Health inequalities: the need to move beyond bad behaviours

Srinivasa Vittal Katikireddi,1,2 Martin Higgins,2 Katherine Elizabeth Smith,3 Gareth Williams4

Health inequalities have been observed internationally across a number of dimensions (including, eg, socioeconomic position, ethnicity and gender) and have persisted over time.1 The lack of progress in addressing them has disappointed many within public health, particularly given an apparent prioritisation of health inequalities in UK policy.2 Building on recent research highlighting the limitations of addressing health inequalities by trying to change health behaviours of individuals,3 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 among decision makers that wider social and economic factors are important.4 This approach has been reinforced by researchers focusing on addressing health inequalities by modifying health behaviours through individual-level interventions, which do not fully take into account the impact of the social and economic environments in which people live over time.5 This preoccupation is illustrated by a recent King’s Fund study that reported increasing inequalities in UK policy.2 Building on recent research highlighting the limitations of addressing health inequalities by trying to change health behaviours of individuals,3 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.

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.7

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’.8 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 socioeconomic conditions, which highlights the cumulative effects of disadvantage and adversity over the life course.9 Since patterning of health behaviours reflects underlying inequalities in material and social resources, it is unlikely that the growing inequality in health behaviours can be addressed without tackling these social factors.9 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 refocusing of both policy and research is necessary (table 1). There is a need to stop prioritising research on individually targeted or community-targeted interventions, and study the relationship between broad determinants and health inequalities, and 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:3 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; the medical paradigm that dominates public health research and funding favours evaluations of individualised interventions; and there seems to be a wariness among researchers, funders and policymakers about risky research that may not yield clear results, combined with a cautionousness about being ‘political’.

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

‘Interventions at the higher, more regulatory or structural ... appear to do more to reduce health inequalities than information based approaches.’10

Ekermo and Mackenbach show that focusing on upstream determinants, such as education, may have considerable potential in reducing health inequalities.1 Similarly, Lorenc and colleagues note downstream measures, especially media-driven behaviour change campaigns, seem most likely to produce intervention-generated inequalities.9 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 (eg, education or housing).

Second, there continues to be a lack of evidence to allow assessments of the differential health impacts of interventions.3 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.8 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’.11

This means health inequalities researchers cannot restrict themselves to assessing the impacts of policies and programmes specifically intended to reduce health inequalities. Rather, there is a 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, while paying greater attention to health

1 Evaluation of Social Interventions Programme, MRC/CSO Social and Public Health Sciences Unit, Glasgow, UK; 2 Public Health and Health Policy, NHS Lothian, Edinburgh, UK; 3 Global Public Health Unit, School of Social and Political Sciences, University of Edinburgh, Edinburgh, UK; 4 Cardiff Institute of Society and Health, School of Social Sciences, Cardiff University, Cardiff, UK

Correspondence to Dr Srinivasa Vittal Katikireddi, Evaluation of Social Interventions Programme, MRC/CSO Social and Public Health Sciences Unit, 4 Lhybank Gardens, Glasgow G12 8RZ, UK; vkatikireddi@spshs.mrc.ac.uk
Table 1 Potential ways forward in health inequalities research

<table>
<thead>
<tr>
<th>For policymakers</th>
<th>For researchers</th>
<th>For research funders</th>
</tr>
</thead>
<tbody>
<tr>
<td>▶ Emphasise addressing underlying social inequalities through universal, upstream policies</td>
<td>▶ Research or read existing research about the actors, ideas and institutions affecting the policies that impact on the social determinants of health and their unequal distribution</td>
<td>▶ Provide more interdisciplinary funding opportunities by engaging in more collaborative funding calls (eg, between different research councils). This should help promote research involving multiple methods and perspectives</td>
</tr>
<tr>
<td>▶ 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)</td>
<td>▶ Engage in more interdisciplinary research with researchers who are not health focused</td>
<td>▶ 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)</td>
</tr>
<tr>
<td>▶ Try to achieve a shift to a longer-term, future-oriented health agenda.</td>
<td>▶ Research the social processes underlying the unequal distribution of the social determinants of health, intergenerational equity, and links between public health and sustainability.</td>
<td>▶ Create more funding opportunities for international, historical and future-oriented research</td>
</tr>
<tr>
<td>▶ Invest more resources in assessing the impacts of non-health policies on social determinants of health and their unequal distribution</td>
<td>▶ 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</td>
<td>▶ Ring-fence some public health funding for higher risk ‘blue-skies’ research projects</td>
</tr>
</tbody>
</table>

Consequences of historical and international policy shifts could broaden the scope of ‘interventions’ to be assessed. The scope of the field must be broadened to be fit-for-purpose in the age of ecological public health. This involves looking outward (to other countries and regions), onwards (to the future) and upwards (to social determinants), in addition to learning from historical policy shifts.12

Third, researchers need to develop a better understanding of the actors, ideas and institutions affecting the policies impacting 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 (eg, 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.

Fourth, 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’.7 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 requires public as well as political will.2 Health inequalities researchers, therefore, need to pay 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 with other areas of public health) there are few third-sector organisations to take on this role. The responsibility for advocacy, therefore, requires further consideration and debate.

Acknowledgements SVK is funded by the Chief Scientist Office at the Scottish Health Directorate as part of the Evaluating Social Interventions programme at the MRC/CSO Social and Public Health Sciences Unit (Grant number MC_US_A540_0013). KS is supported by an ESRC Future Research Leader Grant (Grant number ES/K001728/1).

Contributors All authors jointly contributed to the ideas and argument expressed in this article. SVK wrote the first draft and MH, KS and GW subsequently revised the article.

Competing interests All authors have completed the Unified Competing Interests form at 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 3 years; no other relationships or activities that could appear to have influenced the submitted work.

Provenance and peer review Not commissioned; externally peer reviewed.

To cite Katikireddi SV, Higgins M, Smith K E, et al. J Epidemiol Community Health Published Online First: [please include Day Month Year] doi:10.1136/jech-2012-202064

Received 14 October 2012
Revised 31 January 2013
Accepted 17 February 2013

REFERENCES