

## **Health inequalities: the need to move beyond bad behaviours**

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Health inequalities have been observed internationally across a number of dimensions (including, for example, socio-economic position, ethnicity and gender) and have persisted over time.<sup>1</sup> The lack of progress in addressing them has disappointed many within the field of public health, particularly given an apparent prioritisation of health inequalities in UK policy.<sup>2</sup> Building on recent research highlighting the limitations of addressing health inequalities by trying to change health behaviours of individuals,<sup>3</sup> we argue that attempts to tackle health inequalities are impeded by the current framing that dominates much public health policy and research. We suggest some alternative ways forward.

Policy analysts have drawn attention to a recurrent policy emphasis on health behaviours in the UK, despite acknowledgment amongst decision-makers that wider social and economic factors are important.<sup>4</sup> This approach has been reinforced by researchers focusing on addressing health inequalities by modifying health behaviours via individual-level interventions, which do not fully take into account the impact of the social and economic environments in which people live over time.<sup>5</sup> This preoccupation is illustrated by a recent King's Fund study that reported increasing inequality in what the authors call the 'clustering of unhealthy behaviours over time' in England.<sup>6</sup> Even when governments commit to addressing social determinants of health, specific actions and interventions often revert to trying to modify individuals' behaviours. Hilary Graham describes this process as follows:

A recurrent slippage occurs as the policy statements move from overarching principles to strategic objectives, with a broad concept of determinants giving way to a narrower focus on individual risk factors.<sup>7</sup>

While there is clearly a role for addressing health behaviours as part of efforts to reduce health inequalities, this 'lifestyle drift', neglects the compelling evidence that it is 'social injustice that is killing people on a grand scale.'<sup>8</sup> Framing health inequalities as a problem of individuals or particular communities rather than societies makes it easier to ignore much of the available evidence on why unhealthy behaviours remain prevalent under certain socio-economic conditions, which highlights the cumulative effects of disadvantage and adversity over the life course.<sup>5</sup> Since the patterning of health behaviours reflects underlying inequalities in material

and social resources, it is highly unlikely that the growing inequality in health behaviours can be addressed without tackling these social factors.<sup>9</sup> Yet 'upstream causes' and associated solutions are only briefly acknowledged in much policy and research, reinforcing claims that the 'politics' of evidence and policy are often ignored in public health circles.

To address health inequalities effectively, a re-focusing of both policy and research is necessary. Research on health inequalities needs to stop prioritising research on individually-targeted or community-targeted interventions and study not just the relationship between broad determinants and health inequalities, but also the effects of changes in these determinants. Such research poses methodological difficulties, requiring a mixture of quantitative and qualitative methods and multiple disciplinary perspectives. There are understandable reasons why researchers and policymakers have not been successful at plugging this evidence gap.<sup>3</sup> First, research, funding, policy and advocacy all tend to be divided into silos that mirror each other and which encourage a focus on particular health issues and/or behaviours. Second, the medical paradigm that dominates public health research and funding favours evaluations of individualised interventions. Third, there seems to be a wariness amongst researchers, funders and policymakers about risky research that may not yield clear results, combined with a cautiousness about being 'political'.

Yet, existing evidence suggests some ways forward. First, policy interventions with the greatest chance of reducing health inequalities should target the population and not the individual. Macintyre has noted:

'Interventions at the higher, more regulatory or structural...appear to do more to reduce health inequalities than information based approaches.'<sup>10</sup>

Eikemo and Mackenbach show that focusing on upstream determinants, such as education, may have considerable potential in reducing health inequalities.<sup>1</sup>

Similarly, Lorenc and colleagues note that downstream measures, especially media-driven behaviour change campaigns, seem most likely to produce intervention-generated inequalities.<sup>3</sup> This suggests policymakers committed to reducing health

inequalities ought to focus on universal, upstream policies and think particularly carefully about the potentially unequal impacts of health promotion campaigns. Researchers, in turn, need to do more to recommend *which* universal, upstream policies are likely to be most important. This is likely to require much more interdisciplinary research with economists and experts in relevant policy areas (e.g. education or housing).

Second, researchers need to develop a better understanding of the actors, ideas and institutions affecting the policies that impact on the social determinants of health and their unequal distribution. In particular, health inequalities researchers need to pay more attention to the influence of business interests profiting from unhealthy behaviours (e.g. smoking, drinking alcohol and eating unhealthy foods) on research, policy and public debate. So far, public health research has been poor at investigating the myriad influences of industry, with the exception of tobacco control from which valuable lessons might be learnt.

Third, there continues to be a lack of evidence to allow assessments of the differential health impacts of interventions.<sup>3</sup> This is partly because many of the most promising interventions for reducing health inequalities operate outside of the health sector, as high-level reviews of health inequalities make clear<sup>8</sup>. Indeed, engaging with non-health stakeholders motivates the European Commission's health in all policies (HiAP) workstream.

HiAP: 'addresses all policies such as transport, housing, the environment, education, fiscal policies, tax policies and economic policies. It is based on values and principles similar to those in the WHO's call for multisectoral action for health, and the concept of building healthy public policies, or the whole government approach'.<sup>11</sup>

This means that health inequalities researchers cannot restrict themselves to assessing the impacts of policies and programmes specifically intended to reduce health inequalities. Rather, health inequalities researchers need to investigate the differential health impacts of non-health policies; a shift which is likely to be dependent on the support of major research funders. More interdisciplinary projects

with researchers who do not have a health focus would be a step forward, whilst paying greater attention to health consequences historical and international policy shifts could broaden the scope of ‘interventions’ that health inequalities researchers might assess. The scope of the field must be broadened to be fit-for-purpose in the age of ecological public health. This involves looking outwards (to other countries and regions), onwards (to the future) and upwards (to social determinants).<sup>12</sup>

Fourth, as Graham points out, the social factors that impact on the health of individuals and populations are not the same as the ‘the social processes underlying the unequal distribution of these factors’.<sup>7</sup> Yet, both researchers and policymakers continue to conflate the two. This may be one reason for the continuing privileging of health sector interventions over broader approaches. More work exploring the social processes which underlie the unequal distribution of the social determinants of health and varying perceptions of these processes is needed.

Finally, determined action to address health inequalities will require public as well as political will. This requires health inequalities researchers to pay much more attention to public and media understandings of health inequalities and to public preferences for different policy proposals. It may also require stronger links between research and public health advocacy, which can be a difficult and uncomfortable boundary to negotiate. Not all health inequalities researchers are likely to view themselves as advocates, yet (in contrast to other areas of public health) there are few third sector organisations to take on this role. The responsibility for advocating to reduce health inequalities therefore requires further consideration and debate.

Box 1: Potential ways forward in health inequalities research

<b>For policymakers</b>	<b>For researchers</b>	<b>For research funders</b>
<ul style="list-style-type: none"> <li>• Emphasise addressing underlying social inequalities through universal, upstream policies.</li> </ul>	<ul style="list-style-type: none"> <li>• Research or read existing research about the actors, ideas and institutions affecting the policies that impact on the social determinants of</li> </ul>	<ul style="list-style-type: none"> <li>• Provide more interdisciplinary funding opportunities by engaging in more collaborative funding calls (e.g. between different research</li> </ul>

<ul style="list-style-type: none"> <li>• Implement a HiAP, cross-departmental approach, which pays more attention to the potential health impacts of non-health policy. This may involve shifting policy responsibility for health inequalities into central departments (such as the Cabinet Office, in the UK)</li> <li>• Try to achieve a shift to a longer-term, future-orientated health agenda.</li> <li>• Invest more resources in assessing the impacts of non-health policies on social determinants of health and their unequal distribution.</li> </ul>	<p>health and their unequal distribution.</p> <ul style="list-style-type: none"> <li>• Engage in more interdisciplinary research with researchers who are not health-focused.</li> <li>• Research the social processes underlying the unequal distribution of the social determinants of health; intergenerational equity; and links between public health and sustainability.</li> <li>• Evaluate the impacts of upstream policy developments on: (a) the distribution of the social determinants of health and (b) differential health outcomes across different social groups.</li> </ul>	<p>councils). This should help promote research involving multiple methods and perspectives.</p> <ul style="list-style-type: none"> <li>• Provide more funding opportunities for assessing the impacts of non-health policies on population health and health inequalities (including those mediated by social and economic determinants).</li> <li>• Create more funding opportunities for international, historical and future-orientated research.</li> <li>• Ring-fence some public health funding for higher risk 'blue-skies' research projects.</li> </ul>
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### Competing Interest Statement

All authors have completed the Unified Competing Interest form at [http://www.icmje.org/coi\\_disclosure.pdf](http://www.icmje.org/coi_disclosure.pdf) (available on request from the corresponding author) and declare: no support from any organisation for the submitted work [or describe if any]; no financial relationships with any organisations that might have an interest in the submitted work in the previous three years; no other relationships or activities that could appear to have influenced the submitted work.

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