the passive smoking. I wouldn't say that, that it was the environment that's caused my problems.'

(Taken from Airey 2003:132)

Concluding discussion

Overall, the papers reviewed suggest that people living in a variety of different communities in the UK have sophisticated understandings of the underlying causes of socioeconomic health inequalities which closely mirror popular, research-informed theories about health inequalities (Bartley 2004, Marmot 2010). This aspect of the findings could be read in at least two ways. On the one hand, the overlap between academic and lay accounts of the health impacts of social determinants could be used to reinforce claims about the validity of the broad social determinants of health approach (Marmot *et al.* 2010). On the other, it could be used to question the intellectual utility of continuing to expand the mass of academic research exploring the causal pathways linking social and economic disadvantage to poor health outcomes (Heath 2007).

As Bolam *et al.* (2006) conclude, participants' accounts highlight the importance of both material-structural factors and social constructions of individual and collective experiences (i.e. of the deeply intertwined nature of materialist and psychosocial explanations of health inequalities). In particular, the emphasis that participants placed on experiences of employment, poor quality jobs and worklessness as health determinants reflects extensive epidemiological evidence (Bambra 2011). Indeed, while the complex and dynamic relationships linking people's experiences of socioeconomic deprivation to poor health make singular policy solutions unlikely, the findings add weight to calls for 'upstream' policy responses to health inequalities and suggest supportive employment policies are one of the most promising areas to focus on.

Likewise, the importance participants attached to experiencing feeling fearful, stressed and socially isolated, and their concern (and sometimes anger) at feeling judged or disrespected, all reflect research evidence concerning psychosocial pathways and relative social status and equality (Marmot 2015). A recently published ethnographic and interview-based study of lay perspectives on health inequalities in north east England (not included in this meta-ethnography as it was only published after our analysis had been completed) also emphasised the importance of psychosocial pathways, identifying 'fatalism' (linked to low sense of control) as a key psychosocial pathway linking disadvantage to poor health (Garthwaite and Bambra, 2017). This dimension of the findings underlines the importance of the ways in which public servants (from teachers to Job Centre staff and social workers) interact with the communities they serve. Indeed, in several cases, single experiences of disrespect, coercion or discrimination appeared to have had long-term consequences for participants. This suggests that the increased conditionality of welfare support (combined with cuts in public spending), in which those seeking benefits are required to provide an array of information to demonstrate their commitment to finding work (or to support their claim to be unable to work) is impacting negatively on health in Britain's poorer communities, further exacerbating health inequalities.

Finally, participants consistently described proximal, behavioural contributors to poor health, such as high alcohol consumption, drug use, unhealthy diets and smoking, as 'coping' mechanisms or forms of escapism (i.e. as understandable responses to the multiple other factors impacting on wellbeing). This reinforces research claims that policy interventions aimed only at this level are unlikely to be effective in reducing health inequalities (Scott *et al.* 2013, Whitehead 2007).

In sum, the lay explanations for the drivers of health inequalities in the papers we have reviewed are presented as sophisticated, multidimensional and correspond well with current academic models of the impact of inequality on health (Marmot 2010, Popay *et al.* 2003a, Smith and Stewart 2016). Indeed, the overlap between academic and lay accounts of the ways

in which socioeconomic circumstances shape health raise questions about the value of further analysis of these pathways. Yet, seemingly paradoxically, the findings also suggest that people experiencing socioeconomic deprivation are unwilling to acknowledge the logical consequence of all this in naming the existence of health inequalities. We argue (as several authors of included studies have also done) that this reflects not a lack of understanding but an attempt to resist some of the stigma and shame associated with poverty (Walker *et al.* 2013) and poor health (Scambler 2008) and to exert a sense of individual agency. As Elliott and colleagues (2016: 229) note, this presents a dilemma for qualitative researchers since, 'acknowledging the impact of deprivation, disadvantage and exclusion is potentially to reinforce an identity that people may be trying to resist'.

In this context, media coverage of health inequalities was described by one participant as a means of 'kicking' communities that were already struggling (see Figure 2). This raises serious questions about Roberts's (2009) and Bolam and colleagues' (2004: 1364) conclusion that we ought to be working to increase people's awareness of health inequalities in the hope that wider public discourse might, in itself, support attempts 'to tackle these injustices'. Such optimism, while well intended (perhaps even attractive in an era of 'research impact' - Smith and Stewart 2017), seems misplaced in the context of Wacquant's (2007) observation that territorial stigma is a 'stamp of dishonour' which 'media and certain scholarly discourse' reinforce and which residents of affected places work hard to resist by adopting such strategies as hiding their address (or making excuses for their neighbourhood) and avoiding having family and friends visit them at home. Even where efforts to raise public awareness are intended to target more advantaged communities (who may have less direct understanding of the multiple ways in which socioeconomic circumstances shape health and also be less likely to experience public discussions of health inequalities as stigmatising), we suggest researchers have an ethical obligation to work to limit the negative (unintended) effects of such media coverage on disadvantaged communities.

We are not, of course, arguing that researchers should avoid engaging in public discussions about health inequalities since there are also strong ethical reasons to do so, including as part of efforts to effect change (Elliott *et al.* 2016). Nor do we agree with Wacquant's pessimistic conclusion that 'the precariat is a sort of still-born group [that] can only make itself to immediately unmake itself' (Wacquant, 2007: 73). Rather, we make three tentative suggestions as to how researchers working in this area might engage in public discussions that both avoid contributing to the stigmatisation of particular places and communities (labels that, Pearce 2012 notes, can be both enduring and highly mobile) and begin enabling people to 'imagine transformation' (Elliott *et al.* 2016). First, most obviously, researchers need to be careful with the language and labels they employ in discussing health inequalities, particular places and communities. Second, linked to this, we could do more to challenge narratives of binary oppositions in popular culture (e.g. 'poor' versus 'rich', 'healthy' versus 'unhealthy') and instead explore the consequences of inequality for all of us. The unintentional implications of multiple studies that focus only (or even largely) on more disadvantaged communities (of the kind this review identified) are that these are the *only* people for whom inequality really matters and that it is in these communities that research like this is most needed. An alternative perspective might take inspiration from Susan George's (2015) observations that people experiencing socioeconomic disadvantage already understand their situations very well. Hence, rather than further research focusing on disadvantaged communities, it might be more useful to analyse how people across a wider range of social positions understand and engage with health (and other) inequalities. Third, the focus of future health inequalities research should shift away from merely analysing the problem (where the risk of reinforcing people's sense of stigma, shame and powerlessness seems greatest), to better understanding potential proposals for their

amelioration. One way of achieving this might be to experiment with deliberative democratic forms of engagement (Blacksher 2013) and/or with participatory practices specifically intended to overcome alienation (Blencowe *et al.* 2015). Others might include analysing the political processes and decisions that create the initial conditions identified in this review (see George 2015 again). In other words, researchers could both avoid contributing to stigmatising 'labelling' processes and do more to critically engage with 'those doing the labelling' (Bush *et al.* 2001).

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