Tackling health inequities: Strengths and Gaps

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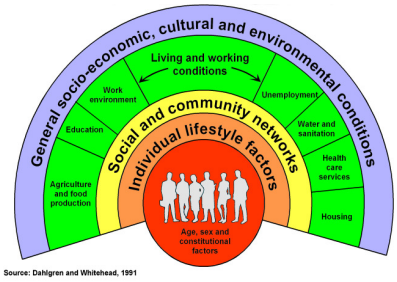
The public health jigsaw

"Research studies use a variety of methods, are of variable quality, and may appear to have contradictory findings…Research information can seem to users like small jigsaw pieces in a box where there may be several pictures, several duplications and several missing pieces. Under these circumstances it can be difficult for the researcher, research funder or user to make sense of the research or take stock of the knowledge base"

(Trevor Sheldon, 1998)



"Public health research's "focus has often been on what can be measured easily…rather than on the immensely more complex issues of the broader social forces that affect health, directly or indirectly"

Beaglehole et al. (2004)

Broadly, peoples' living and working conditions, their lifestyles, what they eat, drink, where they live, work

The public health evidence base

- Not enough evaluations
- Where there are evaluations, they are not experimental
- Where there are experimental evaluations (trials), there are few descriptions of process/implementation issues;
- Where there are trials with detailed descriptions of process/implementation, the evidence may not be generalisable
- …it ignores issues of inequalities
- …it has too much of a short-term focus (on "behaviours" vs health outcomes)
- All this needs addressed if our knowledge of health inequity and how to tackle it is to be improved

- Moreover, public health evidence has a "utilitarian bias" * - focussing on the greatest health gains for the greatest number of people –
- Rather than on the distribution of health (or on differential effects)
- A significant missing piece of the jigsaw relates to the effects of interventions on health inequalities

Jeremy Bentham

***Jackson, Waters et al., J Public Health (2004)**

"Evidential nihilism"?

- Robust evidence on the effectiveness of public health interventions is in short supply, and often hard to find
- It's easy to sift through the evidence and conclude that there isn't enough of it, and what there is, isn't very good anyway (too many missing jigsaw pieces)
- …which, while true, is not a particularly useful contribution to decision-making

- What are the strengths?
- At least 3 major strengths…

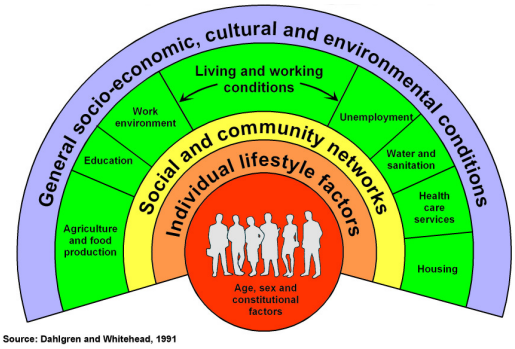
Among the strengths are…

- 1. A strong theory base – well-developed theories on the sources of health inequalities…

…and possible ways of reducing them

- The importance of this should not be underestimated- when you have gaps, theories can build bridges

- Materialist and neo-materialist explanations (pointing to the importance of structures and resources - such as income - in shaping health)
- Psychosocial hypotheses, describing psychological and physiological pathways by which health inequalities may be created (in the case of employment, control and social support, for example)
- Theories and "Ways of thinking" are as important as empirical evidence (though you need this to test the theories)



Source: Dahlgren and Whitehead, 1991

- Whitehead (2007) has also argued that there are four categories of intervention aimed at tackling inequalities in health:
- **Category 1**: strengthening individuals through health educational measures;
- **Category 2:** strengthening communities;
- **Category 3:** improving living and working conditions and access to essential goods and services; and
- **Category 4:** promoting healthy macro-policies

2. Tools

- As well as “thinking” to guide action, we have “tools”:
- HIA – as a means of putting health equity “on the table” in policymaking and practice
- Guidance on where/how to intervene
- Methodological tools: evidence syntheses/systematic literature reviews to distil the evidence on what we might do
- CSDH, and The Marmot Review

3. And we do have evidence

- 3. Good empirical evidence of the nature and size of inequalities and how they are created
- Evidence ranging from large epidemiological studies (e.g. Whitehall), to in-depth, qualitative research (e.g. Hilary Graham’s work on poverty and smoking)

Whitehead & Dahlgren, 2007 (“Levelling up”)

- Policies should level up, not level down;
- The main approaches to reducing social inequities in health are interdependent and should build on one another. These approaches involve targeting people in poverty; narrowing the health divide; and reducing social inequities throughout the whole population;
- Policies should have dual purpose of promoting health gain in the population as a whole, as well as reducing health inequities;
- Action should be concerned with tackling the social determinants of health inequalities (e.g. poor working conditions);
- The possibility of actions doing harm must be monitored;
- Appropriate tools should be used to measure the extent of inequities and progress towards goals;

– Make concerted efforts to give a voice to the voiceless;

– Where possible, social inequities in health should be described and analysed separately for men and women;

– Relate differences in health by ethnic background or geography to socioeconomic background (because the magnitude and causes of ethnic differences tend to differ by social position); and

– Build health systems on equity principles

– *…and other systems*

- And the evidence base is growing…

Interventions (housing, regeneration, transport, employment)

- Injury/falls prevention; housing and area regeneration; rental assistance; welfare rights advice; organisational and other changes to the work environment
- E.g. social housing improvement can improve mental health and inequalities in mental health, and quality of life:
- *"The greatest potential for investment in housing as a health improvement strategy appears to lie in targeting improvements in warmth at vulnerable individuals who have poor health and live in poor housing."* (Thomson et al. 2009)
- 2001:18 studies; 2009: 45 studies

Transport

- **Transport interventions**: evaluations of mostly focussed on health effects of engineering interventions, which seem to improve health (deaths, injuries, respiratory health), but little evidence on inequalities
- Some evidence on effectiveness of behaviour change interventions (incentives, alternative transport services) - but these may increase inequalities

Work environment: participation, changes to work organisation, privatisation

- Potential to reduce work-related inequalities through improving control, participation in decisionmaking, reducing stress (consistent with observational data suggesting that inequalities are created by low control/high demand, low support
- Adverse effects need to be mitigated (an Australian study found that for a "team working" intervention, stress, strain, tiredness increased in the lowest grade employees only)

So, what can research contribute to understanding of the Social Determinants of Health?

1. **Characterising the problem:** providing knowledge about the *existence, size and nature* of public health problems, who they affect and how;
2. **Exploring causes and mechanisms**: including studies that help to *understand social processes relevant to health*;
3. **Finding out "what works":** *evaluations* of the health effects of policies

Strengths in areas 1 and 2, and 3 is growing

Putting the findings in context

World Health Organization

- The Measurement and Evidence Network of the WHO CSDH identified several challenges to improving the public health evidence base, including
- Lack of precision in specifying causal pathways; lack of clarity about gradients/gaps; impact of context in interpreting evidence - the latter is a major challenge

Commission on social determinants of health

Keeping an equity perspective

- Maintaining an equity perspective is crucial - keeping equity on the agenda
- This means emphasising the importance of considering the effects of what we do (in all sectors) on inequalities
- Mitigating the potential negative effects/harms
- Seeking new opportunities to collect robust data on the effects of policies on health and health inequalities

Are we too focussed on health?

- Creating better evidence about inequalities means understanding the effects of non-health sector policies on human wellbeing - which includes but of course is not limited to health outcomes
- For all the public health rhetoric about "social determinants" of health, we are still overly-focussed on health, and health behaviours, and illness and not enough on the social determinants themselves
- So we still know less than we should about their contribution to inequalities – and about hidden harms

- "Hidden harms" of beneficial policies…
- Social housing improvement policies produce better housing, but may increase rents, which may impact on household spending and healthy diet
- Transport: new road building may be good for businesses/economy, but may contribute to community severance

An aside

- *"We spend so much public money on research – why don't we know more about what works in reducing inequalities?"*
- One reason is that doing evaluations to find out whether things "work" or not, is sometimes seen as unhelpful – so they don't get done


MRC Social and Public Health Sciences Unit

Randomised controlled trials of social interventions: Report of a pilot study of barriers and facilitators in an international context.

Helen Roberts[1], Mark Petticrew[2], Sally Macintyre[3], Kristin Liabo[1], Madeleine Stevens[1].

(Funded by MRC Social & Public Health Sciences Unit (SPHSU) and the International Collaboration on Complex Interventions (ICCI). ICCI is funded by the Canadian Institutes of Health Research)

Occasional Paper No 19

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1. Social Science Research Unit, Institute of Education, 18 Woburn Square, London WC1H 0NR
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Roberts et al. 2008
Occasional paper
(No.19)

www.sphsu.mrc.ac.uk

Interviews with researchers and policy advisors in UK and other countries on the use of RCTs, and how they are viewed by policymakers; whether they are valued or if not, what types of evidence holds value instead

Politically unhelpful evaluation

- "… there are costs to having really good evaluations not just the financial cost, they do cost more obviously but you know, if … it's really good and the results you know tell you that your intervention isn't working then you're in trouble, and I think to some extent …people would rather have you know vaguer information about processes, which …carries less risk of being hostages to fortune to some extent…

- "…I mean, people like the idea of the process of continuous quality improvement with evaluation, you know, contributing something to improve the way you implement your … new policy or your intervention, and I think, to some extent, that's preferred to evidence which .. tell(s) you pretty starkly that you ought to stop and that you're wasting public money." (Policy advisor, UK)

- "*Certainly in British politics, the power of a story beats almost anything.*" (Policy advisor, UK)
- This suggests that the well-rehearsed ethical, methodological and other barriers are only part of the story
- "Softer," descriptive evaluations are also more expedient/more acceptable

Moving from magic bullets to general principles

- The CRD review on inequalities (Arblaster, 1996) outlined some general characteristics of health service interventions which are likely to be successful. It noted for example that that approaches should be

- Systematic and intensive;
- That involve improvements to the accessibility of services, prompts to increase use of services, and multi-faceted strategies may be effective;
- that strategies should involve collaboration between interest groups;
- that inequalities interventions should address the expressed or identified needs of the target population;
- and that the involvement of peers in the delivery of interventions can be effective.
- These may still be valuable general principles

A nearly-final thought on gaps and strengths

- There has been a sea change in recent years in:
- Awareness of and interest in tackling inequalities
- Funding for research on inequalities
- Research activity
- Re: Evaluation - there has been a low base in most western countries, so need to build capacity (and stimulate interest) to do this sort of research – but the interest is certainly there
- And barriers between researchers, and practice and policy, are eroding

- *"Strategies that rely only on intervention in one part of the system will be insufficient to make the necessary difference to patterns of inequality…A whole-system approach is needed in which organisations and people work together with activity at national, regional, local and individual levels"*

(Chapter 5, The Marmot Review)

Progress-Plus framework

- **PROGRESS**
- **Place of Residence** Rural/urban, country/state, housing characteristics
- **Ethnicity** Ethnic background
- **Occupation** Professional, skilled, unskilled, unemployed etc.
- **Gender** Male or female
- **Religion** Religious background
- **Education** Years in and/or level of education attained, school type
- **Social Capital** Neighbourhood / community / family support.
- **Socio-economic position** (SEP), Income, means tested benefits/welfare, affluence measures,

- **PLUS**
- **Age**
- **Disability** Existence of physical or emotional/mental disability
- **Sexual orientation**
- **Other vulnerable groups** - School non-attenders, looked after YP, YP in criminal justice system, victims of abuse, runaways, teenage parents

http://equity.cochrane.org