Health inequalities: what's changed and what now?

David Walsh, Glasgow Centre for Population Health

Gerry McCartney, University of Glasgow

November 2023

Glasgow Centre for Population Health

University of Glasgow

Today

- Question 1: what's happened to health inequalities since the GCPH seminar series started 20 years ago?
- Not good things….
- Question 2: why?
- Because of politics (4 broad examples)
- Question 3: what do we do about it?
- (Gerry's department)

Scotland’s health

THE SCOTSMAN

News you can trust since 1817

News Ukraine Crisis World Opinion Sport

Is Scotland still the 'sick man of Europe'?

By The Newsroom
Friday, 23rd September 2016, 11:27 am
Updated Wednesday, 5th October 2016, 2:32 pm

Scottish Daily Mail

TUESDAY, JULY 6, 2021 80p

Agony for Emma as she bows out (and did Wimbledon knock out Kate too?

Quarantine: Kate at the tennis on Friday

SEE PAGES 2 & 3 AND 5

‘SICK MAN OF EUROPE’

THE SCOTSMAN

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Health

Scotland still failing to shrug off its position as the Sick Man of Europe

SCOTLAND remains the “sick man of Europe”, a new study has revealed.

The Herald

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Ukraine Crisis Home News Coronavirus Health Education Transport World News Environment

Fears Scotland's 'sick man of Europe' tag won't shift as four in five turn to 'harmful' lockdown habits

19th May 2020

By Martin Williams
Senior News Reporter

Fears Scotland's 'sick man of Europe' tag won't shift as four in five turn to 'harmful' Covid-19 habits

SCOTLAND will emerge from the coronavirus lockdown unhealthier, with four out of five people reporting an increase in harmful habits, including smoking, drinking and unhealthy eating, a new study has found.

Only just over a third (35%) of Scots answering a new YouGov survey plan to shake off their new habits after lockdown.

And in spite of a rise in online fitness classes and government encouragement to get outside to exercise, over one in four of Scots said they had actually exercised less than before lockdown began.

The Herald

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Ukraine Crisis Home News Coronavirus Health Education Transport World News Environment

PREMIUM

Glasgow's 'sick man of Europe' tag could return

23rd April

By Caroline Wilson
Senior Reporter

Dr Linda de Caestecker has retired from her role as Glasgow's director of public health after 16 years. Pictures: Elaine Livingstone

Glasgow's "sick man of Europe" tag was "not always accurate" but the cost of living crisis on top of years of austerity risks the city regressing, a leading doctor has said.

Dr Linda de Caestecker said life expectancy among the most deprived had stalled in common with other UK cities after years of improvements.

She said there was strong evidence that Westminster imposed austerity measures were to blame and said there was a real risk rising pressures on household incomes could reverse Glasgow's health gains.

The Herald

News Politics Sport Voices Business HQ Features Campaigns Our Writers Notices

PREMIUM

Glasgow could shake off 'sick man of Europe' tag with the political will

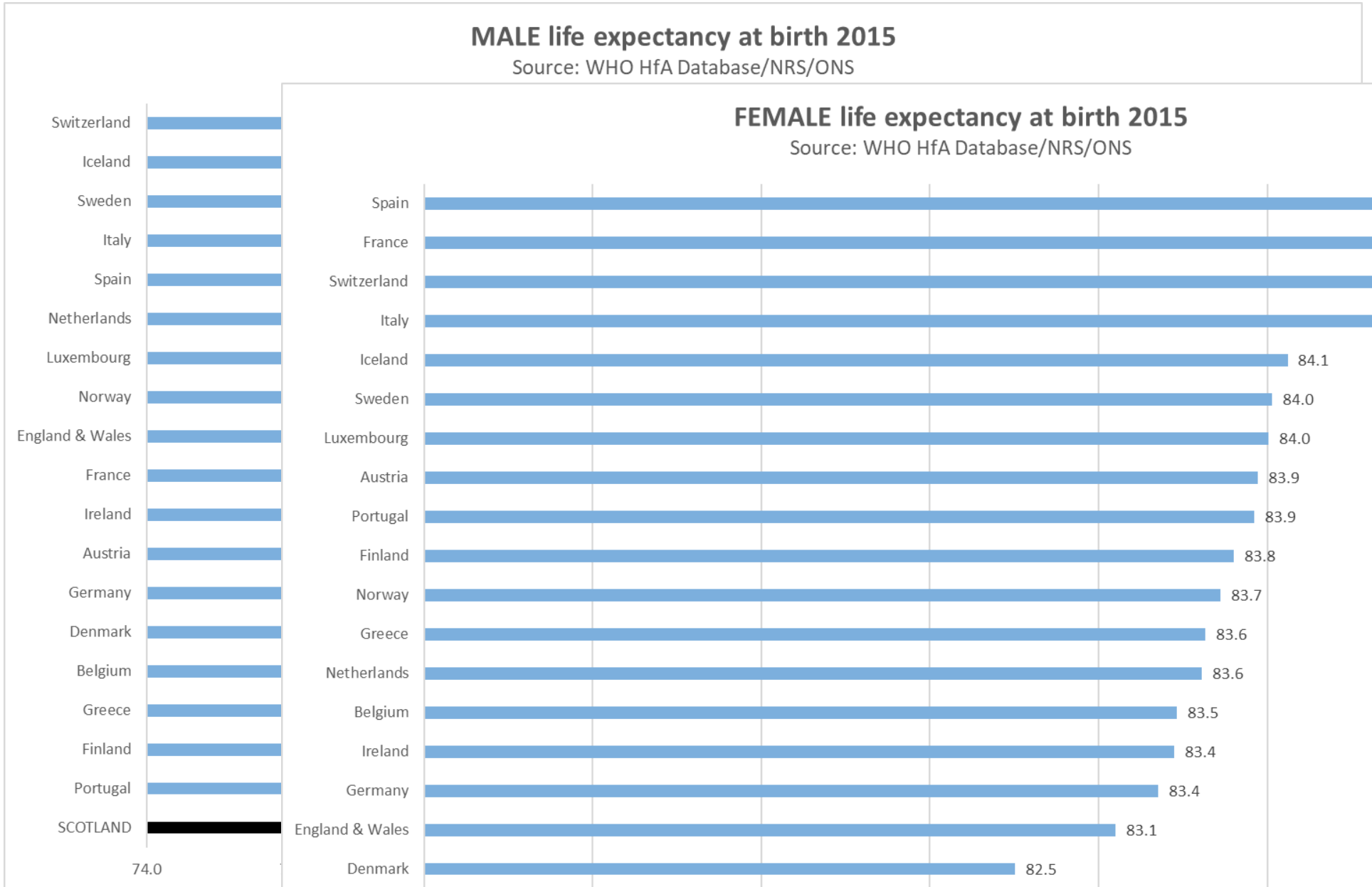
7th January

By Caroline Wilson
Senior Reporter

How Glasgow could finally shake off 'sick man of Europe' tag

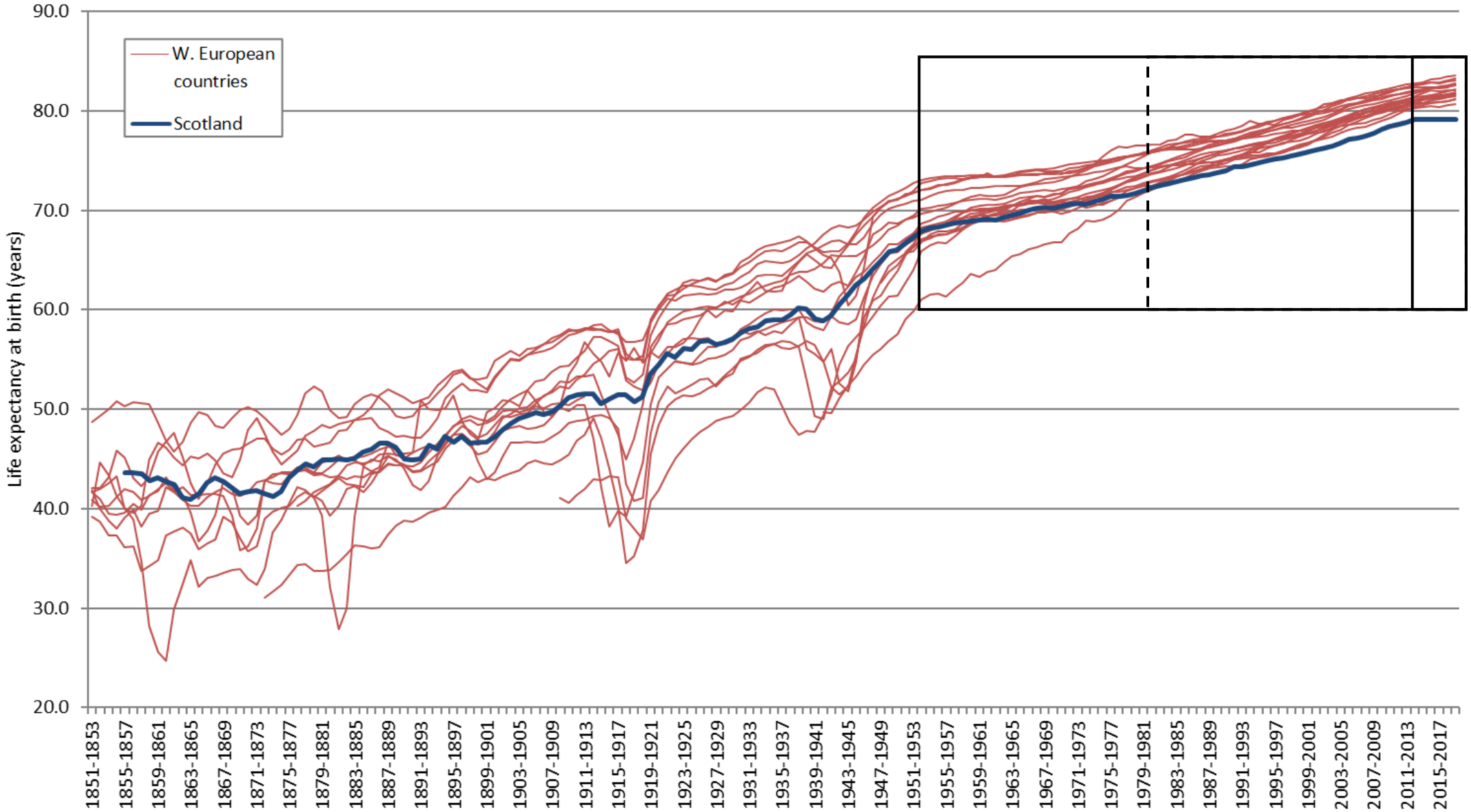
The "sick man of Europe" tag began to surface in Glasgow more than half a century ago.

Then, in 2010, it was backed up by groundbreaking research which showed that Glaswegians had a 30 per cent higher risk of dying under the age of 65 that in


MALE life expectancy at birth 2015
Source: WHO HfA Database/NRS/ONS
Switzerland
Iceland
Sweden
Italy
Spain
Netherlands
Luxembourg
Norway
England & Wales
France
Ireland
Austria
Germany
Denmark
Belgium
Greece
Finland
Portugal
SCOTLAND
74.0
FEMALE life expectancy at birth 2015
Source: WHO HfA Database/NRS/ONS
Spain 85.5
France 85.4
Switzerland 85.3
Italy 84.8
Iceland 84.1
Sweden 84.0
Luxembourg 84.0
Austria 83.9
Portugal 83.9
Finland 83.8
Norway 83.7
Greece 83.6
Netherlands 83.6
Belgium 83.5
Ireland 83.4
Germany 83.4
England & Wales 83.1
Denmark 82.5
SCOTLAND 81.2
79.0
80.0
81.0
82.0
83.0
84.0
85.0
86.0

Male & female life expectancy:
Scotland and 18 other Western European Countries, 1851-2019

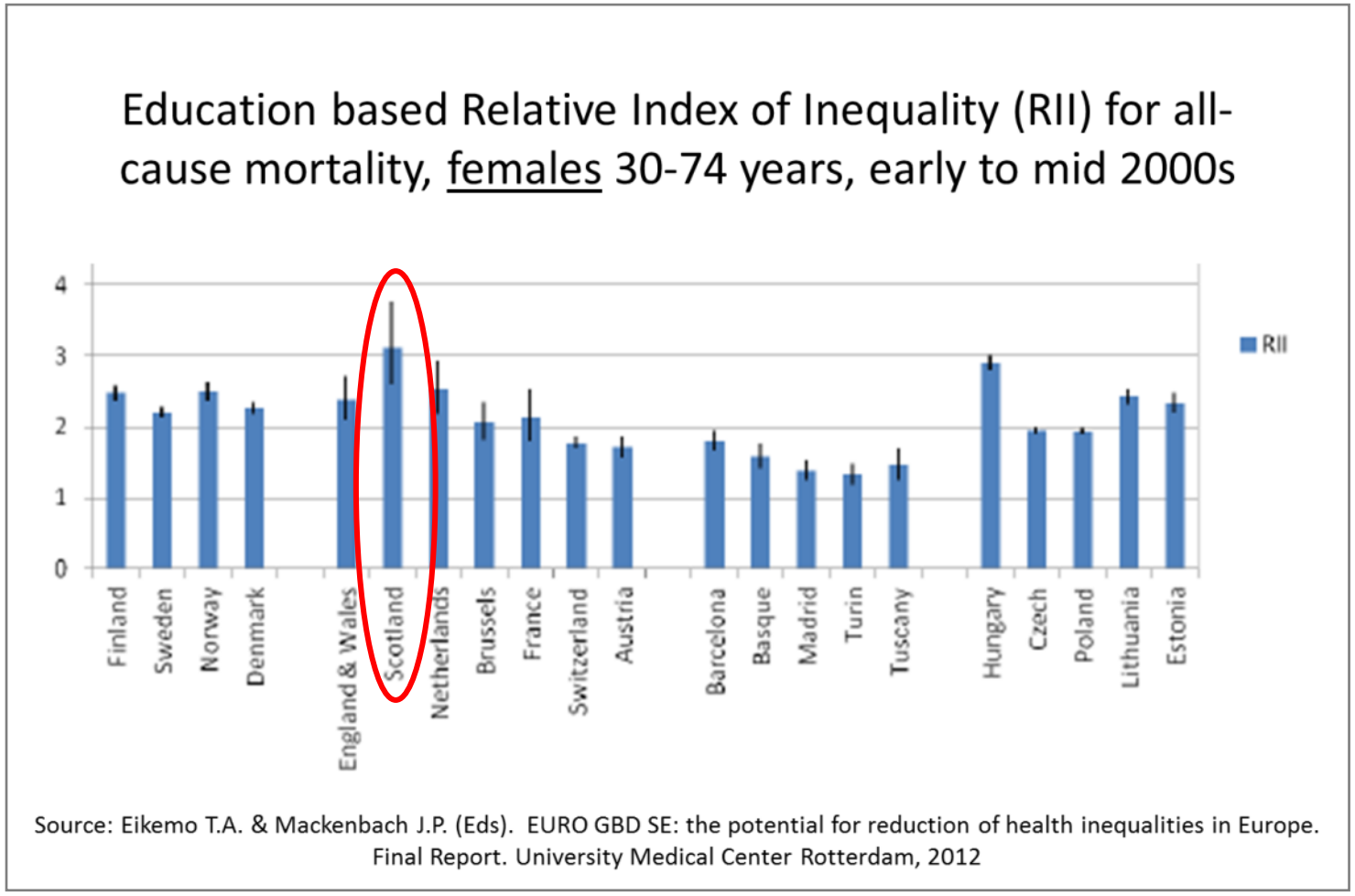
Source: Human Mortality Database



It's political (1): understanding national trends

- Life expectancy is low because inequalities are wide

Scotland: widest health inequalities in W. Europe



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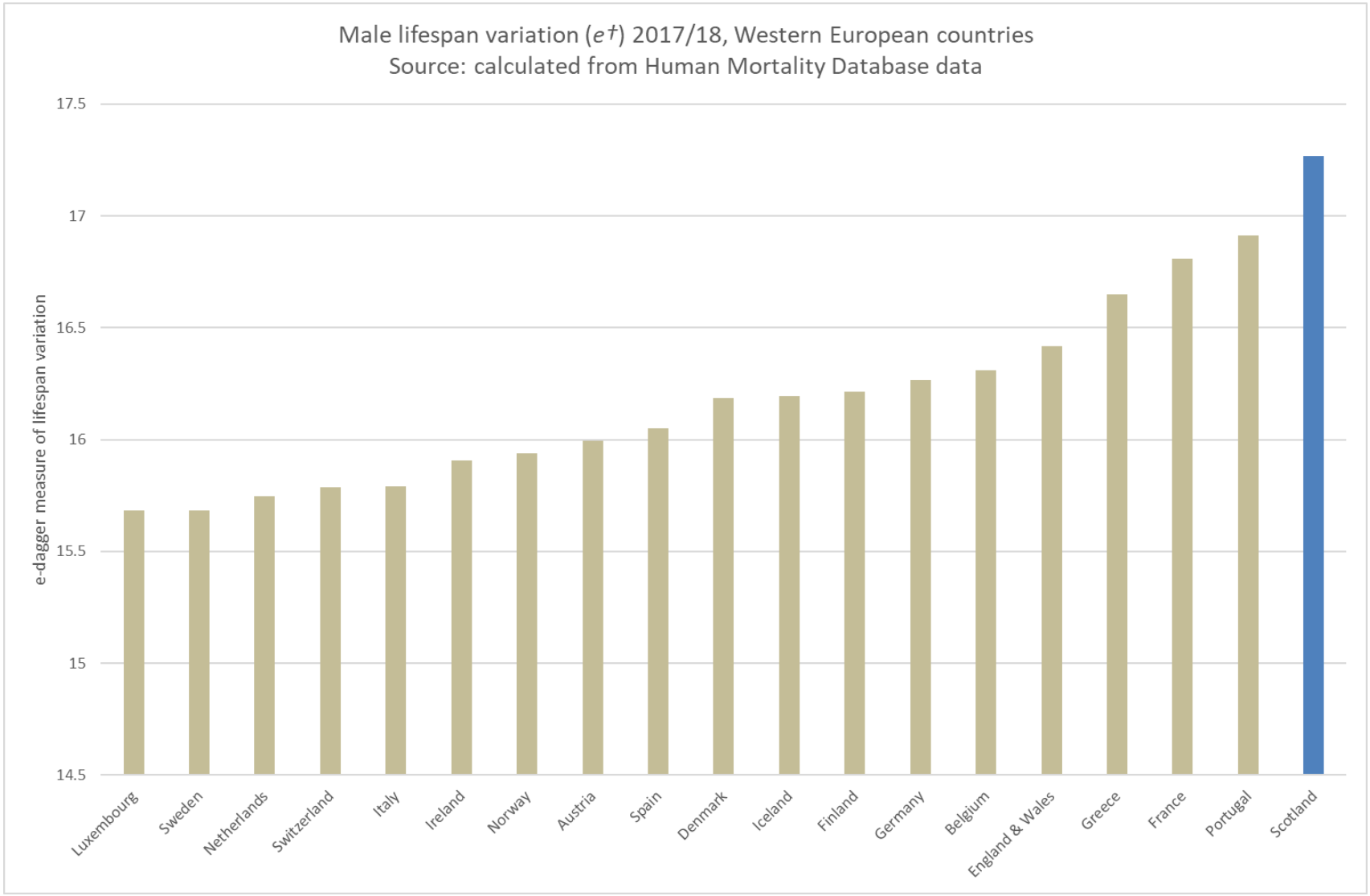
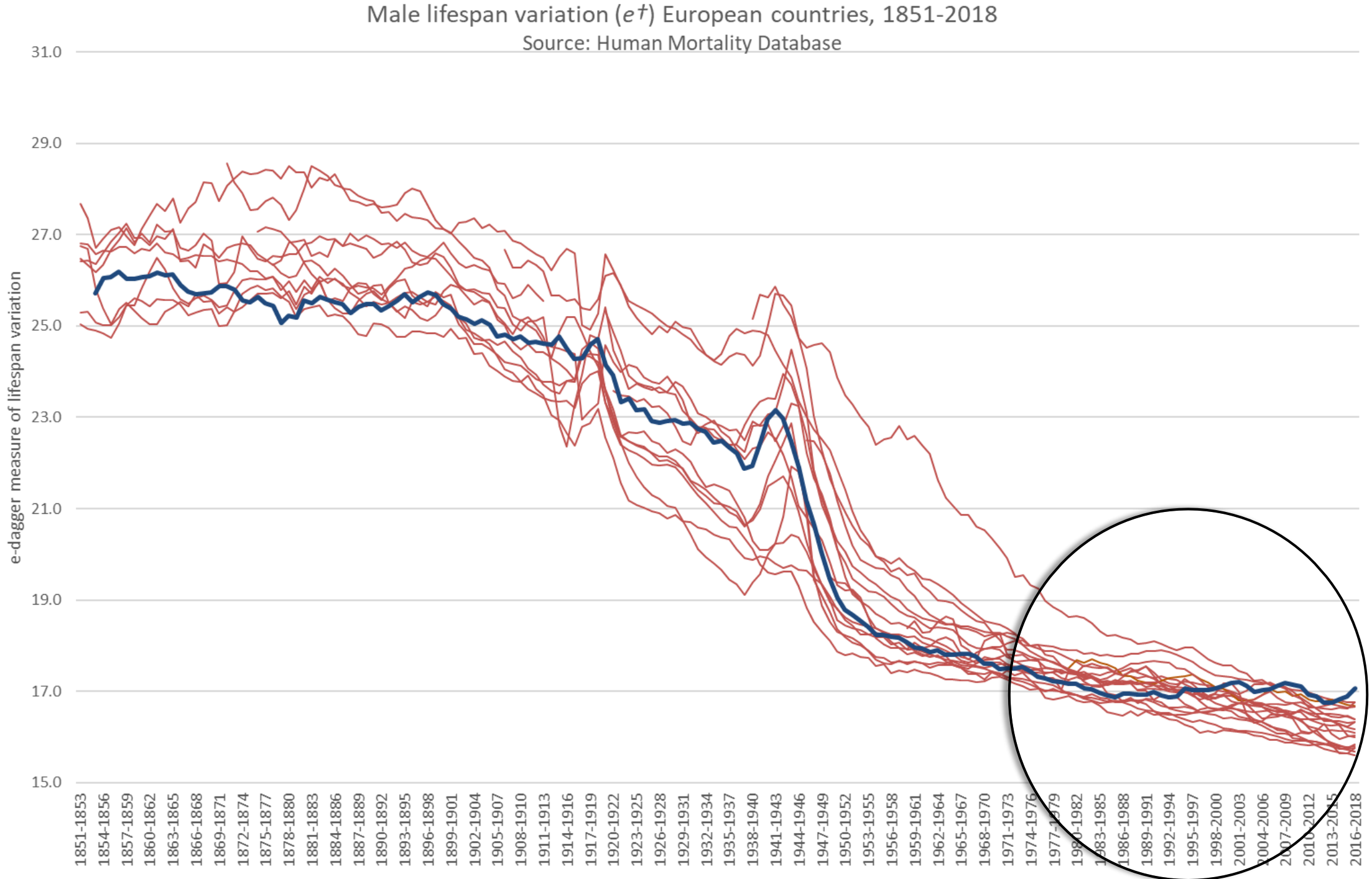


It's political (1): understanding national trends

- Life expectancy is low because inequalities are wide
- And health inequalities have widened considerably in that period (1979→)


Male lifespan variation ($e^{\dagger}$) European countries, 1851-2018
Source: Human Mortality Database
e-dagger measure of lifespan variation
31.0
29.0
27.0
25.0
23.0
21.0
19.0
17.0
15.0
1851-1853
1854-1856
1857-1859
1860-1862
1863-1865
1866-1868
1869-1871
1872-1874
1875-1877
1878-1880
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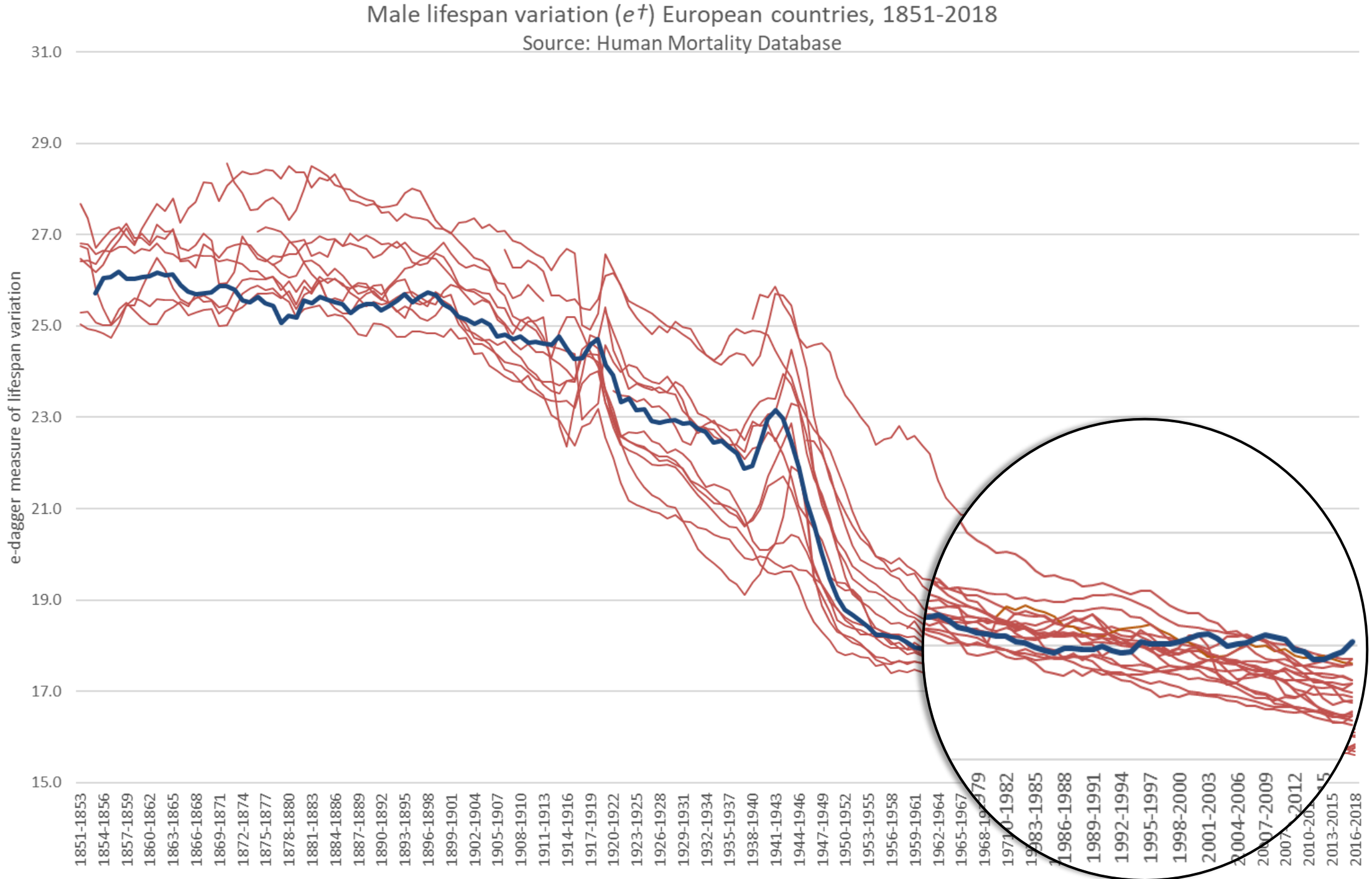
2010-2012
2013-2015
2016-2018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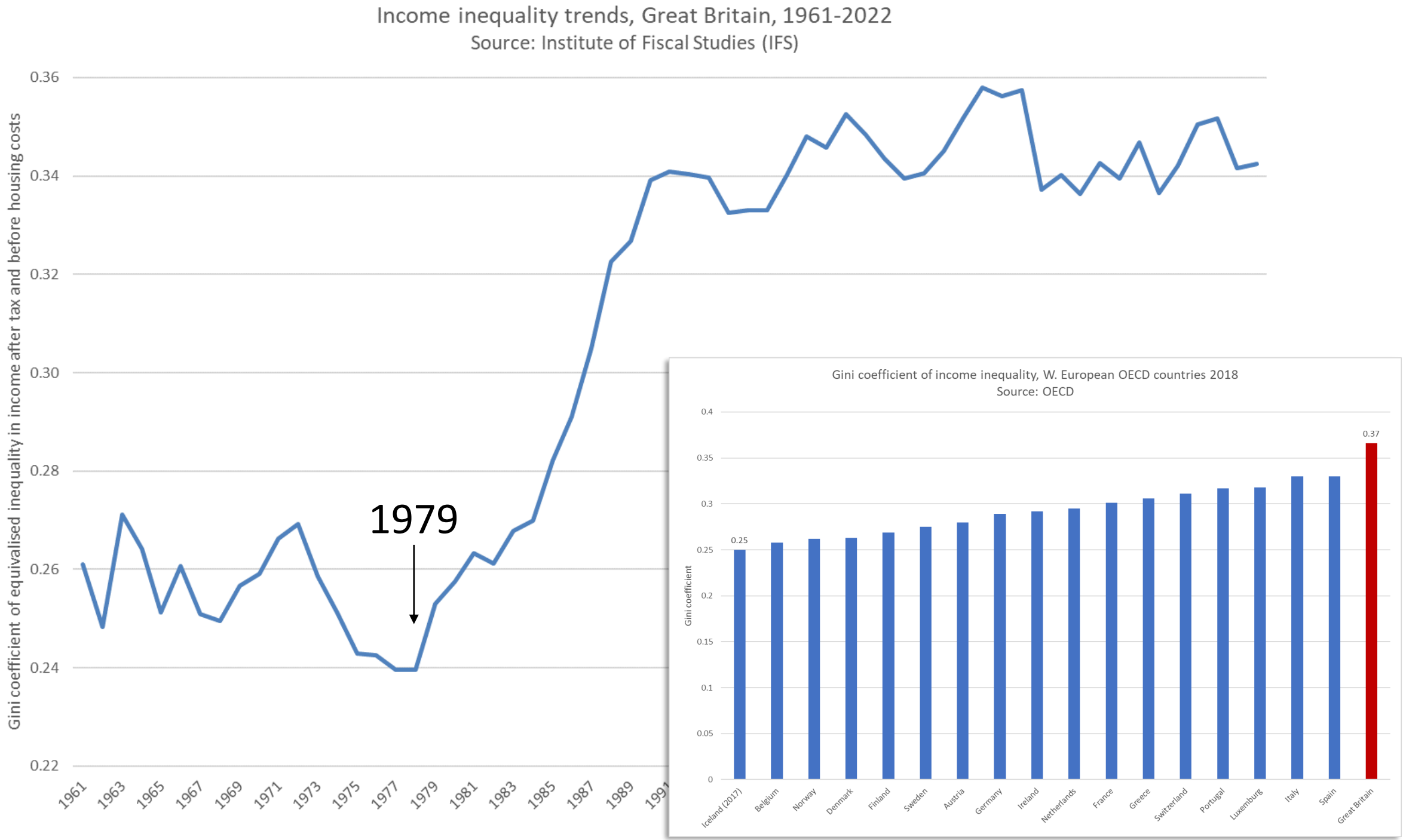
2001-2003
2004-2006
2007-2009
2007-2012
2010-2015
2013-2015
2016-2018

It's political (1): understanding national trends

- Life expectancy is low because inequalities are wide
- And health inequalities have widened considerably in that period
- They have widened because society has become fundamentally more unequal in that period


Income inequality trends, Great Britain, 1961-2022
Source: Institute of Fiscal Studies (IFS)
Gini coefficient of equivalised inequality in income after tax and before housing costs
0.36
0.34
0.32
0.30
0.28
0.26
0.24
0.22
1961
1963
1965
1967
1969
1971
1973
1975
1977
1979
1981
1983
1985
1987
1989
1991
1979
Gini coefficient of income inequality, W. European OECD countries 2018
Source: OECD
Gini coefficient
0.4
0.35
0.3
0.25
0.2
0.15
0.1
0.05
0
0.25
0.37
Iceland (2017)
Belgium
Norway
Denmark
Finland
Sweden
Austria
Germany
Ireland
Netherlands
France
Greece
Switzerland
Portugal
Luxemburg
Italy
Spain
Great Britain

It's political (1): understanding national trends

- Life expectancy is low because inequalities are wide
- And they have widened considerably in that period
- They have widened because society has become fundamentally more unequal in that period
- Caused by political/economic decisions


Income inequality trends, Great Britain, 1961-2022
Source: Institute of Fiscal Studies (IFS)
Gini coefficient of equivalised inequality in income after tax and before housing costs
0.36
0.34
0.32
0.30
0.28
0.26
0.24
0.22
Thatcher 1979-90
Major 1990-97
Blair 1997-07
Brown 2007-10
Cameron 2010-16
May 2016-19
Johnson 2019-22
Truss (20 mins last year)
1979
1961
1963
1965
1967
1969
1971
1973
1975
1977
1979
1981
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1987
1989
1991
1993-94
1995-96
1997-98
1999-00
2001-02
2003-04
2005-06
2007-08
2009-10
2011-12
2013-14
2015-16
2017-18
2019-20
2021-22

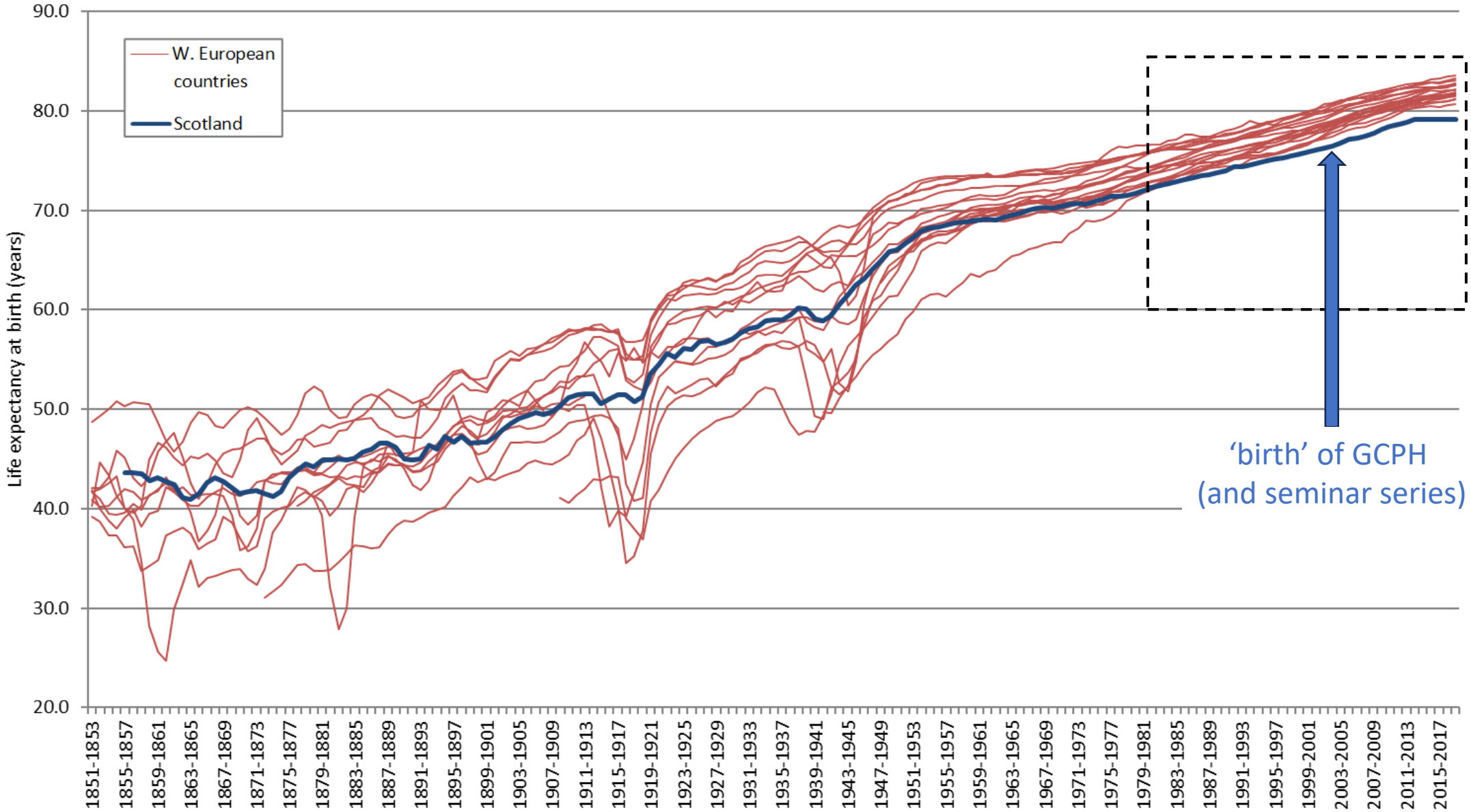
However….

- In Scotland's/West Central Scotland's case, there is a bit more to it than that
- Other influences **on top of** those UK-wide effects
- But still all political….

It’s political (2): understanding **regional** trends

Male & female life expectancy:
Scotland and 18 other Western European Countries, 1851-2019

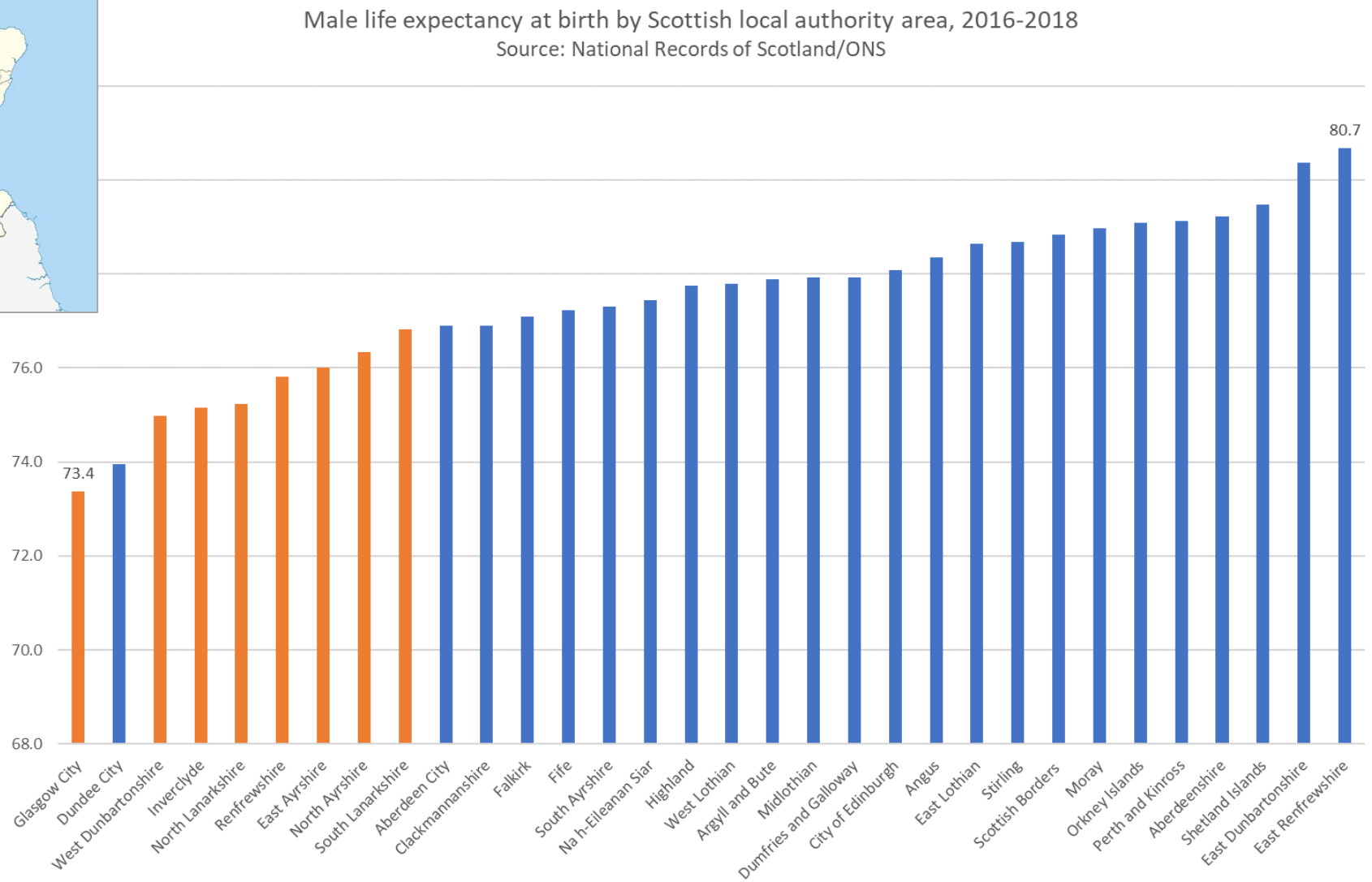
Source: Human Mortality Database



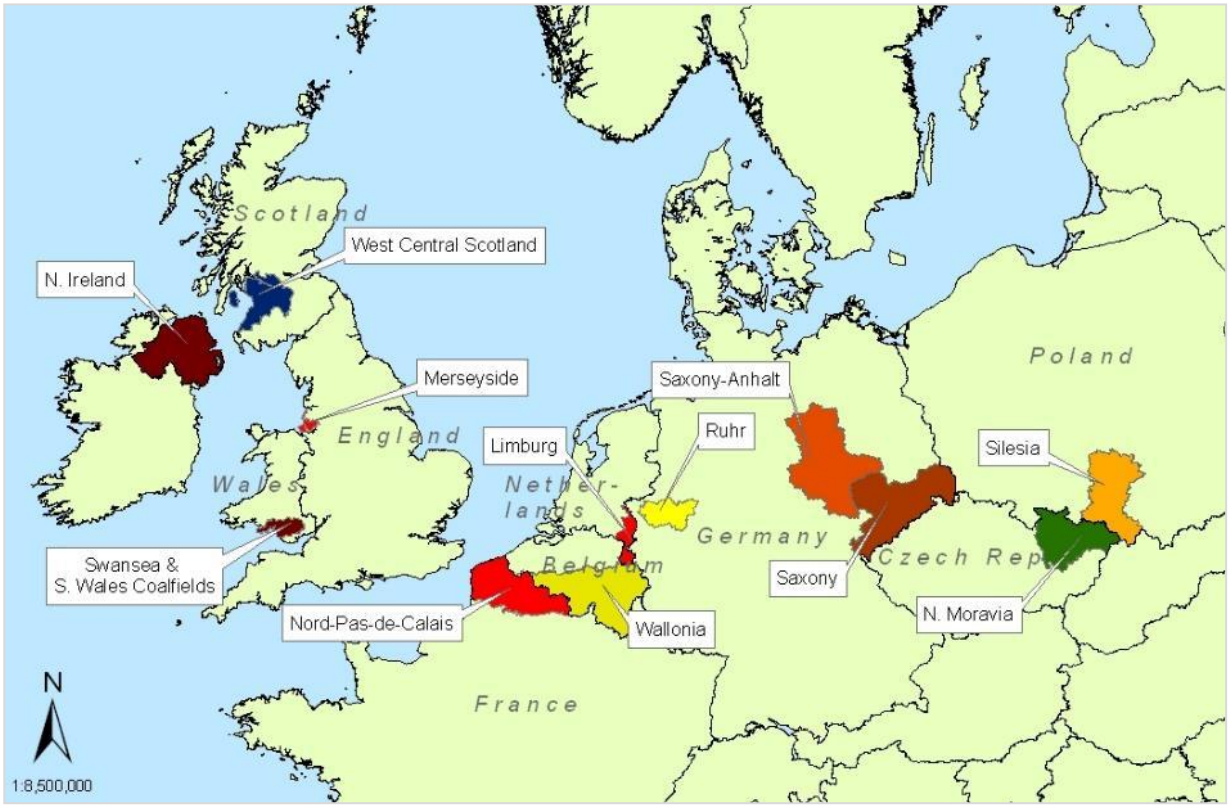
It’s political (2): understanding regional trends

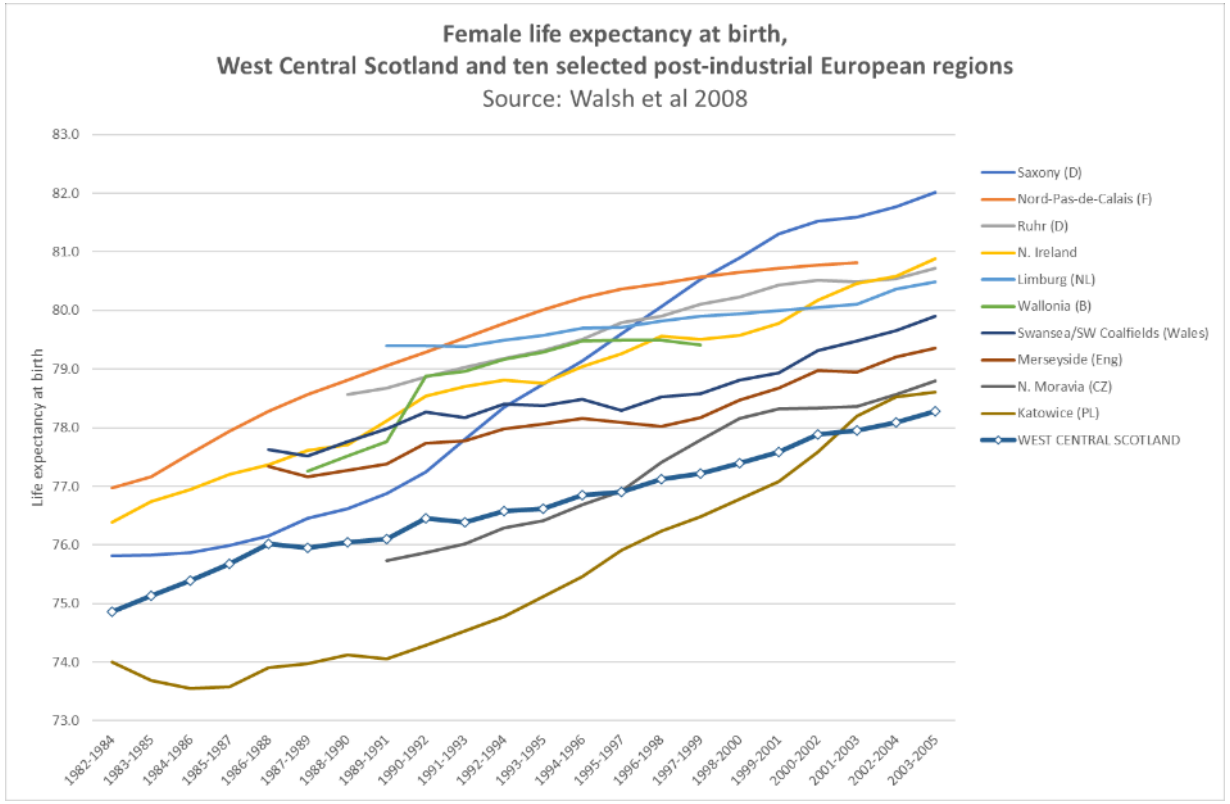
- Country comparisons can be difficult
- Particular (deindustrialised) nature of different parts of Scotland important to understand
- We explored this in the early(ish) days of GCPH

ical (2): European post-industrial regions



It's political (2): European post-industrial regions



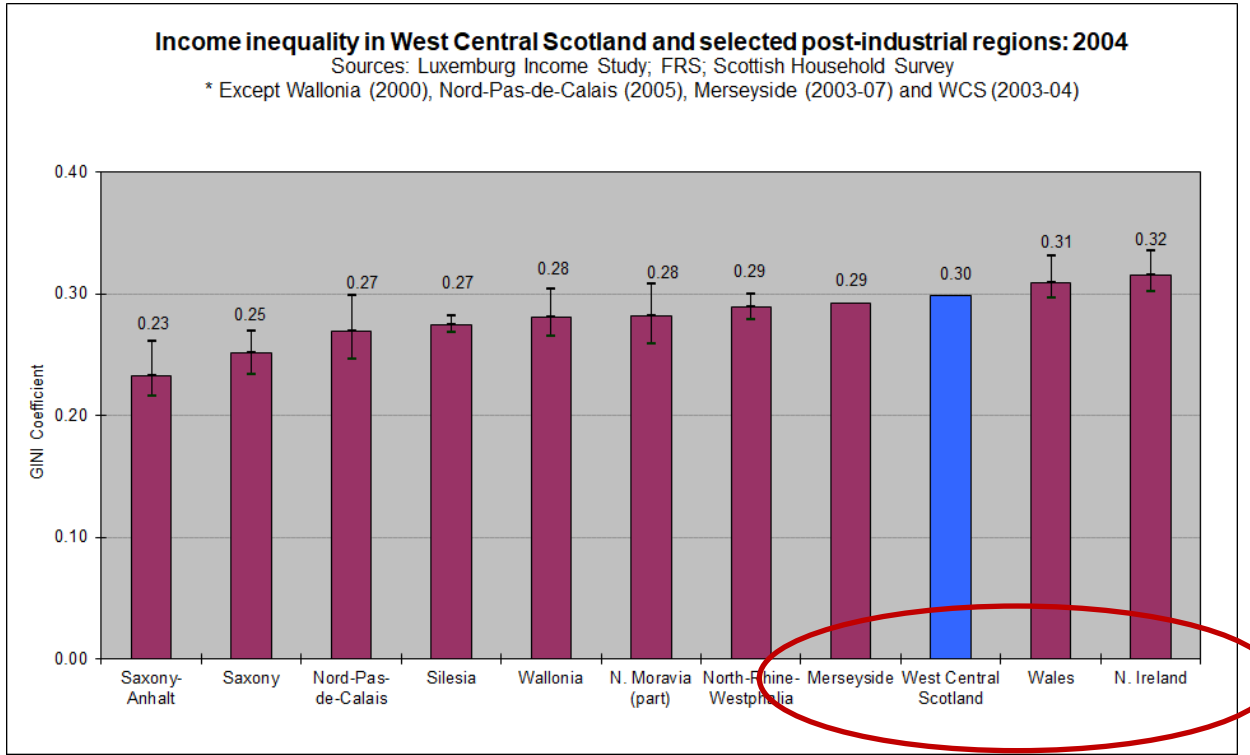


It's political (2): European pos

- Quantitative analyses:
  - Collected data
  - Crunched numbers
  - Killed trees
- Actually main insights from qualitative/policy work
- And the reasons for health differences across regions: all **political**…

It's political (2): European post-industrial regions

- Income inequalities wider in Scottish (and UK) regions…
- But overall: better political decision-making in European regions compared to Scottish (and UK) areas e.g…



- Katovice (P)
- Significant state investment
- Better redevelopment
- Mitigation – increased social security during transition

- Northern Moravia (CZ)
- Industry retained
- Mitigation – increased social security during transition

- Nord-Pas-de-Calais (F)
- Diversification into new technologies
- Mitigation: early retirement schemes, better social security

- Ruhr (D)
- Better investment and planning
- Mitigation: quality training, compensation, social security

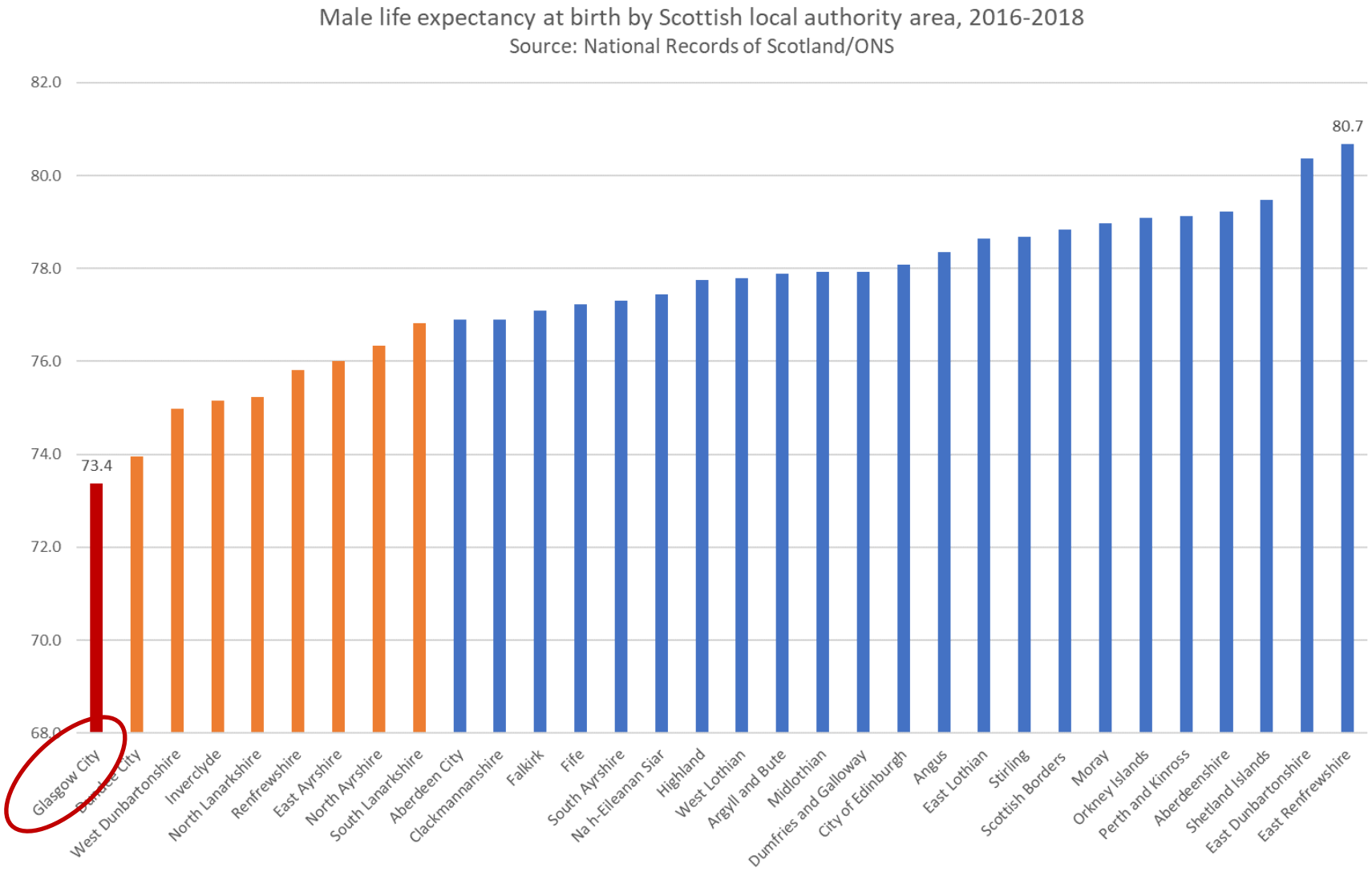
It's all political

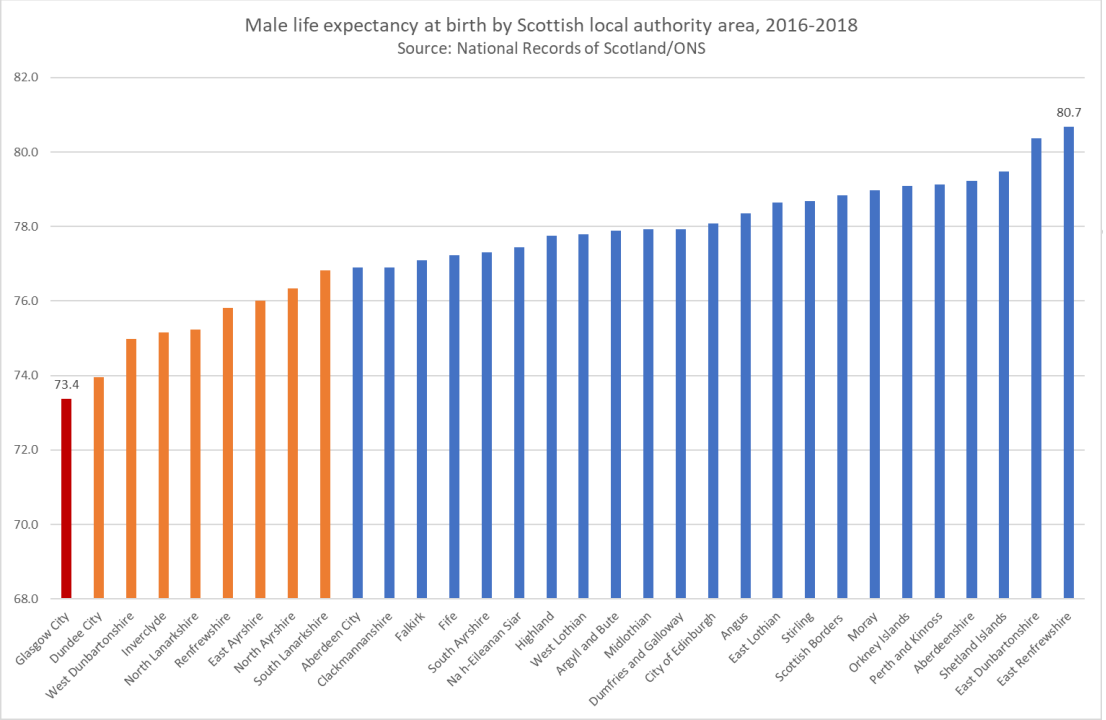
Source: Daniels, Gordon A. Underlying influences on health and mortality trends in post-industrial regions of Europe. PhD thesis, University of Glasgow; 2014

However…. (again)

- In Glasgow's case, there is a bit more to it than that…
- Other city-level influences **on top of** those regional and UK-wide effects
- But still all political….

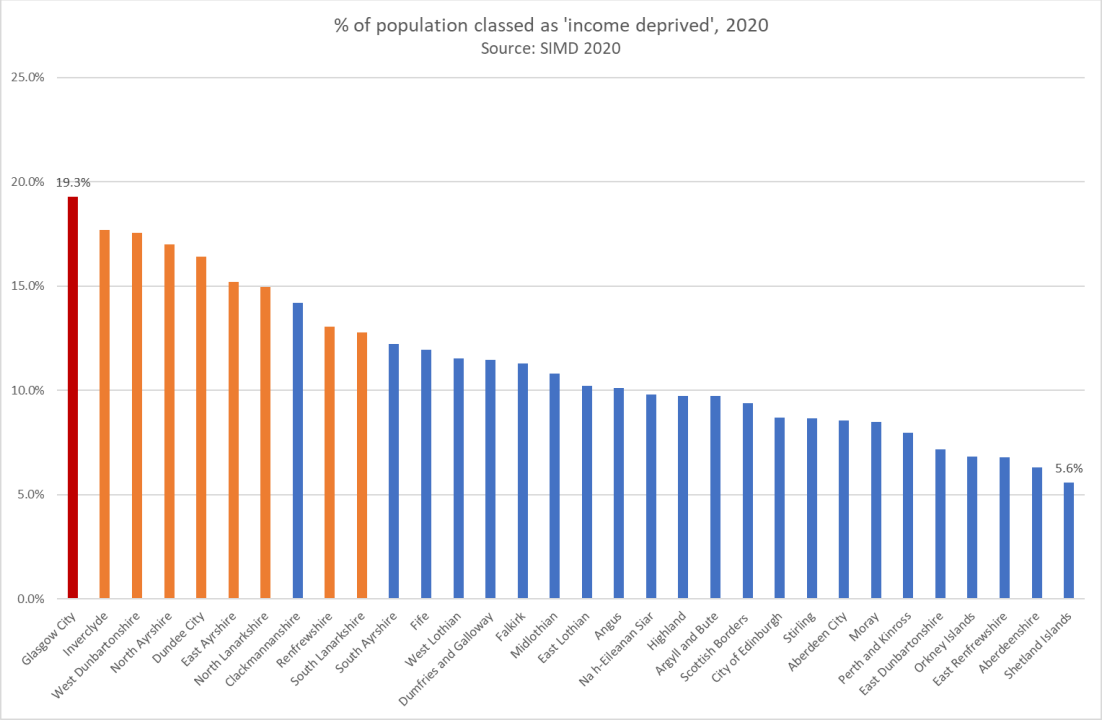
It's political (3): Excess mortality in Glasgow





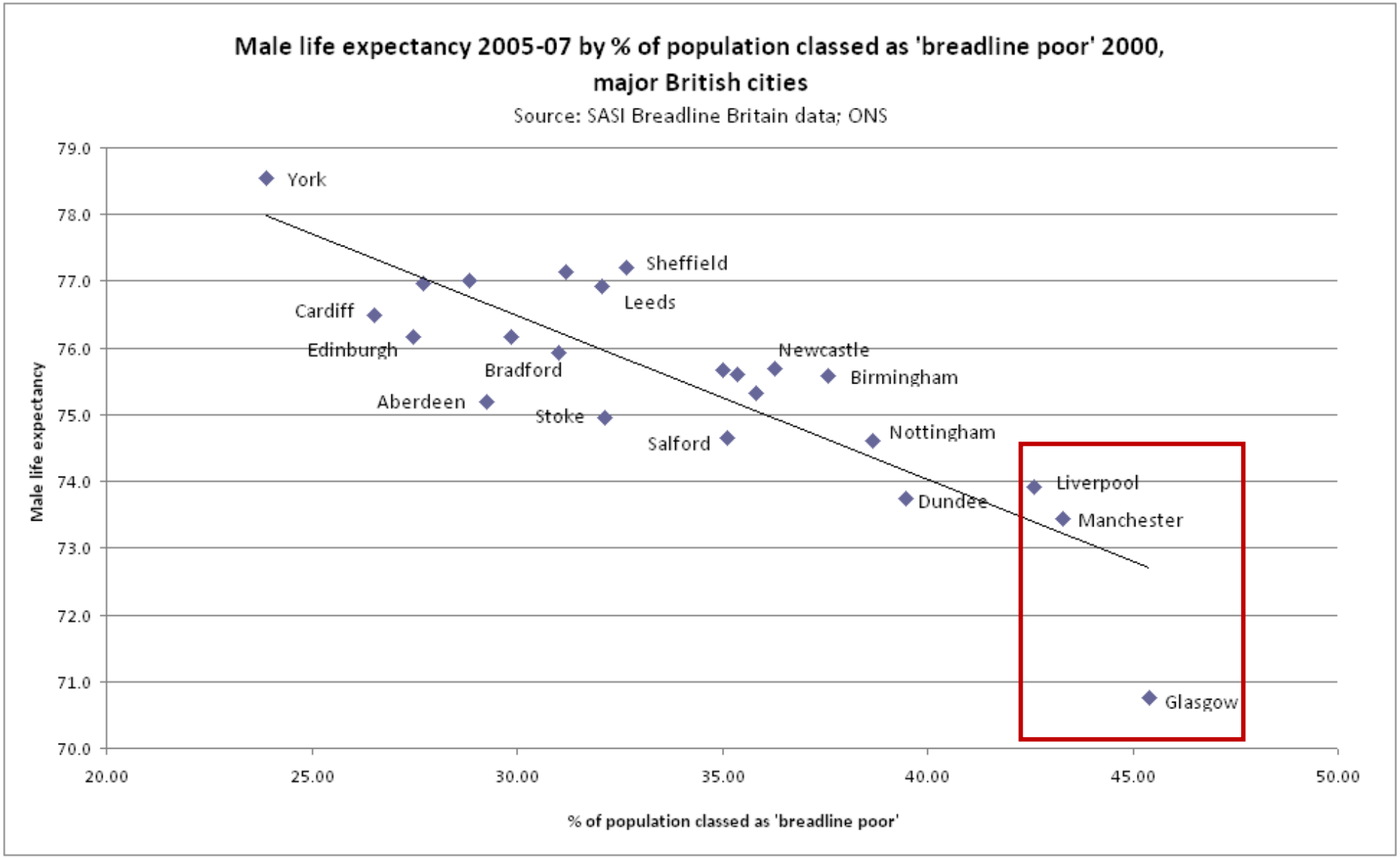
s mortality in Glasgow

Life expectancy

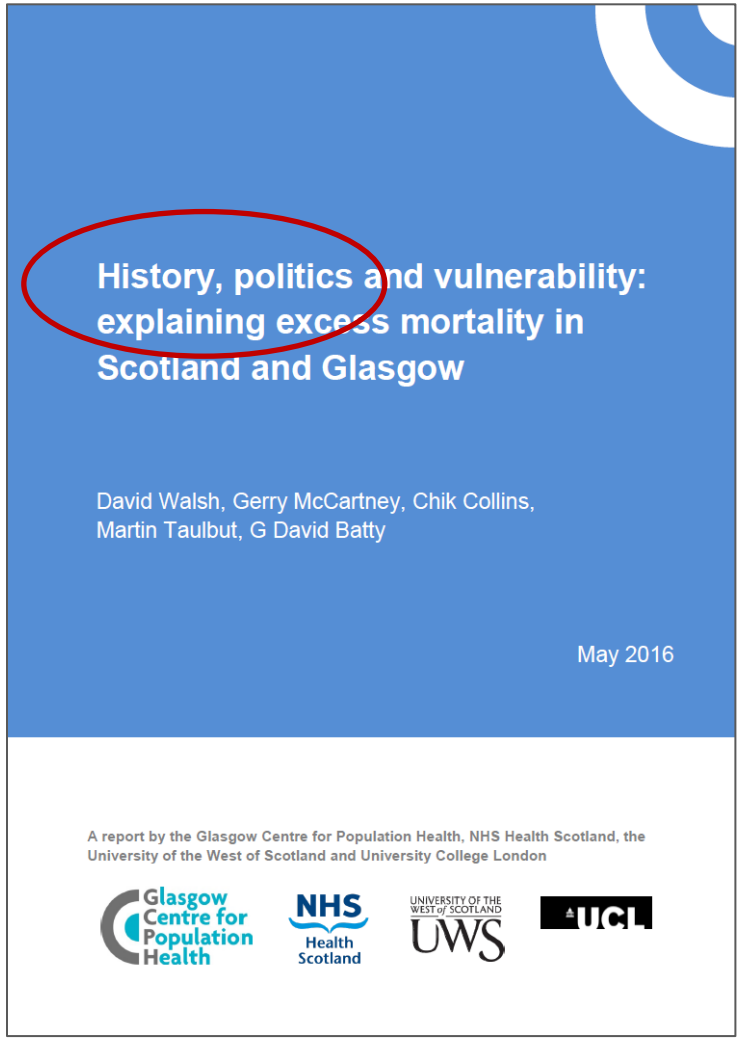


Poverty

It's political (3): Excess mortality in Glasgow



Answer: it's all political…



History, politics and vulnerability: explaining excess mortality in Scotland and Glasgow

David Walsh, Gerry McCartney, Chik Collins, Martin Taulbut, G David Batty

May 2016

A report by the Glasgow Centre for Population Health, NHS Health Scotland, the University of the West of Scotland and University College London

Glasgow Centre for Population Health · NHS Health Scotland · University of the West of Scotland UWS · UCL

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Public Health

journal homepage: www.elsevier.com/puhe

Original Research

History, politics and vulnerability: explaining excess mortality in Scotland and Glasgow

D. Walsh [a,*], G. McCartney [b], C. Collins [c], M. Taulbut [b], G. David Batty [d]

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[b] NHS Health Scotland, Glasgow, Scotland, UK
[c] University of the West of Scotland, Paisley Campus, Scotland, UK
[d] University College London, London, UK

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ABSTRACT

Objectives: High levels of excess mortality (i.e. that not explained by deprivation) have been observed for Scotland compared with England & Wales, and especially for Glasgow in comparison with similar post-industrial cities such as Liverpool and Manchester. Many potential explanations have been suggested. Based on an assessment of these, the aim was to develop an understanding of the most likely underlying causes.

Note that this paper distils a larger research report, with the aim of reaching wider audiences beyond Scotland, as the important lessons learnt are relevant to other populations.

Study design: Review and dialectical synthesis of evidence.

Methods: Forty hypotheses were examined, including those identified from a systematic review. The relevance of each was assessed by means of Bradford Hill's criteria for causality alongside—for hypotheses deemed causally linked to mortality—comparisons of exposures between Glasgow and Liverpool/Manchester, and between Scotland and the rest of Great Britain. Where gaps in the evidence base were identified, new research was undertaken. Causal chains of relevant hypotheses were created, each tested in terms of its ability to explain the many different aspects of excess mortality. The models were further tested with key informants from public health and other disciplines.

Results: In Glasgow's case, the city was made more vulnerable to important socioeconomic (deprivation, deindustrialisation) and political (detrimental economic and social policies) exposures, resulting in worse outcomes. This vulnerability was generated by a series of historical factors, processes and decisions: the lagged effects of historical overcrowding; post-war regional policy including the socially selective relocation of population to outside the city; more detrimental processes of urban change which impacted on living conditions; and differences in local government responses to UK government policy in the 1980s which both impacted in negative terms in Glasgow and also conferred protective effects on comparator cities. Further resulting protective factors were identified (e.g. greater 'social capital' in Liverpool) which placed Glasgow at a further relative disadvantage. Other contributory factors were highlighted, including the inadequate measurement of deprivation.

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E-mail address: David.Walsh.2@glasgow.ac.uk (D. Walsh).
http://dx.doi.org/10.1016/j.puhe.2017.05.016

EXPLAINING EXCESS MORTALITY

40 potential explanations have been examined, based on evidence gathered over many years

Key to our understanding is the concept of vulnerability which has been shown to be important in understanding differences in health between populations.

Glasgow's population has a heightened vulnerability, generated by a series of historical processes which have cumulatively impacted on the city.

These processes include:

Lagged effects of high historical levels of deprivation

Glasgow (alongside other Scottish areas) has endured notably higher levels of deprivation than comparator areas, as evidenced by overcrowding.

The nature and scale of urban change in the post-war period (1945-1980)

Glasgow differed from the comparator cities in terms of: larger-scale slum clearances and demolitions; larger within-city (poor quality) peripheral council house estates; greater emphasis on high-rise development; and much lower per capita investment in housing repairs and maintenance.

Scottish Office regional policy from the late 1950s, including the socially selective New Town programme.

Both industry and some of the population (generally younger, skilled workers, often with families) were relocated to New Towns and other growth areas, away from Glasgow, as part of a wider regional 'modernisation' agenda.

Differences in local government responses to UK government economic policy in the 1980s.

Local responses in Glasgow prioritised inner-city gentrification and commercial development, potentially exacerbating the damaging impacts of UK policy on what was already a vulnerable population.

In the comparator cities, however, responses were more likely to have mitigated these damaging impacts, either by slowing them (Manchester) or by mobilising local opposition against them (Liverpool).

Related to this is that Liverpool, compared with Glasgow, has historically higher levels of social capital - a protective factor which places Glasgow at a further relative disadvantage.

A further key point of understanding is the inadequate measurement of poverty and deprivation used to date - which can fail to capture the 'lived reality' of poverty in Glasgow, compared with the comparator cities.

It is likely that unmeasured aspects of deprivation potentially include a more negative physical environment, as well as aspects of educational attainment.

There are also several smaller, additional factors, the individual impacts of which are likely to be very small, but which can cumulatively affect aspects of population health.

FIND OUT MORE:

http://www.gcph.co.uk/publications/635_history_politics_and_vulnerability_explaining_excess_mortality

Historical living conditions

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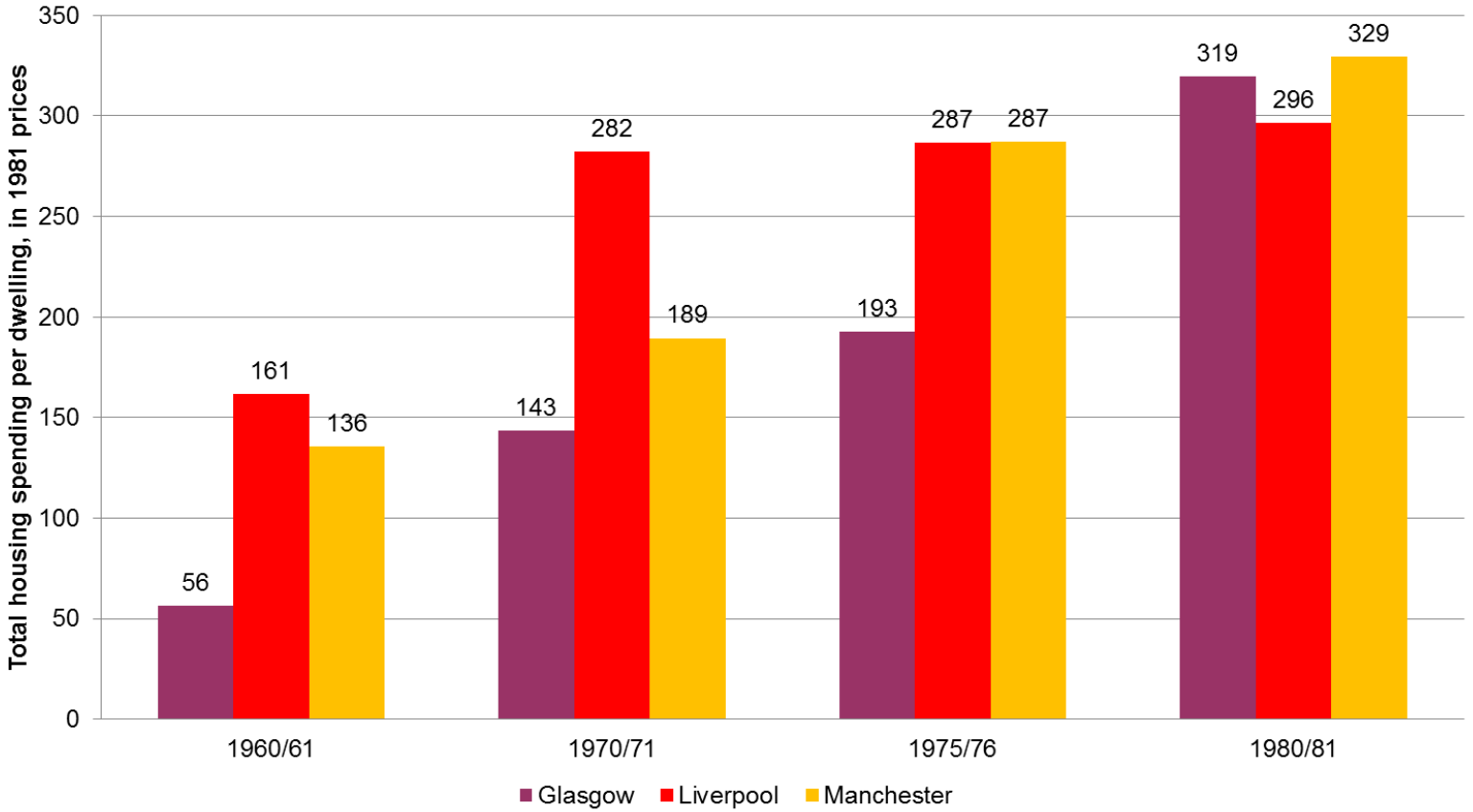
Expenditure on repairs, supervision and maintenance per local authority dwelling (1981 prices), Glasgow, Liverpool and Manchester

Source: Taulbut et al 2015 (calculated from various sources)



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FIND OUT MORE:

http://www.gcph.co.uk/publications/635_history_politics_and_vulnerability_explaining_excess_mortality

UK Government (Scottish Office) regional policy 1950s onwards

- 'Wrote off' (sacrificed) the city
  - Officially designated a "declining city"
  - All economic investment outside the city
  - Socially selective movement of people outside the city

EXPLAINING EXCESS MORTALITY

40 potential explanations have been examined, based on evidence gathered over many years

Key to our understanding is the concept of vulnerability which has been shown to be important in understanding differences in health between populations.

Glasgow's population has a heightened vulnerability, generated by a series of historical processes which have cumulatively impacted on the city.

These processes include:

Lagged effects of high historical levels of deprivation

Glasgow (alongside other Scottish areas) has endured notably higher levels of deprivation than comparator areas, as evidenced by overcrowding.

The nature and scale of urban change in the post-war period (1945-1980)

Glasgow differed from the comparator cities in terms of: larger-scale slum clearances and demolitions; larger within-city (poor quality) peripheral council house estates; greater emphasis on high-rise development; and much lower per capita investment in housing repairs and maintenance.

Scottish Office regional policy from the late 1950s, including the socially selective New Town programme.

Both industry and some of the population (generally younger, skilled workers, often with families) were relocated to New Towns and other growth areas, away from Glasgow, as part of a wider regional 'modernisation' agenda.

Differences in local government responses to UK government economic policy in the 1980s.

Local responses in Glasgow prioritised inner-city gentrification and commercial development, potentially exacerbating the damaging impacts of UK policy on what was already a vulnerable population.

In the comparator cities, however, responses were more likely to have mitigated these damaging impacts, either by slowing them (Manchester) or by mobilising local opposition against them (Liverpool).

Related to this is that Liverpool, compared with Glasgow, has historically higher levels of social capital – a protective factor which places Glasgow at a further relative disadvantage.

A further key point of understanding is the inadequate measurement of poverty and deprivation used to date – which can fail to capture the 'lived reality' of poverty in Glasgow, compared with the comparator cities.

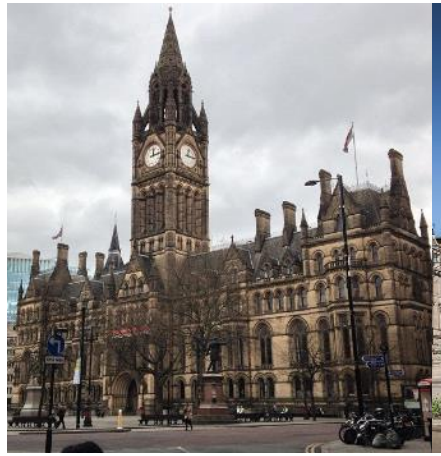
It is likely that unmeasured aspects of deprivation potentially include a more negative physical environment, as well as aspects of educational attainment.

There are also several smaller, additional factors, the individual impacts of which are likely to be very small, but which can cumulatively affect aspects of population health.

FIND OUT MORE:

http://www.gcph.co.uk/publications/635_history_politics_and_vulnerability_explaining_excess_mortality

Local government 1980s



Manchester

Glasgow

Liverpool

- Different local government responses to widening societal inequalities
- Much less done in Glasgow for poorer populations
- Or.. it was all **political**
- So NB: it's not a 'Glasgow effect', it's a 'political effect'

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Cities
Resilient cities

The Glasgow effect: 'We die young here - but you just get on with it'

Research based on newly released 1970s policy documents suggests Glaswegians' higher risk of premature death was caused by 'skimming the cream' - rehousing skilled workers in new towns, and leaving the poorest behind

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Revealed: 'Glasgow effect' mortality rate blamed on Westminster social engineering

Scotland 2016
@BBCScot2016

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It's been known as the 'Glasgow Effect' for

Scotland Office policies blamed for Glasgow Effect in forthcoming report

The Glasgow Effect: Activism as a public health issue

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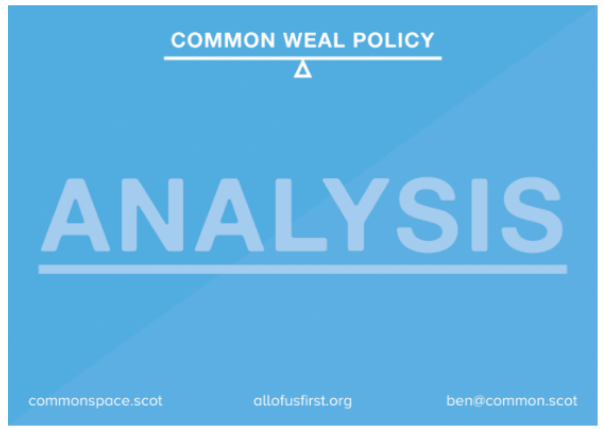
Labour let down Glasgow's poor. Nicola Sturgeon must not do the same.

Kevin McKenna
23 May 2016

Comment: Kevin McKenna on the Glasgow Effect and why it damns politicians and policy makers.



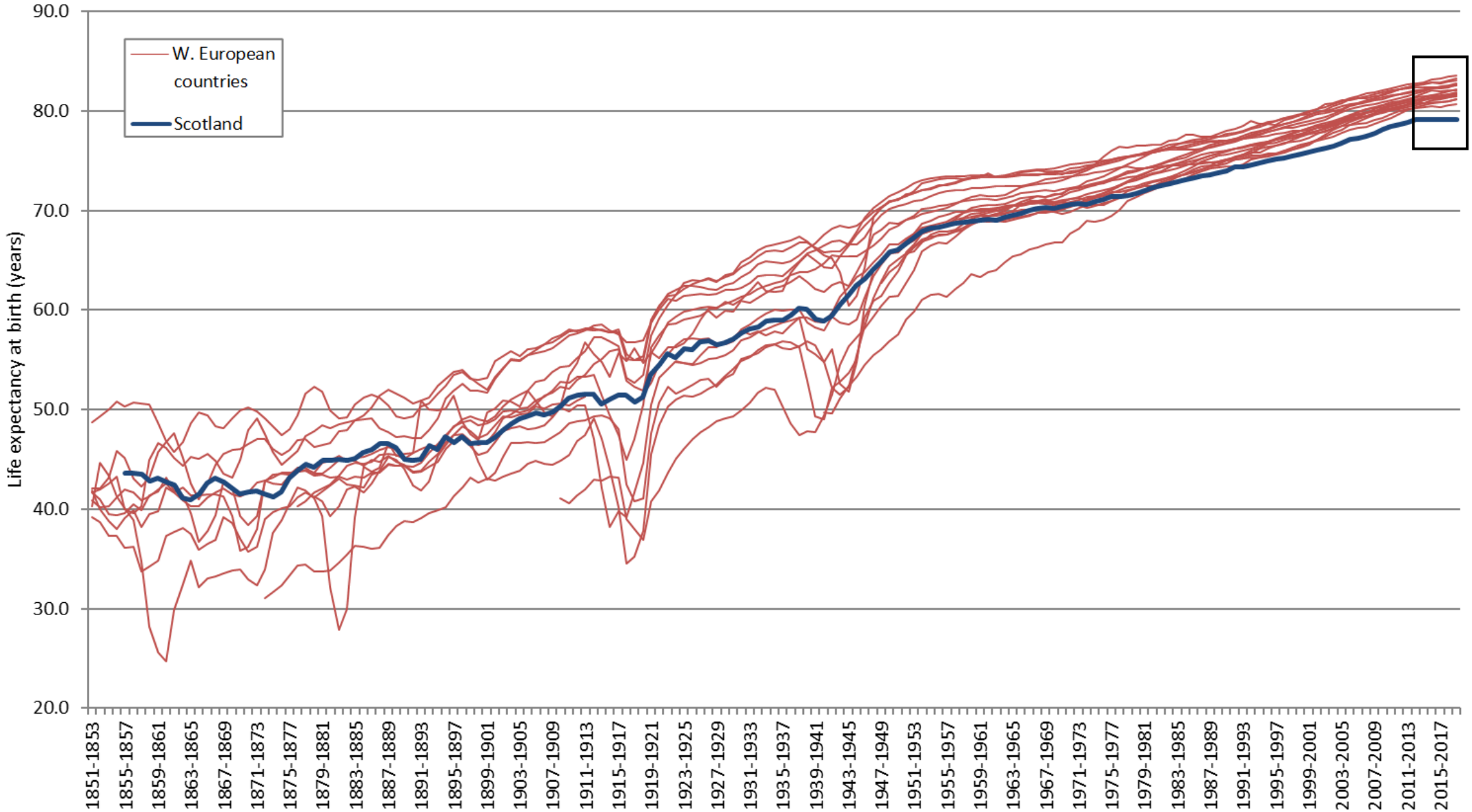
Common Weal Policy look at a new report on The Glasgow Effect – the excess mortality that comes from living in Glasgow as compared to cities with a similar socio-economic profile – and find the role of politics and activism at the grassroots level to be influential in public health outcomes

However…. (again, again)

- All of this is overshadowed by what has happened in the past decade
- The impact of political decisions on inequalities is arguably worse than what occurred in the 1979→ period

Male & female life expectancy:
Scotland and 18 other Western European Countries, 1851-2019

Source: Human Mortality Database



It’s political (4): the last decade

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Health

Life expectancy progress in UK 'stops for first time'

By Alex Therrien
Health reporter, BBC News

25 September 2018 Share

Life expectancy in the UK has stopped improving for the first time since 1982, when figures began.

Women's life expectancy from birth remains 82.9 years and for men it is 79.2, the figures from the Office for National Statistics, for 2015-17, show.

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Scotland Scotland Politics Scotland Business Edinburgh, Fife & East Glasgow & West

Scottish life expectancy improvements stall

14 August 2019 Share

Although the population is aging, life expectancy is no longer showing clear progress

Life expectancy improvements have stalled, according to a report from the National Records of Scotland.

It said the change came after three decades in which Scottish residents have been

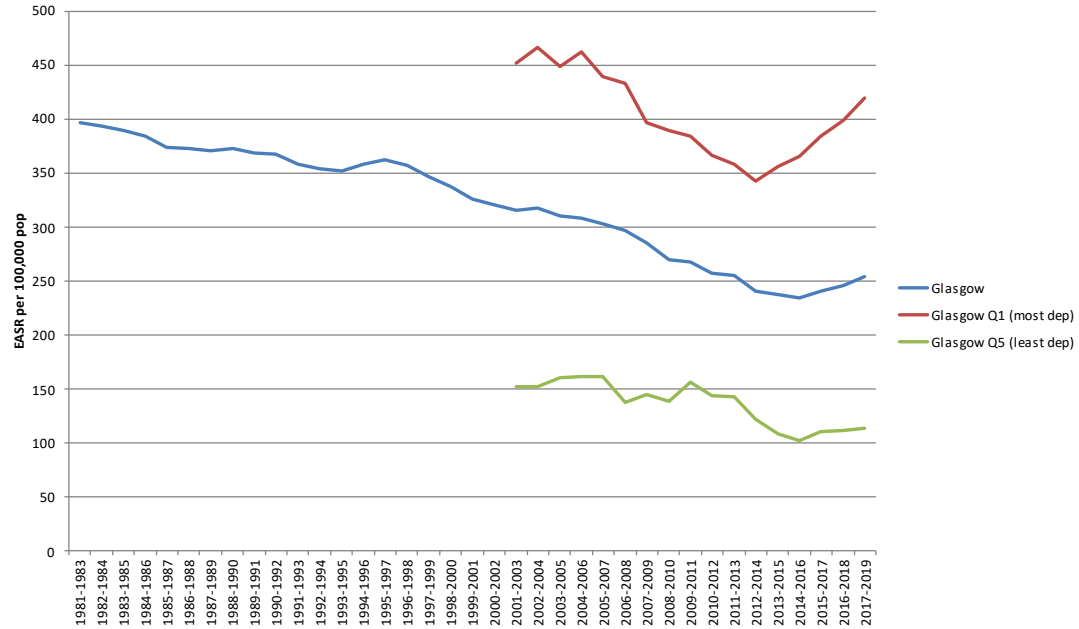
Changing mortality rates in the UK

Females, 0-64 years, all cause: European age-standardised mortality rates

Rolling three-year averages per 100,000 population

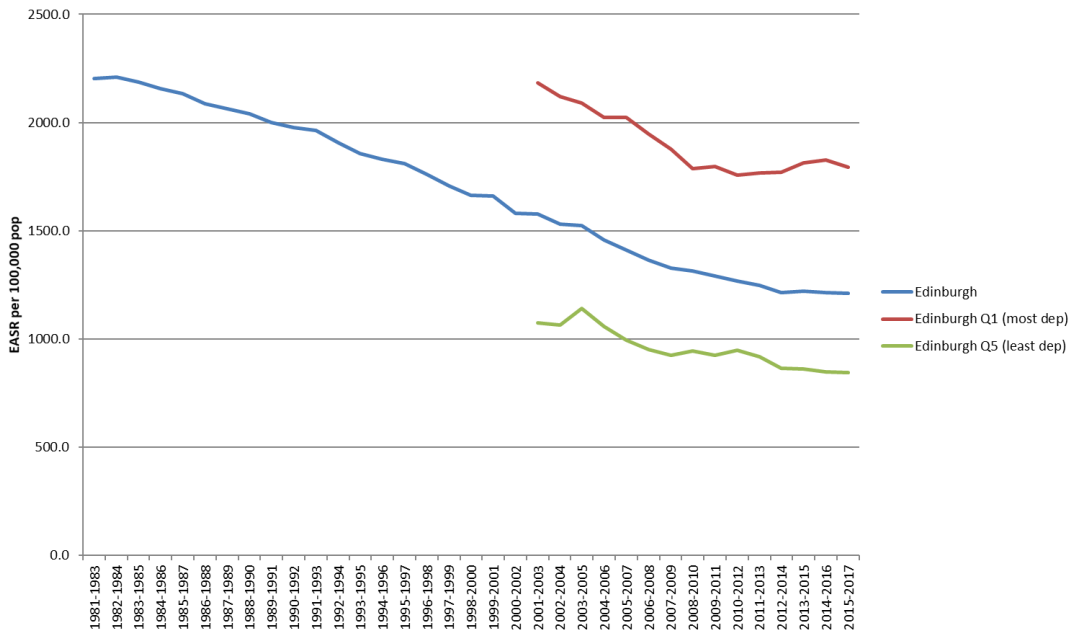
Females, 0-64 years, all cause: European age-standardised mortality rates

Rolling three-year averages per 100,000 population



Males, all ages, all cause: European age-standardised mortality rates

Rolling three-year averages per 100,000 population



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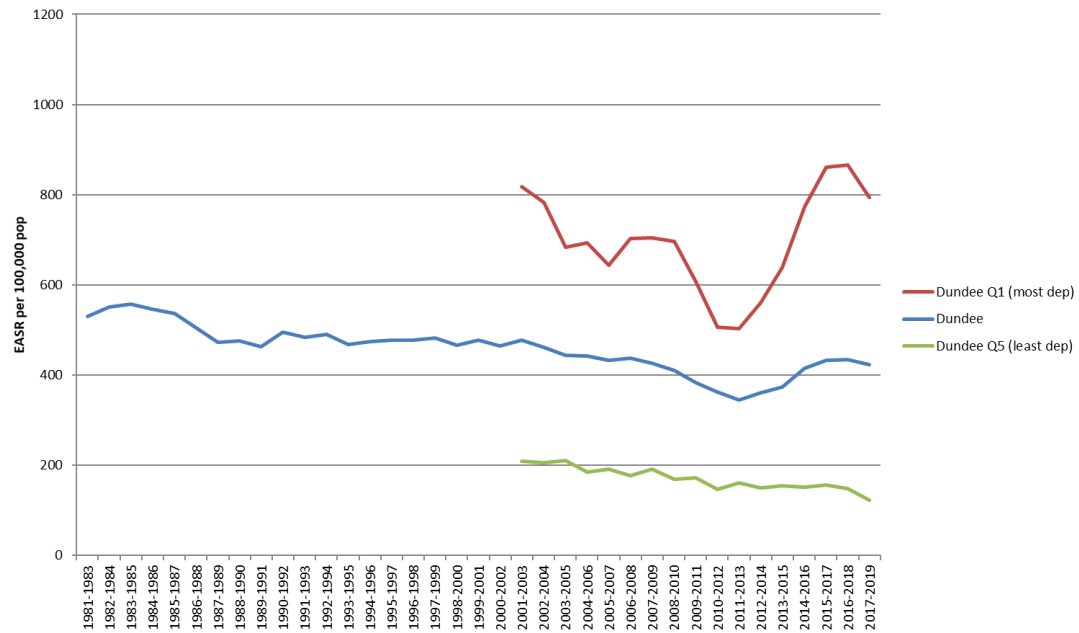

Females, all ages, all cause: European age-standardised mortality rates

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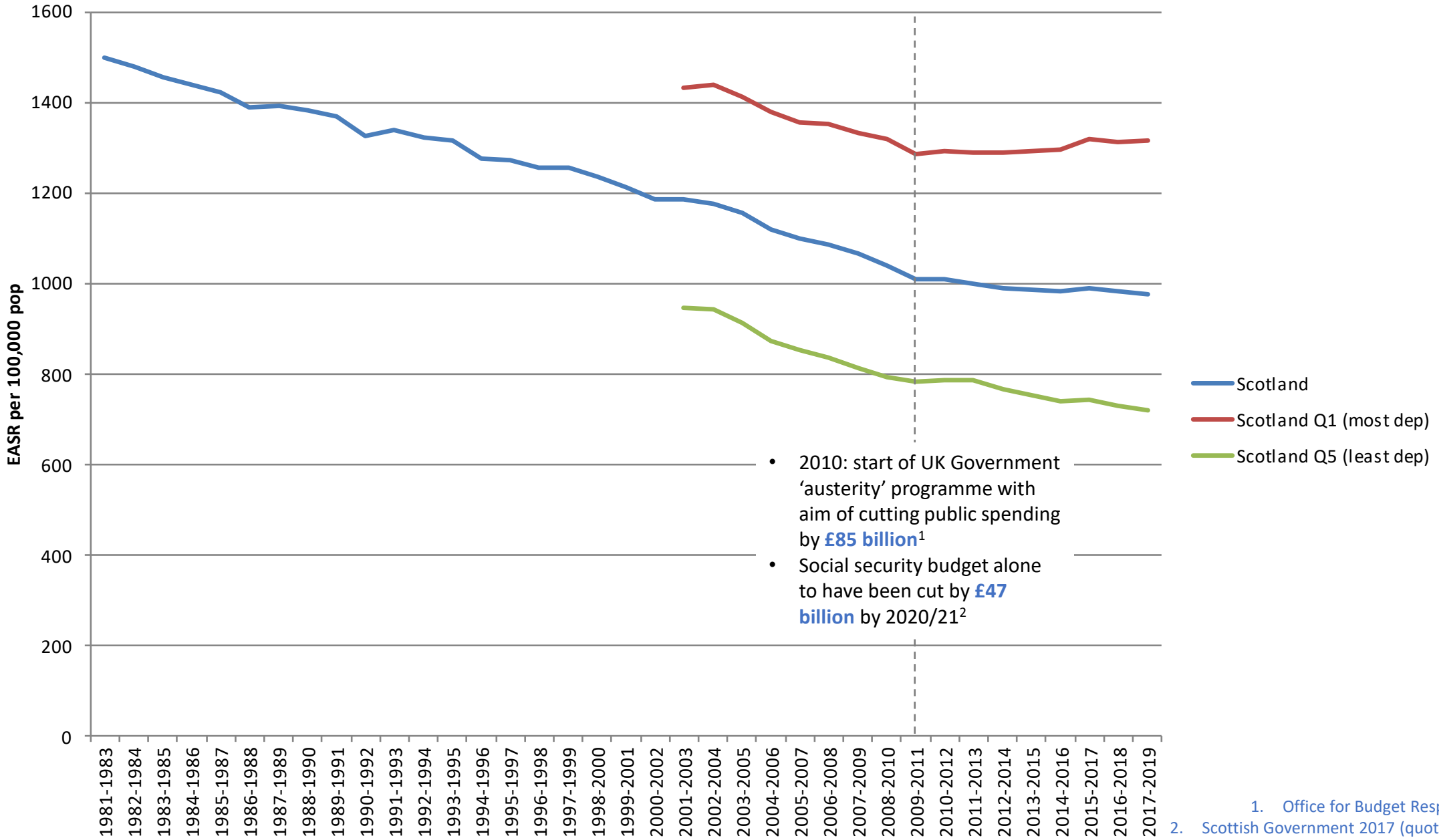

1. Office for Budget Responsibility 2013.
2. Scottish Government 2017 (quoting OBR figures)

Is there evidence to support this?

- Er, yes..

The evidence...

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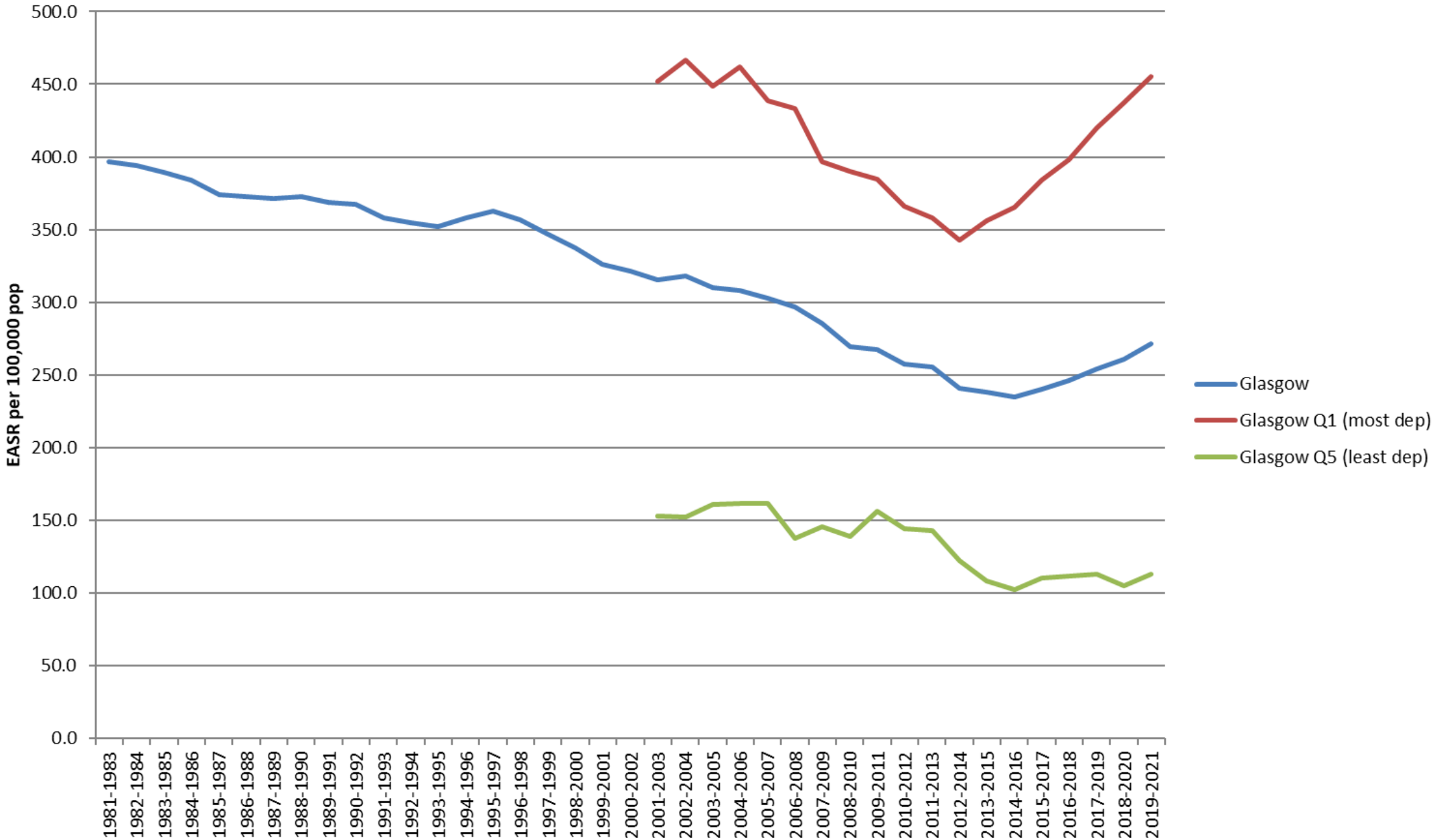
Is there evidence to support this?

See: www.gcph.co.uk/life-expectancy

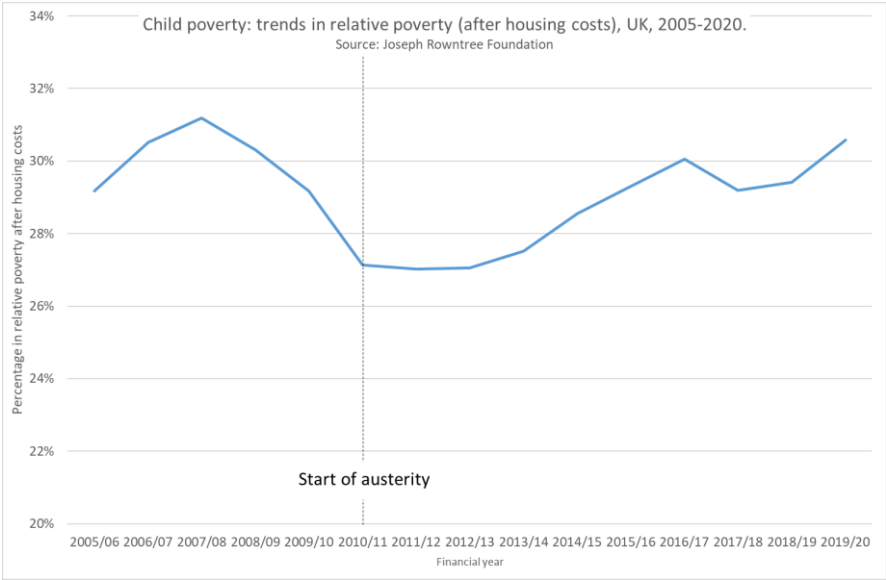
Females, 0-64 years, all cause: European age-standardised mortality rates

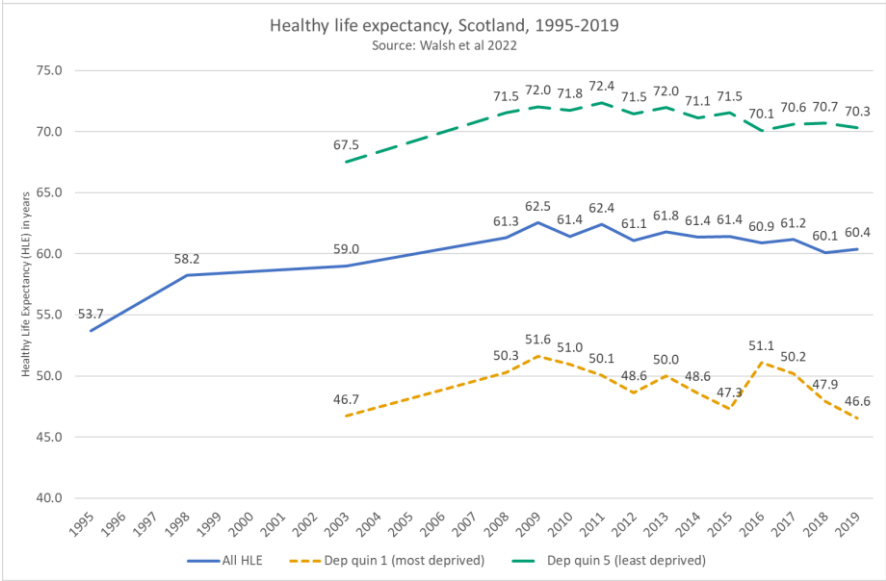
Rolling three-year averages per 100,000 population



It’s political (4): the last decade

- The impact of austerity on Scottish and UK society is hard to overstate…
- **Food banks**
- **Child poverty**
- Mortality trends
- **Healthy life expectancy**
- Mental health trends
- Maternal outcomes
- When I said things weren’t good, I wasn’t joking





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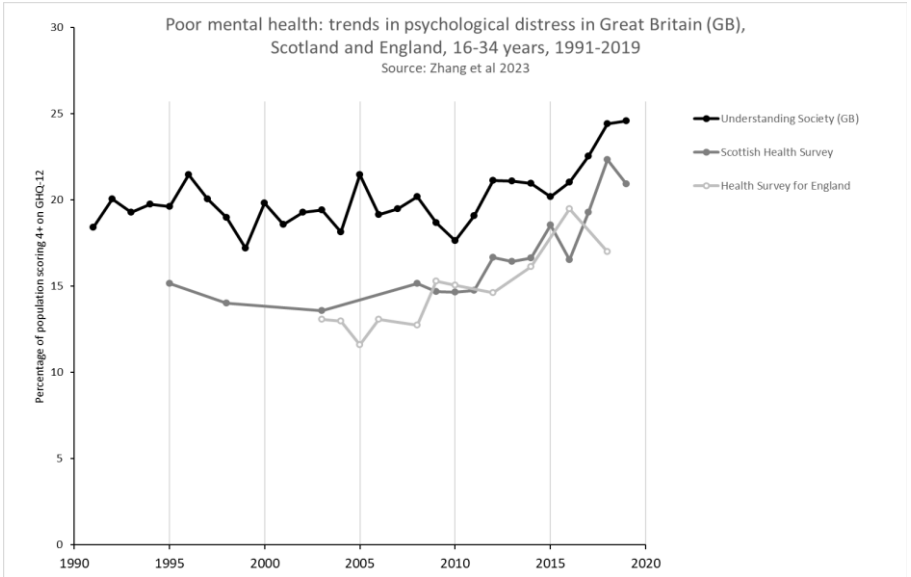

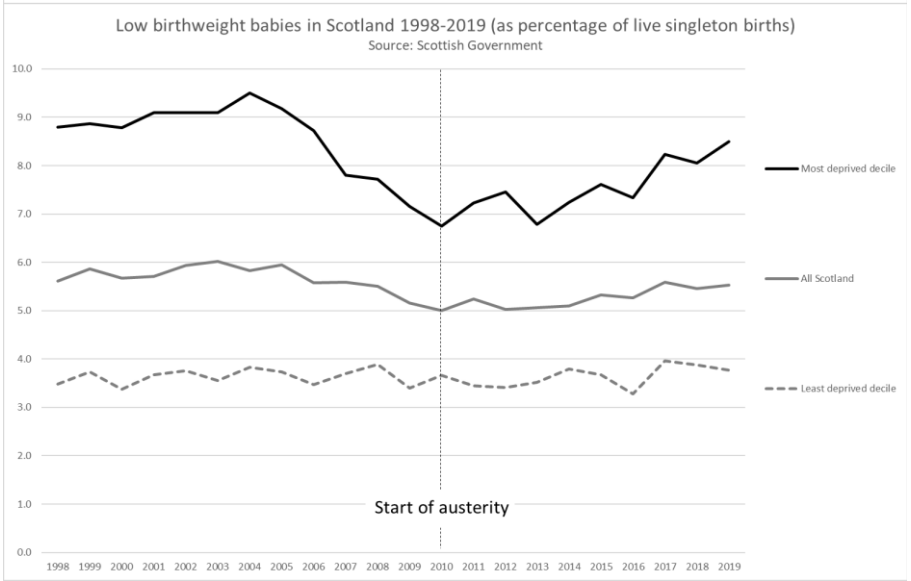

What should we do?

- Weep
- Weep some more
- But then shout about this!
- People are either unaware or don’t care

Orginal research

J Epidemiol Community Heal

OPEN ACCESS

Scaling COVID-19 against inequalities: should the policy response consistently match the mortality challenge?

Gerry McCartney [1], Alastair Leyland,[2] David Walsh [3], Dundas Ruth [2]

► Supplemental material is published online only. To view please visit the journal online (http://dx.doi.org/10.1136/jech-2020-214373).

For numbered affiliations see end of article.

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Published Online First
3 November 2020

To cite: McCartney G, Leyland A, Walsh D, *et al*. *J Epidemiol Community Health* 2021;**75**:315–320.

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Original research

J Epidemiol Communit

OPEN ACCESS

Bearing the burden of austerity: how do changing mortality rates in the UK compare between men and women?

Davi
Rosi

► Additional supplemental material is published online only. To view, please visit the journal online (http://dx.doi.org/10.1136/jech-2022-219645).

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BMJ

The Guardian
Newspaper of the year

Austerity

Over 330,000 excess deaths in Great Britain linked to austerity, finds study

Research comes as government signals fresh round of public spending cuts

Patrick Butler *Social policy editor*

Wed 5 Oct 2022 00.01 BST

Additional deaths over eight years prior to Covid pandemic may reflect people dying prematurely due to reduced income, ill-health, poor nutrition and housing, and social isolation. Photograph: Guerilla/Alamy

More than 330,000 excess deaths in Great Britain in recent years can be attributed to spending cuts to public services and benefits introduced by a UK government pursuing austerity policies, according to an academic study.

The authors of the study suggest additional deaths between 2012 and 2019 - prior to the Covid pandemic - reflect an increase in people dying prematurely after experiencing reduced income, ill-health, poor nutrition and housing, and social isolation.

Previously improving mortality trends started to change for the worse after austerity policies introduced in 2010 when tens of billions of pounds began to be cut from public spending by the Tory-led coalition government, the

Responding to the challenge

Long history of evidence-informed recommendations

Long history of evidence-informed recommendations

- Consistent over time, with a gradual increase in the depth and triangulation of the evidence
- Fundamental causes: inequalities in income, wealth and power

Power is arguably the overarching framework here: incorporates economic power as well as the structures of racism and discrimination


Zoom out (Ctrl+Minus)

Social Science & Medicine 282 (2021) 114173

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Power and the people's health

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ARTICLE INFO

Keywords:
Health inequities
Power
Structure
Agency
Public policy

ABSTRACT

Public policy plays a central role in creating and distributing resources and conditions of daily life that matter for health equity. Policy agendas have tended to focus on health care delivery and individualised interventions. Asking why there is a lack of policy action on structural drivers of health inequities raises questions about power inequities in policy systems that maintain the status quo.

In this paper we investigate the power dynamics shaping public policy and implications for health equity. Using a Health Equity Power Framework (HEPF), we examined data from 158 qualitative interviews with government, industry and civil society actors across seven policy case studies covering areas of macroeconomics, employment, social protection, welfare reform, health care, infrastructure and land use planning.

The influence of structures of capitalism, neoliberalism, sexism, colonisation, racism and biomedicalism were widely evident, manifested through the ideologies, behaviours and discourses of state, market, and civil actors and the institutional spaces they occupied. Structurally less powerful public interest actors made creative use of existing or new institutional spaces, and used network, discursive and moral power to influence policy, with some success in moderating inequities in structural and institutional forms of power.

Our hope is that the methodological advancement and empirical data presented here helps to illuminate how public interest actors can navigate structural power inequities in the policy system in order to disrupt the status quo and advance a comprehensive policy agenda on the social determinants of health equity.

However, this analysis highlights the unrealistic expectation of turning health inequities around in a short time given the long-term embedded power dynamics and inequities within policy systems under late capitalism. Achieving health equity is a power-saturated long game.

1. Background

Pursuit of health equity recognises the need to redress the unequal distribution of power, money and resources, which shape people's life chances and conditions of daily living (Abel and Frohlich, 2012; Cockerham et al., 1993). Public policy influences these resources and their distribution. In this paper, we examine the power dynamics that are at play in public policy processes and the implications for health equity.

More than 10 years ago, the World Health Organization Commission on the Social Determinants of Health (CSDH, 2008) made policy recommendations aimed at improving peoples' daily living conditions and redressing the structural biases that shape those conditions in order to improve health equity. Getting effective action on the daily living conditions that affect health (e.g. urban planning) remains challenging. Even more difficult is getting action in the issues that challenge the distribution of power, money and resources e.g. trade, infrastructure and racism (Shankardass et al., 2012). Such policy recommendations have been marginalized in favour of a focus on health care delivery and individual behaviours (Donkin et al., 2018; Rasanathan, 2018).

Arguably the lack of effective multi-sectoral policy is because a focus on the social determinants and health equity challenges established political and policy assumptions. A political economy perspective

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Health inequalities, funda
towards the practice of g

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Abstract Reducing health inequalities
world. Beginning from Lewin
as a good theory", this paper
'fundamental cause theory', er
encapsulation of the challenge
potential to support the practic
Moreover, it is argued that rec
opportunity for further theoret
concept of *power* (Dickie *et a*
element in maintaining, increa
including health inequalities –
also enhance the capacity to c
levels and scales. This paper p
framework to help to identify
power, as well as the social sp
usefully test, elaborate and adapt this framework, or indeed ultimately replace it
with something better, to help focus actions to reduce inequalities.

Keywords: power, health inequalities, fundamental causes, democracy, health

Introduction

Health inequalities, as defined in this article and in many others, are the systematic, avoidable and unfair differences in health outcomes that can be observed between populations, between social groups within the same population or as a gradient across a population ranked by social position (McCartney *et al.* 2019a). They are not variations or differences that can be understood to result from 'natural' phenomena such as age, as might be the case with differences in the prevalence of dementia across age groups (something we describe as 'health inequities'). However, the terminology can be confusing because the terms 'health inequities' and 'health inequalities' are used in precisely the opposite way by many researchers, particularly in North America (McCartney *et al.* 2019b).

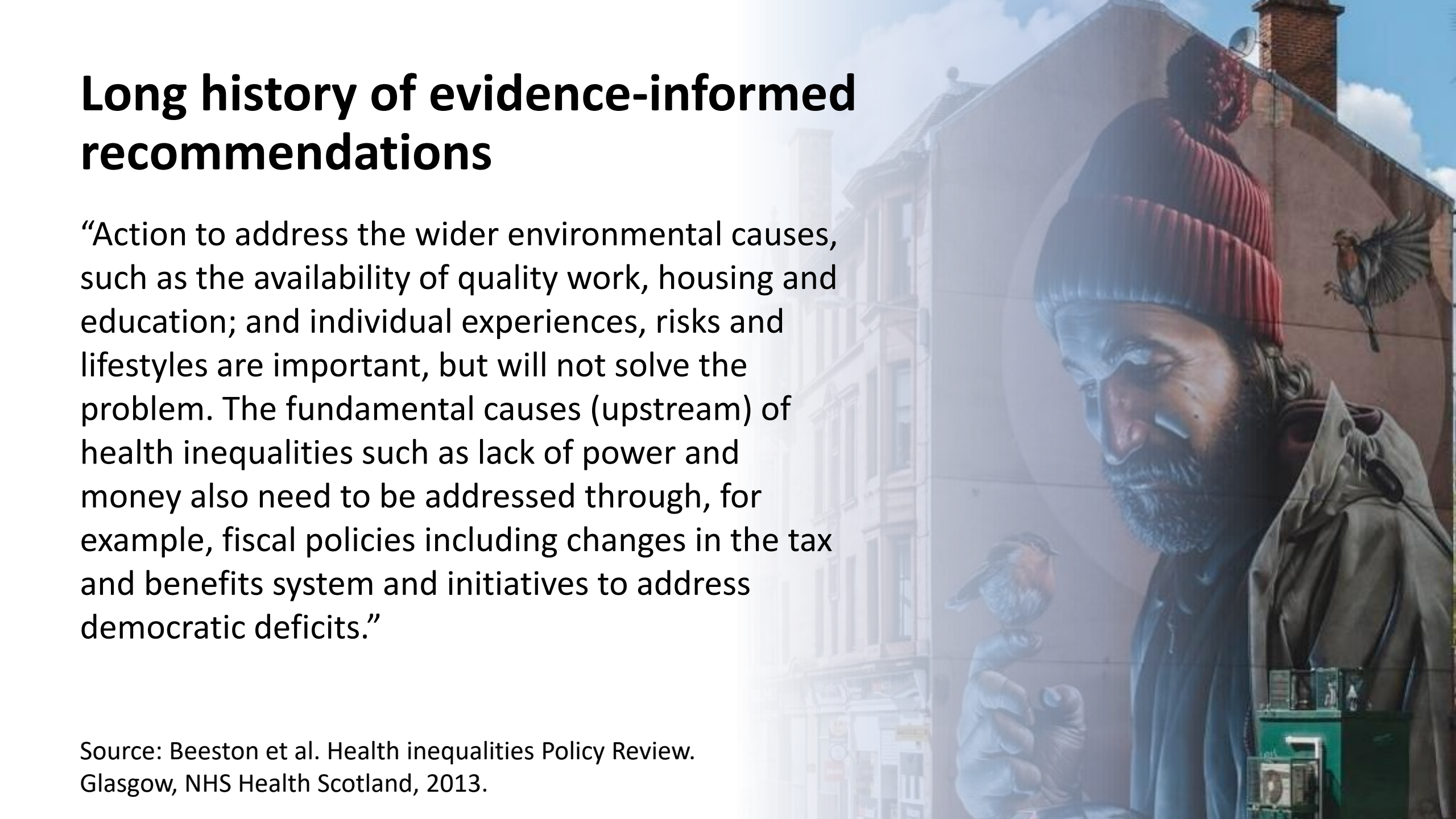
Long history of evidence-informed recommendations

- Consistent over time, with a gradual increase in the depth and triangulation of the evidence
- Fundamental causes: inequalities in income, wealth and power
- Wider environments: quality work, housing, education, etc.
- Individual experiences: including meeting the needs of inclusion health groups
- Use of regulation, legislation and taxation is most effective

Long history of evidence-informed recommendations

“Action to address the wider environmental causes, such as the availability of quality work, housing and education; and individual experiences, risks and lifestyles are important, but will not solve the problem. The fundamental causes (upstream) of health inequalities such as lack of power and money also need to be addressed through, for example, fiscal policies including changes in the tax and benefits system and initiatives to address democratic deficits.”

Source: Beeston et al. Health inequalities Policy Review. Glasgow, NHS Health Scotland, 2013.



Diversions and misdirections?

- An implementation gap?
- Keep Well
- Spending time and resource on things that are known not to work
- Improvement Science to assess effectiveness

Other topics

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ORIGINAL ARTICLE

A critical reflection on the use of improvement science approaches in public health

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Abstract

Objective: 'Improvement science' is used to describe specific quality improvement methods (including tests of change and statistical process control). The approach is spreading from clinical settings to population-wide interventions and is being extended from supporting the adoption of proven interventions to making generalisable claims about new interventions. The objective of this narrative review is to evaluate the strengths and risks of current improvement science practice, particularly in relation to how they might be used in population health. *Methods:* A purposive sampling of published studies to identify how improvement science methods are being used and for what purpose. The setting was Scotland and studies that focused on health and wellbeing outcomes. *Results:* We have identified a range of improvement science approaches which provide practitioners with accessible tools to assess small-scale changes in policy and practice. The strengths of such approaches are that they facilitate consistent implementation of interventions already known to be effective and motivate and empower staff to make local improvements. However, we also identified a number of potential risks. In particular, their use to assess the effectiveness of new interventions often seems to pay insufficient attention to random variation, measurement bias, confounding and ethical issues. ***Conclusions:*** **The use of current improvement science methods to generate evidence of effectiveness for population-wide interventions is problematic and risks unjustified claims of effectiveness, inefficient resource use and harm to those not offered alternative effective interventions. Newer methodological approaches offer alternatives and should be more widely considered.**

Keywords: *Improvement science, quality improvement, evaluation, causality*

Introduction

Public health professionals have a responsibility to use robust, high-quality evidence to inform decisions relating to health and healthcare. This ensures that intended and unintended consequences are better understood, potential risks are mitigated and the most effective, resource efficient and safe policies and practices are adopted.

'Improvement science' (IS) is a term used to describe various approaches to quality improvement. Understanding and applying IS approaches in public health is made difficult by the variety of ways in which this term is used. Traditionally it has been described as a method of studying approaches to improve outcomes by making effective changes to practice. For example, Eccles defines IS as:

> the scientific study of methods to promote the systematic uptake of research findings and other evidence-based practices into routine practice, and, hence, to improve the quality and effectiveness of health services [1].

Other definitions contrast this approach with a focus on the question of the effectiveness of a particular initiative:

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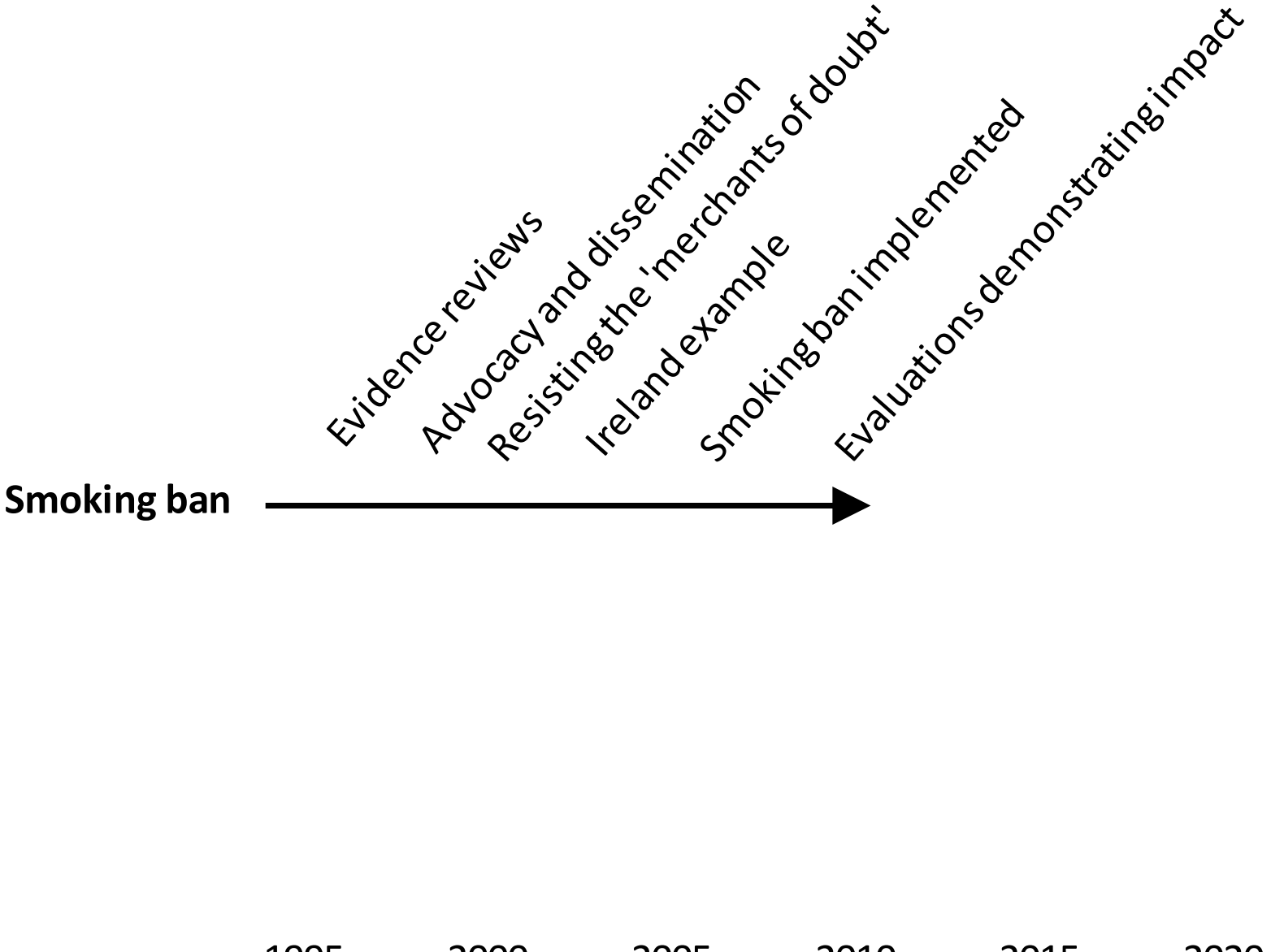
SAGE

On the need for patience and persistence and tackling power: the Commercial Determinants of Health


Evidence reviews
Advocacy and dissemination
Resisting the 'merchants of doubt'
Ireland example
Smoking ban implemented
Evaluations demonstrating impact
Smoking ban
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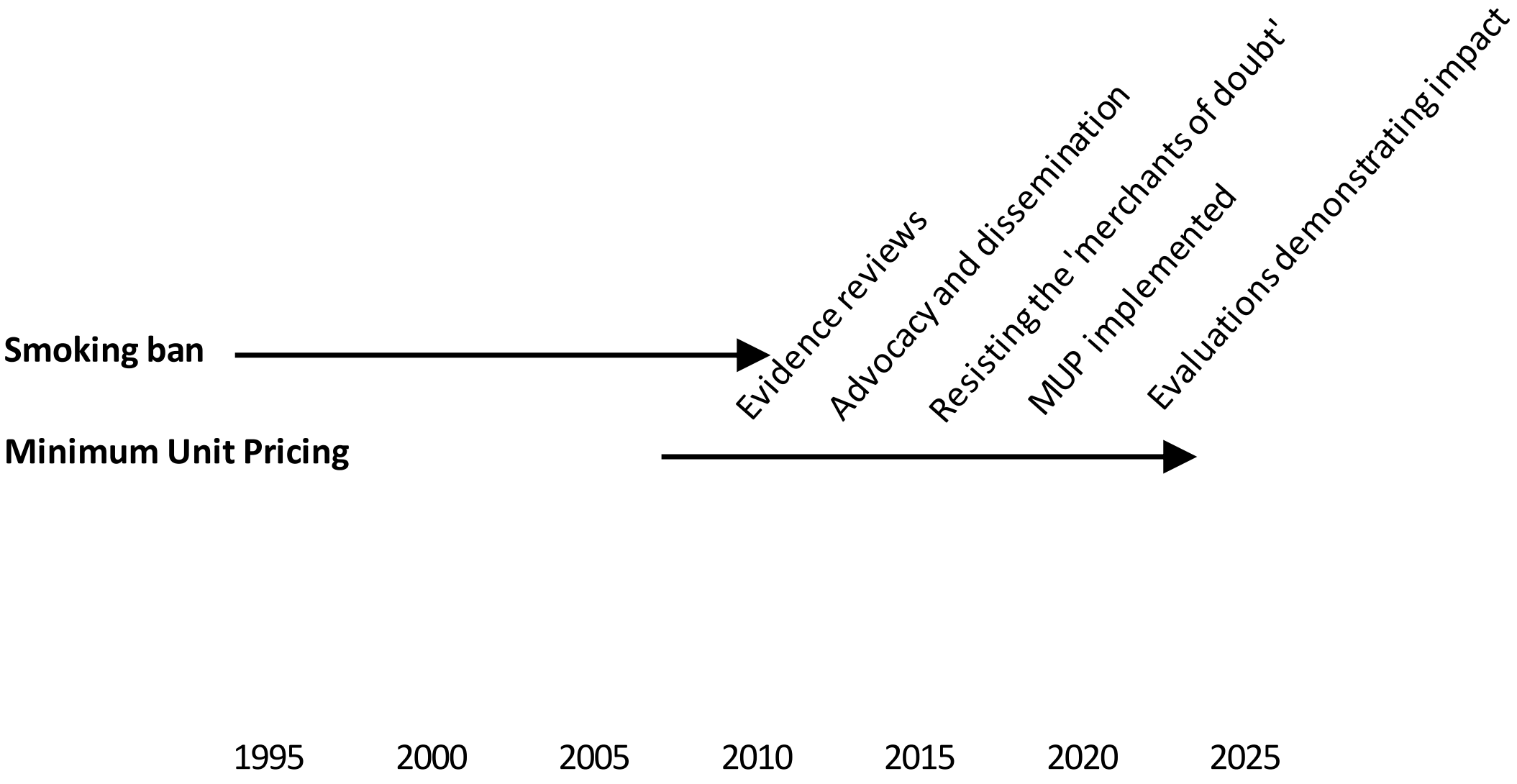
2000
2005
2010
2015
2020


Smoking ban
Minimum Unit Pricing
Evidence reviews
Advocacy and dissemination
Resisting the 'merchants of doubt'
MUP implemented
Evaluations demonstrating impact
1995
2000
2005
2010
2015
2020
2025

On the need for patience and persistence and tackling power: the Commercial Determinants of Health

- Legislation, regulation and taxation
- Evidence and scope for much more on areas of success
- Need to address obvious gaps – e.g. food, landlords
- Many new commercial determinants:
  - Gambling
  - Vaping
  - Digital media
- …but needs to address power and commercial interests
- …and public health needs to provide the evidence, advocacy and steel for politicians to act

Effects of Alcohol Retail Privatization on Excessive Alcohol Consumption and Related Harms

A Community Guide Systematic Review

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Context: Excessive alcohol consumption is the third-leading cause of preventable death in the U.S. This systematic review is one in a series exploring effectiveness of interventions to reduce alcohol-related harms.

Evidence acquisition: The focus of this review was on studies evaluating the effects of the privatization of alcohol retail sales on excessive alcohol consumption and related harms. Using *Community Guide* methods for conducting systematic reviews, a systematic search was conducted in multiple databases up to December 2010. Reference lists of acquired articles and review papers were also scanned for additional studies.

Evidence synthesis: A total of 17 studies assessed the impact of privatizing retail alcohol sales on the per capita alcohol consumption, a well-established proxy for excessive alcohol consumption; 9 of these studies also examined the effects of privatization on the per capita consumption of alcoholic beverages that were not privatized. One cohort study in Finland assessed the impact of privatizing the sales of medium-strength beer (MSB) on self-reported alcohol consumption. One study in Sweden assessed the impact of re-monopolizing the sale of MSB on alcohol-related harms. Across the 17 studies, there was a 44.4% median increase in the per capita sales of privatized beverages in locations that privatized retail alcohol sales (interquartile interval: 4.5% to 122.5%). During the same time period, sales of nonprivatized alcoholic beverages decreased by a median of 2.2% (interquartile interval: −6.6% to −0.1%). Privatizing the sale of MSB in Finland was associated with a mean increase in alcohol consumption of 1.7 liters of pure alcohol per person per year. Re-monopolization of the sale of MSB in Sweden was associated with a general reduction in alcohol-related harms.

Conclusions: According to *Community Guide* rules of evidence, there is strong evidence that privatization of retail alcohol sales leads to increases in excessive alcohol consumption.

(Am J Prev Med 2012;42(4):418 – 427) Published by Elsevier Inc. on behalf of American Journal of Preventive Medicine

Context

Excessive alcohol consumption, including both binge drinking and underage drinking, is responsible for approximately 79,000 deaths per year in the U.S., making it the third-leading cause of preventable death in the nation.[1] In 2009, approximately 23% of adult drinkers (aged ≥18 years) in the U.S. reported binge drinking (consuming five or more drinks per occasion for men and four or more drinks per occasion for women) in the past 30 days, as did 25.2% of high school students.[2,3] Among full-time college students in 2008, 48.6% of men and 34.4% of women reported binge drinking.[4] In 2006,

From the Community Guide Branch, Epidemiology and Analysis Program Office (Hahn, Middleton, Elder, Chattopadhyay, Lawrence, Campbell), National Center for Chronic Disease Prevention and Health Promotion (Brewer), CDC, Atlanta, Georgia; Los Angeles County Department of Health Services (Fielding); University of Minnesota School of Public Health (Toomey), Minneapolis, Minnesota; and the Schools of Medicine and Public Health (Naimi), Boston University, Boston, Massachusetts

Author affiliations are shown at the time the research was conducted.

Names and affiliations of the Task Force members can be found at: www.thecommunityguide.org/about/task-force-members.html.

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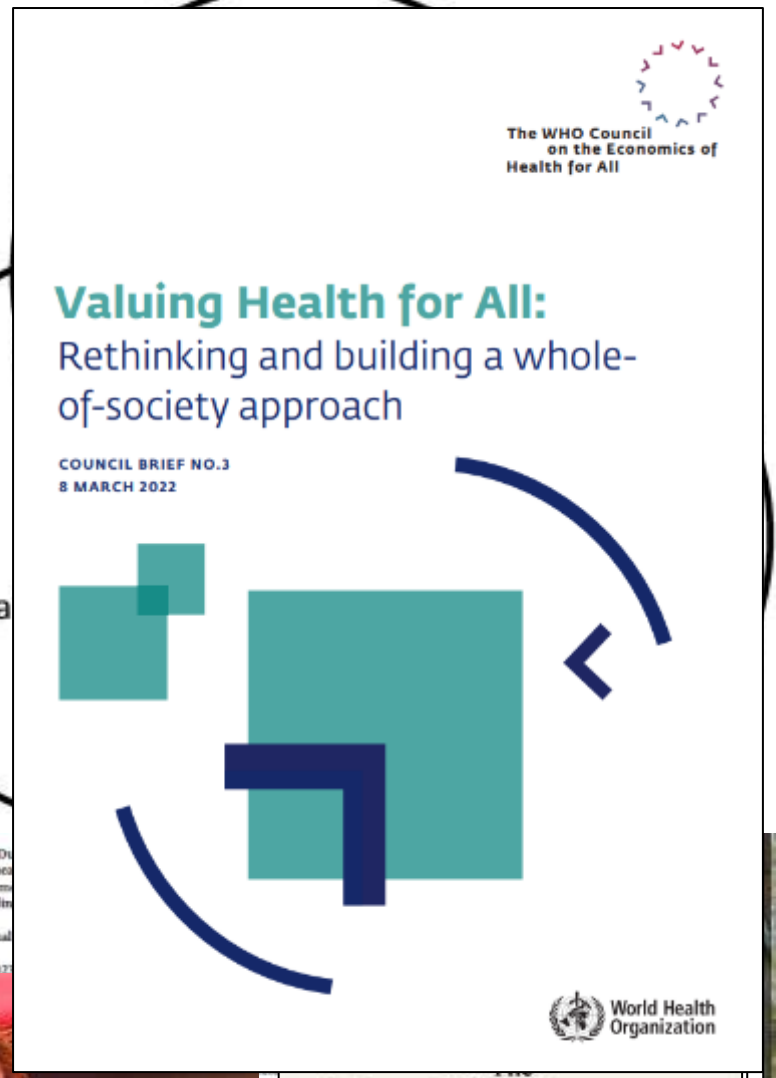
Sharpening our understanding and recommendations on the economy

What would it take to create economies that served these objectives rather than profit for a few? How can we create metrics that reflect what is ultimately of value?

- Opportunities around basic income, minimum income guarantee, child poverty
- ‘Studying up’ and addressing power inequalities
- Action to address climate and ecological crisis c
  also address health and inequalities
- Wellbeing Economy as a useful, but contested,
  for a new economic design



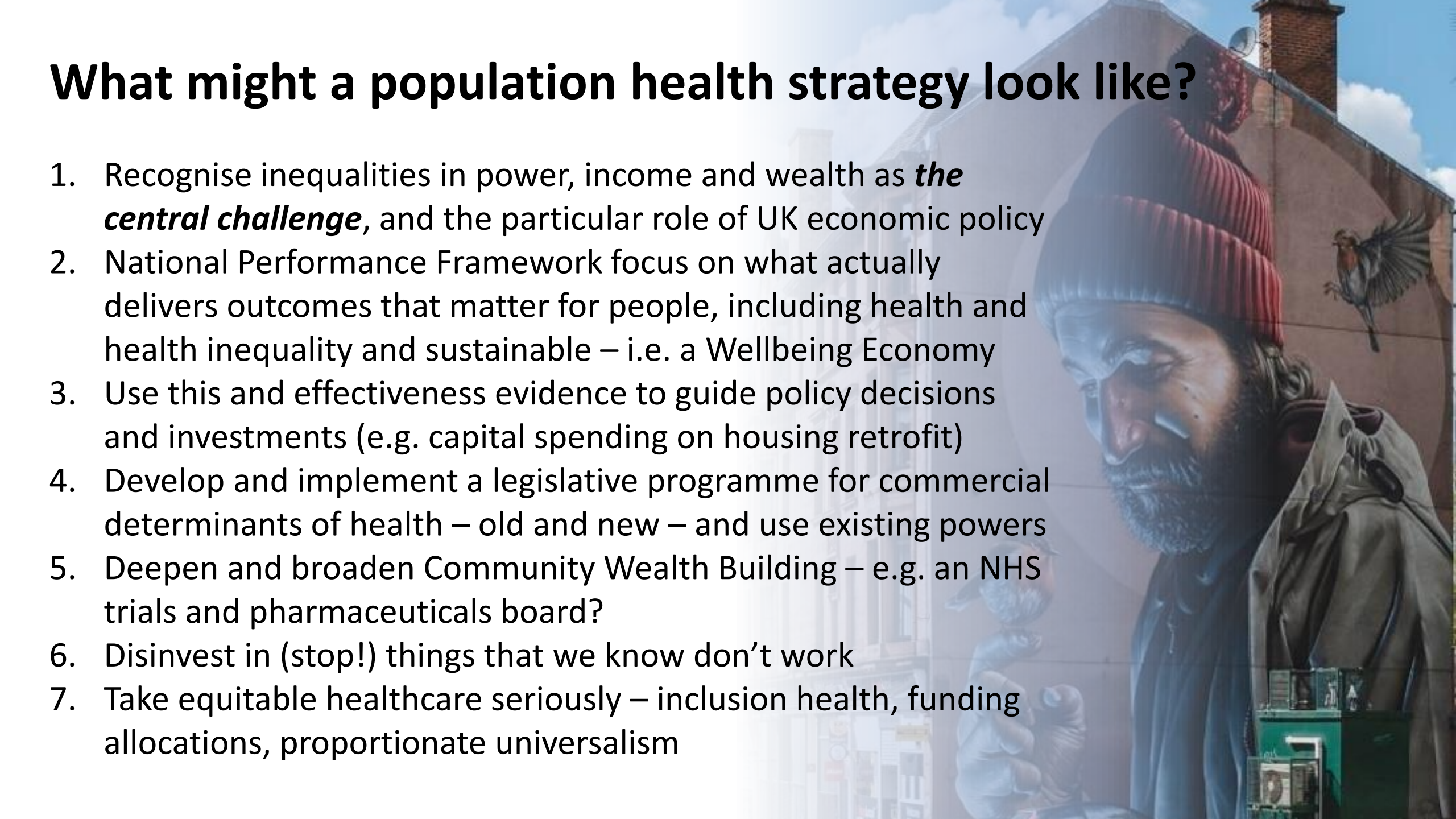
McCartney et al. ‘Superpolicies’ and ‘policy-omnishambles’, Public Health in Practice 2020; 1: 100003, https://doi.org/10.1016/j.puhip.2020.100003.

In union there is

STRENGTH

What might a population health strategy look like?

1. Recognise inequalities in power, income and wealth as ***the central challenge***, and the particular role of UK economic policy
2. National Performance Framework focus on what actually delivers outcomes that matter for people, including health and health inequality and sustainable – i.e. a Wellbeing Economy
3. Use this and effectiveness evidence to guide policy decisions and investments (e.g. capital spending on housing retrofit)
4. Develop and implement a legislative programme for commercial determinants of health – old and new – and use existing powers
5. Deepen and broaden Community Wealth Building – e.g. an NHS trials and pharmaceuticals board?
6. Disinvest in (stop!) things that we know don't work
7. Take equitable healthcare seriously – inclusion health, funding allocations, proportionate universalism



- Thanks to the GCPH for the invitation and co-authors of underlying publications
- Credit to https://www.reddit.com/user/Tess_Tickles89/ for the image of the St Mungo mural
- Thank you for not heckling*

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*written before today's talk, so may or may not apply…

Health inequalities: what's changed and what now?

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November 2023

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