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Conclusion—where next for advocates, researchers, and policymakers trying to tackle health inequalities?

Chapter 21: Conclusion – where next for advocates, researchers and policymakers trying to tackle health inequalities?

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Reducing health inequalities is no easy task. Despite the mass of research that has been undertaken and the multiple policy interventions that have been tried in the UK and other countries(see Chapters 1-4), health inequalities persist and have even widened in many contexts. Reflecting on the various perspectives provided in this book, Box 1 highlights what appear to be the major challenges for understanding and tackling health inequalities. The wide-ranging nature of these challenges underlines the futility of seeking a 'magic bullet' to 'fix' health inequalities. Nonetheless, the various contributions to this book also point to the potential for health inequalities researchers and others to do more in addressing health inequalities, though realisation of this potential may require a departure from the familiarity of traditional approaches.

Box 1: Seven key challenges for better understanding and reducing health inequalities
1. **Generating and maintaining concern for health inequalities:** Although health inequalities have officially been on the UK policy agenda since 1997, policy interest in the issue has fluctuated over time (see Chapters 1 & 2). In many other contexts health inequalities have received low priority as a policy issue (Chapters 4 & 5). Substantial efforts are needed to attract and maintain concern for health inequalities so these remain a central issue in countries' policy agendas.
2. **Challenging dominant neoliberal paradigms:** A recurrent theme throughout this book is the extent to which health inequalities reflect broader social inequalities, which are created and maintained by unequal power relations (Chapters 6-9, 13, & 15-17). Addressing health inequalities therefore requires researchers, policymakers and practitioners to move beyond a focus on individual choice to consider the structural drivers of inequalities. This has particular implications for research methods and health policy (see below), but also requires us to challenge dominant ideologies that privilege individual and market 'liberty' at the expense of social equity and broader freedoms.
3. **Developing clearer policy responses and resisting 'lifestyle drift':** There is a need for those concerned with health inequalities to more clearly articulate the kinds of policy responses required to promote health equity. This is made more difficult by a lack of

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consensus among researchers, policymakers and advocates over the implications of existing evidence (Chapter 6). Nevertheless, several authors in this book highlight the need to resist 'lifestyle drift' in health policy, arguing for a more explicit focus on reducing inequalities in income, wealth and power (Chapters 3, 8, 15 & 16).

4. **Strengthening available evidence.** A number of contributors highlight challenges and opportunities for generating the kinds of evidence needed to support development of effective policy responses to health inequalities. A key challenge is the 'inverse evidence law' (Chapter 18), meaning it's much easier for traditional forms of research to generate evidence on individual ('downstream') interventions compared with social ('upstream') policies. For this reason, health inequalities research often mirrors the 'lifestyle drift' evident in policy (Chapters 6, 8, 15 & 16). There is a need for innovative approaches to generating the kinds of evidence that can inform and support 'upstream' policy responses to health inequalities.

5. **Methodological development.** In order to generate the kinds of evidence needed to address health inequalities, researchers need to move beyond traditional approaches and employ a broader and more sophisticated range of research tools. Health inequalities research has much to gain from broader disciplinary perspectives including geography, sociology and political analysis (Chapters 9 & 13-16), and from the application of social theories that help draw attention to the politics of health inequalities (Chapters 16 & 17). 'Natural experiments', econometric and qualitative methods all offer important methodological tools for future health inequalities research (Chapters 6, 16 & 18).

6. **Understanding and engaging in policy development.** Alongside the need for innovative approaches to generating evidence, there is a sense across this book that those concerned with health inequalities need to develop a more sophisticated understanding of how policy develops and is informed by research, advocacy and public opinion (Chapter 19). Just as economic recessions, 'austerity' policies (Chapter 12) and ongoing policy reforms (Chapters 10 & 11) make it more difficult to achieve reductions in health inequalities, so at other times policy 'windows' may facilitate change (Chapter 2) – particularly with support from third sector and campaigning organisations and strategic engagement with the media (Chapters 6 & 19).

7. **Moving beyond 'knowledge translation'.** Overall, this book challenges the assumption that the use of evidence in decision-making is a neutral, technical matter and instead presents health inequalities research and policy as inherently political and value-oriented. This belies the traditional separation of science and advocacy, and challenges those who study health inequalities to also consider what such inequalities mean for our communities, our society, and ourselves. Such consideration may lead us to take a more active role in tackling inequalities – whether through challenging dominant political and policy paradigms (Chapters 9, 13, 15 & 17) or stepping outside the academic world to share our understanding and ideas with the wider public (Chapters 19 & 20).

In this concluding chapter we develop some ideas for strengthening health inequalities research, reflecting on contributions and insights offered by the contributors in this book. As academics, we are particularly focused on the potential for researcher to help reduce health inequalities, but we also recognise that research is only one part of this effort. We have therefore also set out some suggestions for how individuals working in a range of other professional settings might also contribute to tackling health inequalities.

As Chapters 1-5 make clear, the UK has played a leading role in developing our understanding of health inequalities. There are limits to the lessons that it is possible to garner from one context, however, particularly when efforts to reduce health inequalities here have not been successful. As Chapters 5, 6, 7 and 14 all suggest, the value of UK-based evidence could be substantially enhanced via its integration with more international and historical research on health inequalities. By expanding the range of empirical data we consider through engagement with international and/or historical research findings, we are likely to gain a better understanding of the causes of health inequalities, including how different 'policy packages' influence health inequalities in different contexts.

Second, as Chapters 8, 14, 15 and 16 all imply, in order to challenge the pervasive problem of 'lifestyle drift' we may need to develop new discursive frames for studying and thinking about health inequalities. New frames could help re-orient research and policy away from a focus on health behaviours and towards the contexts in which the upstream determinants of health inequalities are shaped over time. Several contributors note the tendency for health inequalities research (and policy) to focus on the mechanisms by which social inequalities are translated into health inequalities, rather than addressing the underlying causes of the social gradient. In order to 'paddle upstream' (as Douglas puts it in Chapter 8), we may need to broaden our focus from 'health inequalities' to 'social inequalities' (see Chapter 20). Such a reframing can be somewhat uncomfortable for those of us from a health background, but it may also offer potential allies in other fields, including other academic disciplines and broader movements such as social justice and human rights.

Third, the contributions to this book highlight a range of important areas in which health inequalities remain under-studied. These include: (i) moving beyond a focus on social class

to consider how multiple axes of social position interact (Chapter 7); (ii) better understanding how powerful ideologies (Chapters 9 and 17) and actors (Chapters 13 and 19) influence policy; (iii) studying how contemporary policy changes are impacting on health inequalities (Chapters 10, 11, 12 and 15); (iv) working to better understand how the geographical and historical contexts in which we live and work shape patterns of health inequalities over time (Chapter 14); and (v) doing much more to examine health inequalities in other settings, perhaps particularly low and middle income contexts (Chapter 5).

Fourth, there is a need for health inequalities research to move beyond traditional methodologies to employ a broader range of research tools. Chapters 14-18 suggest how traditional public health methods, such as epidemiology, can be enhanced and supplemented by other disciplinary perspectives, particularly those with strong theoretical underpinnings (including sociology, political analysis and other social sciences). Other disciplines also offer potentially valuable research tools, with 'natural experiments' and econometric analyses providing important opportunities to evaluate the impacts of upstream policy changes on health inequalities, while qualitative methods can enhance our understanding of both the drivers and impacts of health inequalities. Indeed, the 'health inequalities evidence industry' (chapter 18) would benefit from taking a plurality of approaches as a way of strengthening our engagement with policymakers and the public (chapters 19 and 20).

Fifth, as Chapters 6, 16 and 17 all suggest, health inequalities researchers should do more to work with the communities most affected by health inequalities and take more seriously the everyday knowledge and experiences evident within these communities. However, in undertaking such work it is essential to ensure that this research in itself is not stigmatising and that the difficulties experienced by such communities are adequately linked by researchers to relevant macro-level policies (see Chapters 9, 15 and 17) and potential solutions. If this does not happen, such research risks locating problems within particular communities and/or providing demoralising (and potentially stigmatising) accounts of life in particular places.

Sixth, in order to maintain (or increase) the policy profile of health inequalities, researchers need to do more than simply generating evidence. There are many ways in which researchers can raise the profile of their work and the issues they seek to address, particularly by engaging with key actors and institutions working to influence policy - including politicians, advocacy organisations (in the third sector and beyond), and mass and social media. Whilst it may not be possible to develop broad coalitions around health inequalities generally (see Chapters 19 and 20 on the difficulties facing those who engage in advocacy work), it may still be possible to develop coalitions around specific, empirically-informed policy proposals.

In order for such coalitions to emerge, actors working in other settings need to be aware of and concerned about health inequalities. Currently, such actors are more likely to be dealing with the consequence of health inequalities in specific areas (this tends to form the focus of most large campaigning organisations representing health professionals, chronic diseases or specific health risks). In order to create the potential for broad-based coalitions, researchers (and others) concerned with health inequalities need to explore how their concerns might coincide with those of third sector and other professional campaigning organisations. As discussed above, a broader framing of 'social inequalities' may help facilitate such coalitions, creating opportunities for those in different areas to work together in calling for greater public and policy attention to the underlying drivers of health inequalities.

The above reflections are primarily focused on ways in which researchers might strengthen the available evidence on health inequalities, and ensure this evidence feeds into public debate and policy development. Recognising that research is only one part of the effort to reduce health inequalities, we also offer some suggestions for how those working in policy and practice might contribute to this agenda. This is by no means a comprehensive or perfect list; rather, it is intended as a starting point for further discussion.

   i)   A recurrent theme in this book is the tendency towards 'lifestyle drift' in policy and practice. While addressing individual behaviours is a relevant part of health promotion, it can, in isolation, detract attention from the broader drivers of such behaviours and further stigmatise those who are already disadvantaged. Both

policymakers and practitioners can be alert to this risk and can draw attention to the situations in which they encounter lifestyle-drift in action (see Chapter 8);

ii) Another recurrent theme is the need for 'better evidence on what works' in reducing health inequalities. Natural experiments offer the best opportunities for evaluating the impact of upstream policy intervention. Those working in policy can help strengthen the available evidence base by making researchers aware of opportunities for studying the impacts of forthcoming policy changes on health inequalities - even where they are not in a position to fund or even officially support such research;

iii) In some instances, there is adequate evidence to guide policy decisions – but (for a variety of reasons) policymakers may pursue interventions that are not supported by this evidence. Those working in policy and practice can challenge policy decisions which appear to run counter to available research evidence (e.g. decisions to shift the locus of responsibility for tackling health inequalities on to local policy groups with limited power). Even where there is little will to reverse such decisions, bringing attention to them will help highlight the ways in which pursuit of other policy goals may come at the expense of widening health inequalities.

iv) As noted above, in order to generate meaningful evidence and give a voice to those most affected by health inequalities, researchers need to engage with relevant communities and learn about their experience and knowledge. Those involved in health practice and advocacy can be instrumental in helping forge such links. They also have an important role to play in bringing together those from academic and other sectors to develop more joined-up, evidence-informed proposals for responding to health inequalities.

In conclusion, the task of reducing health inequalities is a challenging one, and no country has fully succeeded in developing an effective policy package to 'close the gap' between those at either end of the social gradient. While this book describes a range of challenges facing researchers, policymakers and practitioners concerned with health inequalities, it also sets out a number of opportunities and priorities for taking forward this agenda. Key among

these is the need to continue developing our understanding of the causes and remedies of health inequality, even when this does not feature on the public policy agenda, in media discussion or in research funding objectives. One of the most important lessons of the UK and Nordic experiences is that health equity is a long-term project. While we cannot necessarily create the conditions necessary for a broad-based political commitment to addressing health inequalities, we can ensure we are ready to make the best possible use of the next 'policy window' – whenever that may arise.