POLICY BRIEF

The case for a bolder vision and approach to addressing health inequalities in national policy

AUTHORS: BETH CAPPER, JOHN FORD, MICHAEL P. KELLY

SUMMARY

The pattern of inequalities in health in Britain is a knotty problem. National policy has usually defaulted to a focus on individual behaviour change. The wider structural and socioeconomic factors that drive health inequality are seldom the target.

The Covid pandemic compounded population-level health inequalities in England. The pandemic also provided a mandate for bolder, more ambitious action on health inequalities. As the patterns of Covid deaths became clear, a stronger public narrative about the wider determinants of health emerged. However, an analysis of national policy documents published during the pandemic revealed that little has changed in policy thinking. The same old same old individually based 'lifestyle' solutions reappear.

A positive vision of a healthy and equitable society is needed. This requires a delegation of power and resource to local public health teams and local communities and attention to the whole of the social gradient.

FULL DETAILS OF THE RESEARCH

🔗 Capper B., Ford J., Kelly M. Has the pandemic resulted in a renewed and improved focus on heath inequalities in England? A discourse analysis of the framing of health inequalities in national policy, *Public Health in Practice,* 2023, Volume 5,100382.

What did we do?

In response to the impact of the Covid pandemic, Governments across the world sought to help those worst affected. In England, measures and policies were introduced to provide immediate support as well as to address widening inequalities in serious illness and death. We selected 6 national policy documents from NHS England, the Cabinet Office Race Disparities Unit and (former) Public Health England and analysed their language and content to look at how the problem of health inequalities was presented, whether this reflects the evidence base in the scientific health inequalities literature and how this affected the types of policy proposals identified to tackle the problem of health inequalities.

What did we find?

Need for a focus on structures instead of individuals

Our research showed evidence of 'lifestyle drift'[1] in policy documents. While there is initial acknowledgement of the wider structural and socioeconomic factors that affect health, this remains largely perfunctory and, particularly in NHS England and Race Disparities Unit, documents did not cut through to the actual policy solutions put forward. Instead, solutions to address health inequalities largely focused on what individuals could do differently to decrease their own health risks. If behaviour change is the 'fix', this suggests the primary driver of health inequalities is how individuals act – their choices are their responsibility. This disregards the health inequalities research which shows how structural factors impact on individuals' decisions.[2,3]

Need for a clear understanding of health inequalities and a positive vision for health equity

The national policy documents do not have a clear definition of 'health inequalities'. This is a major flaw. The focus and scope of policy solutions to address inequalities in health outcomes and access to and/or experiences of healthcare, or the unequal impact of Covid, have to be very different to what has gone before. It also has to have realistic timescales for change. Without this clarity, delivery, measurement and evaluation of impact is very challenging. The health inequalities literature puts the case for a re-imagining of a future landscape (including socially and economically) in which health inequalities are reduced.[4,5] Setting out in detail where we want to get to, helps thinking about how to get there. There is almost no envisioning of a health equitable future across the documents analysed.
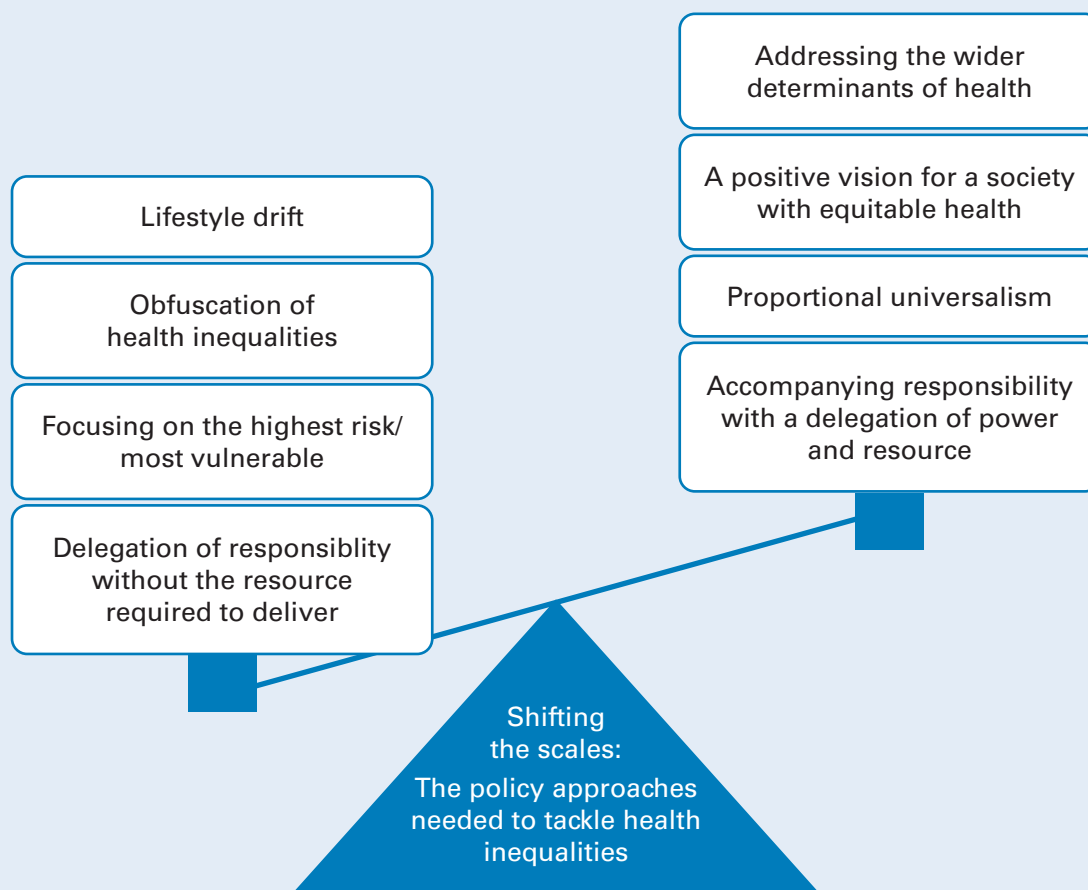
Need for a focus across the social gradient

The target for policy initiatives focuses on those worst off. While this was necessary and understandable at the start of the pandemic, a longer-term strategic approach to health inequalities must apply Michael Marmot's findings that show the need to look across the social gradient and apply a proportionate universalism to interventions i.e. available to all, but allocated according to need.[6]

Need for a delegation of power and resource locally

The policy documents, particularly from NHS and Race Disparities Unit, delegate responsibility and accountability for health inequalities locally. However, there isn't any accompanying delegation of power and resource to enable this. Resources that are made available are ring-fenced to nationally set parameters.

Figure 1: Shifting the scales: the policy approaches needed to tackle health inequalities

Left side:
- Lifestyle drift
- Obfuscation of health inequalities
- Focusing on the highest risk/ most vulnerable
- Delegation of responsiblity without the resource required to deliver

Right side:
- Addressing the wider determinants of health
- A positive vision for a society with equitable health
- Proportional universalism
- Accompanying responsibility with a delegation of power and resource

Shifting the scales: The policy approaches needed to tackle health inequalities

What does this mean?

This research shows that policy solutions introduced during the Covid pandemic to address health inequalities were and are unlikely to work. The evidence from academic literature and findings from this research suggest we need to: 1) shift policy focus towards structural factors and wider determinants of health, 2) develop a positive vision of a health equitable society with those most affected by health inequalities, 3) apply proportional universalism,[7] and 4) delegate power and resources alongside responsibility for tackling health inequalities.

Recommendations

1. Develop evidence-based policy solutions and measurement frameworks to tackling health inequalities across the social gradient that account for the intersectional nature of health inequalities - through collaboration between policy-makers, researchers and community members and representatives. This must go beyond those involved in health policy to include those working across the arenas that drive and perpetuate inequity in health outcomes (including education, housing, income, wealth, employment).

2. Implement parallel short-term and longer-term approaches to addressing health inequalities with measures of success over both timeframes to satisfy the need for immediate action but ensure real progress over time.

3. Explicitly address the unequal distribution of resources and power across society which contribute to unequal determinants of health. This must include investing (resource, time, and giving up of power) in working alongside local communities to undertake work to envision a health equitable future - being ideologically open to new approaches to the economic, social and political environments.

References

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