

# What do researchers think needs to happen to reduce health inequalities and what might be the role of third sector organisations?

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# **Outline of presentation and data sources...**

- **Perspectives on where we are now with efforts to reduce health inequalities (interviews 2011-2012 and focus groups 2012)**
- **What kinds of policies and interventions do researchers believe are likely to reduce health inequalities in the UK? (Online survey results)**
- **What *is* the role of third sector organisations in advocating to reduce health inequalities and what *might* it be? (interviews 2011-2012 & focus groups 2012)**



## Where are we now? Views from different sectors...

Sector	Widely expressed views
Academics	<ul style="list-style-type: none"> <li>• Still waiting for policies to reflect the available evidence</li> <li>• Conscious about the limits on using health inequalities evidence to develop clear policy recommendations</li> </ul>
Civil servants	<ul style="list-style-type: none"> <li>• Unsure about progress in reducing health inequalities (with some optimism in England in relation to targets)</li> <li>• Still waiting for clear, evidence-informed policy recommendations to use</li> <li>• Sense they are limited in a number of ways (public and political mandate, public/media perceptions, political nervousness, etc)</li> </ul>
Politicians	<ul style="list-style-type: none"> <li>• Embarrassed by lack of progress in reducing health inequalities (esp. Labour)</li> <li>• Wary of health inequalities - sense it is 'too big, 'too difficult' and 'too political'</li> </ul>
NGOs, campaigners, etc	<ul style="list-style-type: none"> <li>• Waiting for clear, solution-orientated policy recommendations from researchers</li> <li>• Searching for links between health inequalities and issues they represent</li> <li>• Generally not heavily involved in health inequalities debates</li> <li>• Very concerned about likely impact of current changes to welfare and economic policy on health inequalities and keen for research on this.</li> </ul>
Practitioners and local decision-makers	<ul style="list-style-type: none"> <li>• Some sense of local powerlessness and frustration with national 'lifestyle drift'</li> <li>• Still waiting for evidence-informed, local policy proposals</li> <li>• Very concerned about likely impact of current changes to welfare and economic policy on health inequalities and keen for research on this.</li> </ul>



# Example of NGO frustration with recent policy approaches to health inequalities

Health NGO Chief Executive: *'Some questions need to be asked as to why the last government didn't tackle alcohol and gambling and why it became so permissive. [...] And do I think that's going to have a big impact on inequalities? You bet. I think regeneration was more often about introducing betting shops, pubs and things like that in regeneration areas. [...] [And] clearly on things like redistribution of wealth and all of the wider things, [they] could've gone a lot further.'*



# Upstream evidence-informed recommendations can be too big:


Female participant in 'advocacy' focus group: *"[When] I was looking through some of the papers for this conference, it made me reflect on an experience we've had recently in [Blank] where we're doing some work around [blank], and a lot of the arguments we were making is about well this is an equity issue and all the social determinants arguments. And when you present those in a public forum, often what seems to happen is a kind of drawing back, because people go, 'well, that's just too huge, you're basically asking us to change the whole structure of the economy, you know, the political makeup, the nature of gender relations,' all of those things. It's too big. [...] And then there's kind of what they [researchers] describe as a 'lifestyle drift', an increasing move to, well, what we need to do is focus on the individual on the street and what we can do from there. So I was trying to think in my mind in terms of whether you don't need some kind of two pronged approach. One which is acknowledging the political and policy contexts in which we're operating [...] and the fact that if you go to that government say you need to radically overhaul everything and let's get rid of capitalism you're just going nowhere [...]. But simultaneously I think that it is very important that researchers are finding a way to represent in a way that the wider public can engage with what is actually happening in terms of these wider structural economic changes..."*



# Researchers aren't providing solution-orientated recommendations

Female participant in 'advocacy' focus group: *"My role is very much about taking someone else's research and then trying to lobby on that, and trying to get the change that would support that. And one of the things that's quite difficult is that often the researchers focus on the problem and explaining the problem and evidencing the problem, which you need absolutely, but less focused on solutions and less focused on what could be done about it, examples from what other countries have done to tackle that, things like that. And that's actually really difficult to take to politicians and policymakers, because as soon as you take them a problem they want the solution. And if your answer is well I don't have a solution, they're not interested because actually that's what they need. So from my perspective almost irrespective of what the topic is, what I'd like to see is more research focused on taking a particular issue and saying okay well let's look at this example from Finland where they did something about this, and here was inputs outputs, this is what it made and this is how we could apply it within our context."*





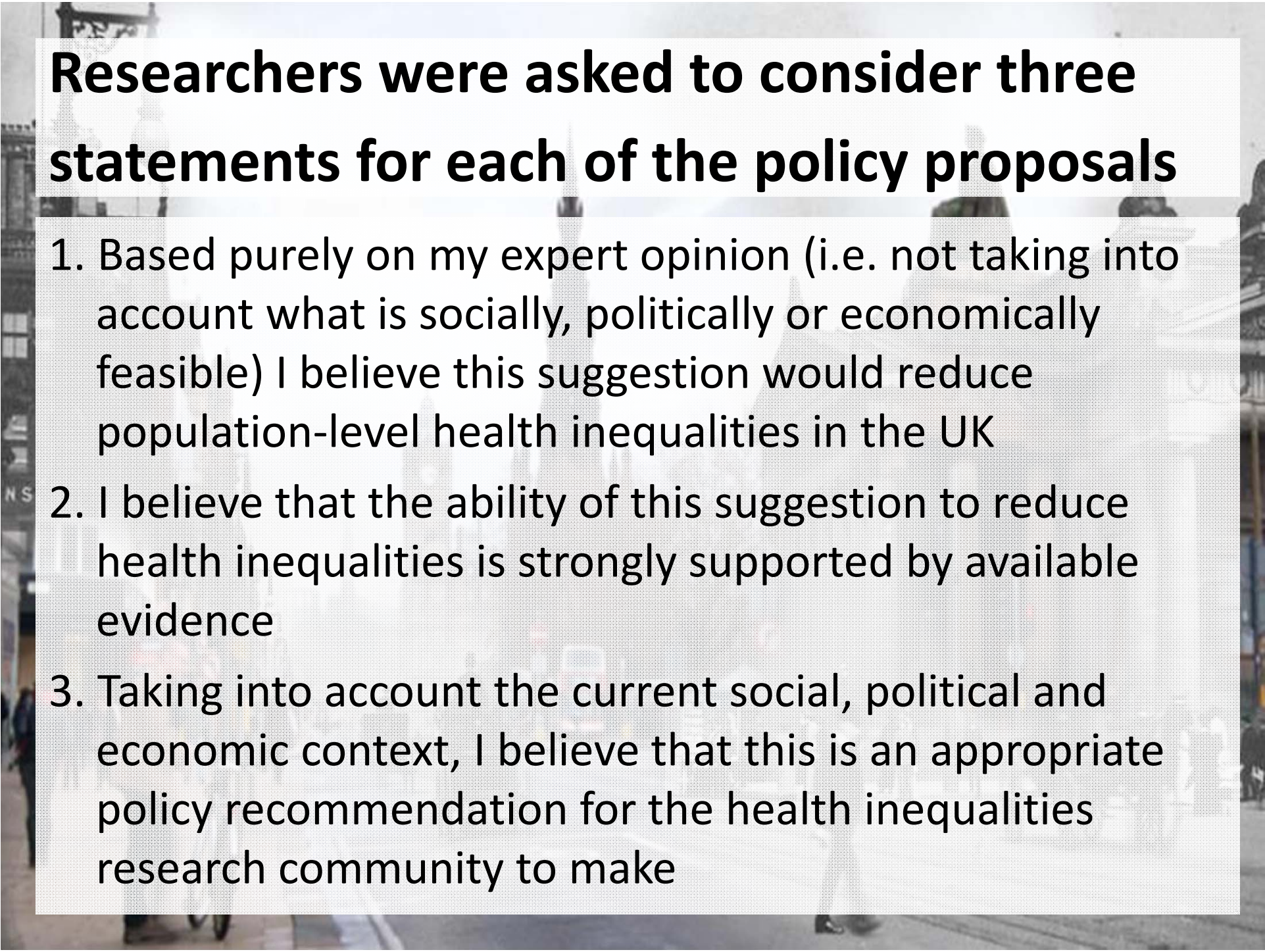
**An online survey: what kinds of policies and interventions do researchers believe are likely to reduce health inequalities in the UK?**



# A bit more info on the survey:

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





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

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



# Results: Based purely on expert opinion...

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



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

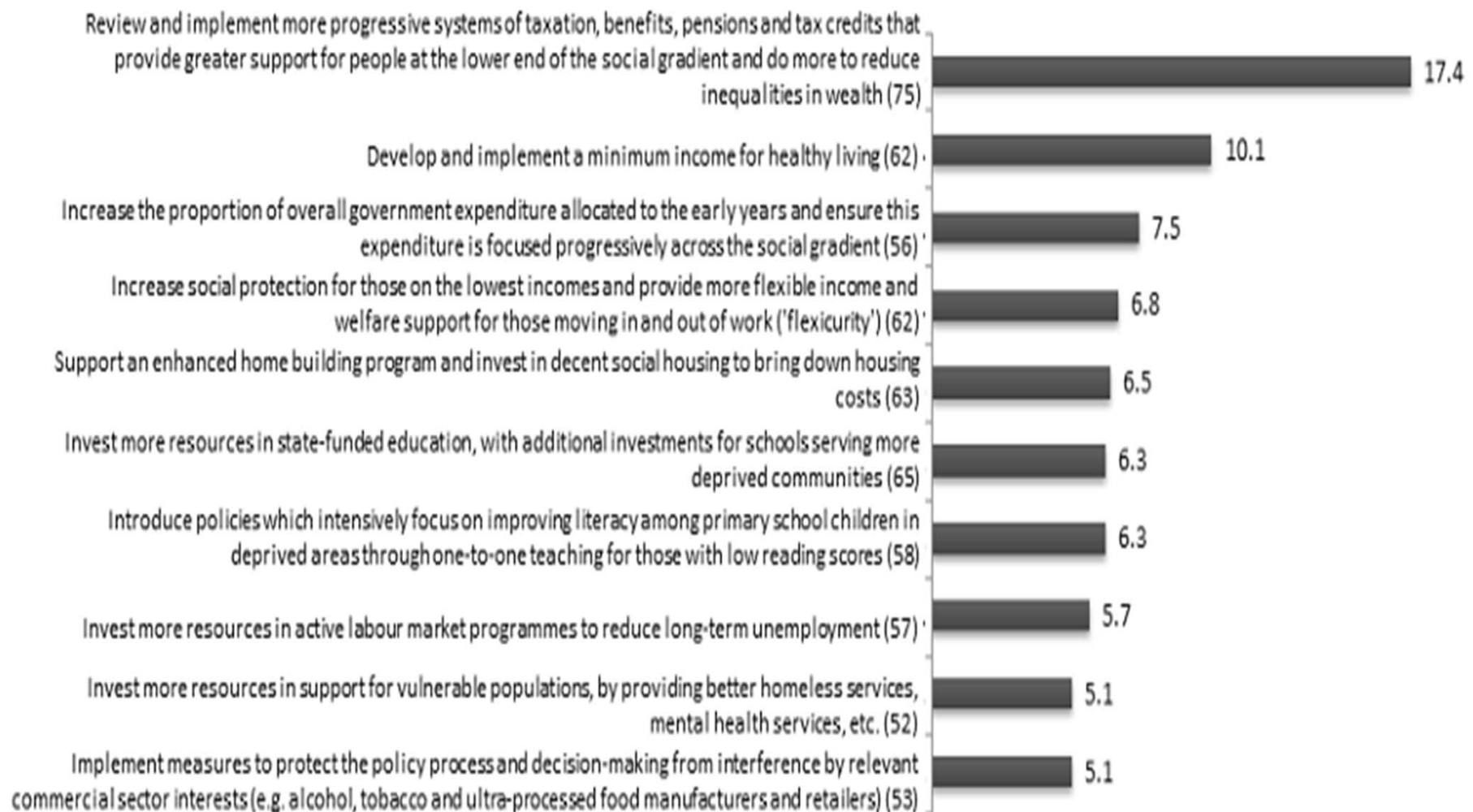


**The results of the second stage of the survey, in which participants were asked to distribute 100 points according to the policy proposals they believed would have most impact on reducing health inequalities**





# 10 Most supported policy proposals





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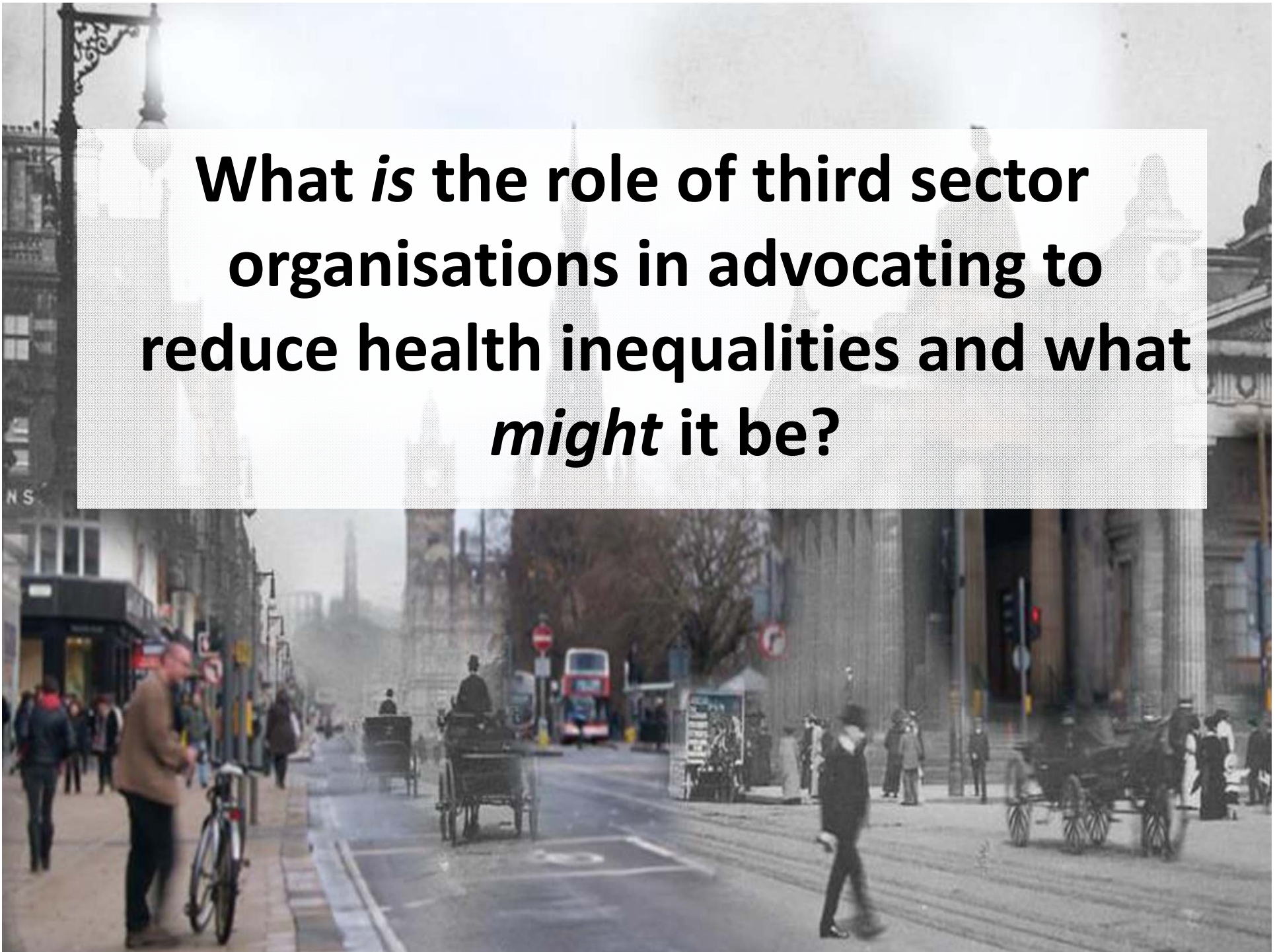


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**What *is* the role of third sector organisations in advocating to reduce health inequalities and what *might* it be?**





# Lack of coherent advocacy-coalition around health inequalities:

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

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



# Belief private interests have 'out-lobbied' public interests for HIs:

Senor civil servant (Wales): *"I think that it's hard for a weak public health community with relatively limited resources to confront an industry. 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."*



# Consensus that more advocacy is needed to reduce health inequalities

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

Focus group participant (male): *“Are [there] some things we shouldn’t bother researching anymore, and that we should be advocating perhaps?”*



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





## But researchers are often uncomfortable with this...

Interviewee (public sector researcher and policy advisor): *“A number of us signed a letter critiquing [recent health reforms] [...] and [a senior health inequalities academic] berated us for having signed that, saying that **s/he thought that we damaged our credibility in doing so.** And I think the opposite - I think that we were the only ones upholding the values of public health and those that didn't sign it were actually damaging public health.”*



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# Growing enthusiasm within third sector for focusing on health inequalities

**‘Advocacy’ focus group participant (female):** *“We’re not saying that researchers suddenly need to become lobbyists. It’s about better contact between researchers, between the research subjects, between community groups, activists and organisations working on the ground, and then also with lobbyists, with those of us working in policy. You know, I’m involved at the moment with a network on cancer prevention, and that’s about bringing together researchers and advocacy groups and people working in public health. And it’s very much about saying okay well, where’s the research agenda, and what are the findings that we can pull from that? What concrete examples can we give for work that’s gone on on the ground that we can say, for example, this worked, and then we can take those messages and feed them in.”*



# **Growth of various third sector initiatives around health inequalities**

- People's Health Movement in Scotland (People's Health Assembly will be in Edinburgh in 2014)
- NHS Health Scotland and policy consultations with third sector around health inequalities
- NHS Health Scotland and Global Public Health Unit forthcoming seminar series focusing on third sector
- This meeting...



# Belief NGOs are likely to be better equipped to lobby on HIs:

NGO CE: *“I don’t think academics have the time or space to do what we do, you know - they’re busy doing the work. The thing about us is we’re an infrastructure organisation, we’re networked, we’re plugged in, you know, because we’re on the advisory groups, because we meet the policy officials, do you see what I mean? [...] You know, trying to inform if not set the agenda, so we’ve got a mechanism for that to happen, that’s what I think the attraction is for that relationship. The extent to which academia might do that or they might see that as beyond them anyway is another matter, but we try and make sure that they’re played into those sorts of arenas as well, so it’s not just us, but we play them in...”*





## And are academics adequately supporting third sector organisations?

NGO CE: *“You do feel sometimes in the meetings [with academics] that you are treated like a second class citizen, because you’re not an academic in that way, even though you have might have the qualifications. The fact you don’t work in academia is that... I think your views are discounted at times sometimes, yeah.”*



# But is it yet a fundamental strand of third sector work in Scotland?


NGO Policy Lead (Scotland): *“I think particularly over the last two or three years health inequalities is a term that most [third sector] organisations engaged in health use. But whether they have a real understanding or try and apply what academics would view as taking an approach that incorporates health inequalities or not is a different question. I think it’s become a term that’s used by people to pursue things they would like to do anyway quite often, as opposed to something that they think is fundamental to the way they might do business.”*



# So where does this leave us?

- There appears to be quite a lot of consensus around the kinds of policies that are likely to reduce health inequalities within the research community;
- However, there's also agreement that it's hard to advocate for many of these policy changes, particularly as solution-orientated research and examples of success remain limited.
- In this context, it currently seems unclear who are (or could be) the advocates for evidence-informed policies to reduce health inequalities in Scotland.
- We need to develop a clearer idea of where overlapping agendas lie between research and third sector work and what kinds of policy proposals it's feasible to promote.





**Thanks for listening. Please email me  
([katherine.smith@ed.ac.uk](mailto:katherine.smith@ed.ac.uk)) if you'd be  
interested in finding out more about the  
findings discussed in this presentation or  
potentially participating in current project  
exploring the role of the third sector in  
public health knowledge translation**