

# Influencing policy – public health advocacy and health inequalities

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## INTRODUCTION

### *The need for research-informed advocacy*

Over the past 40 years the UK has been recognised as a global leader in health inequalities research and policy, with a prominent international expert describing government-led policy efforts to reduce health inequalities here as ‘historically and internationally unique’.<sup>1</sup> Between 1997–2010, the Labour government introduced a raft of policies to reduce health inequalities.<sup>2</sup> In theory, these policies were informed by the wealth of available research,<sup>3</sup> having been constructed against a backdrop of strong political commitments to evidence-based policy;<sup>4</sup> commitments which were widely supported by public health researchers.<sup>5</sup> Yet, by most measures, the UK’s health inequalities have continued to widen.<sup>1,6</sup> This failure has prompted calls by some for more ‘advocacy’ to reduce health inequalities.<sup>3,7,8</sup> Yet, as a *Lancet* editorial notes, there currently appears to be little agreement as to precisely what public health egalitarians ought to be advocating.<sup>9</sup> This paper considers, in practical terms, what engaging with ‘advocacy’ might mean for health inequality researchers.<sup>9</sup>

### *Understanding policymaking and the role of research within policy*

There is a lot of support among researchers and policymakers in the UK for the idea that policies to reduce health inequalities should be based on, or at least informed by, available research evidence.<sup>4,10</sup> Yet it also seems clear from studies of the relationship between health inequalities research and policy<sup>4,11,12</sup> that researchers feel they struggle to influence policy, while policymakers feel the available evidence does not meet their requirements. If we conceptualise policymaking in instrumental, rational terms (as is often the case within public health analyses of policy), there are three common

explanations for the disconnection between public health evidence and policy responses to public health problems. First, ‘politics’ is framed as a barrier to achieving rational decisions – ‘the four-hundred pound brute’ that quashes the ‘six-stone weakling’, evidence, in Pawson’s terms.<sup>13</sup> Second, multiple critiques have been made of the public health evidence base. For health inequalities, for example, the available evidence has been criticised for being overly concerned with behaviours and clinical factors rather than broader social determinants of health; being explanatory rather than evaluative; providing weak accounts of ‘causal pathways’ connecting policies/interventions to outcomes; failing to consider economic factors; and failing to be sufficiently policy-focused/solution-orientated.<sup>4,11,12,14</sup> Third, the communication of research findings to policy (and other non-academic) audiences has often been criticised.<sup>11,12</sup> This way of thinking about policymaking, and these critiques, suggest that researchers seeking to influence policy should focus on ensuring that their research activities are policy relevant and that the outputs they produce are timely, accessible and well-communicated.<sup>15–17</sup> Yet, there are also some good reasons to consider that this advice might be insufficient for achieving effective policy responses to health inequalities. Not least because, as former UK policy advisor Geoff Mulgan argues, in democratically elected countries, ‘the people, and the politicians who represent them, have every right to ignore evidence’.<sup>18</sup>

Indeed, scholars in political science and policy studies tend to take a very different approach to thinking about policymaking, often focusing almost exclusively on the normative and interest-orientated aspects of the policy process.<sup>19–24</sup> From this perspective, evidence (to the extent that it is considered at all) tends to be thought of as just one factor among many that may be influential

when employed by policy actors to further their political, personal or institutional interests. This paper therefore considers what researchers might do to improve the influence of health inequalities research within policymaking if we accept the democratic and political aspects of decision-making processes in the UK.

### **What kinds of policies to reduce health inequalities in the UK do researchers support?**

It is often claimed that the health inequalities research community is fractured,<sup>4,11,25,26</sup> with no clear consensus as to what effective policies to tackle health inequalities involve.<sup>4,9</sup> In this context, a recent study employed a two-stage online survey to examine the level of consensus among researchers around potential policies for tackling health inequalities in the UK.<sup>27</sup> The findings of this survey suggest there are, in fact, clear areas of agreement among researchers as to the kinds of policies they believe most likely to reduce health inequalities.<sup>27</sup> Box I summarises the ten most popular policies for reducing population-level health inequalities in the UK (preferences are listed in order of support, with 1 being the most popular).

As Box I demonstrates, favoured policies focus on: means of achieving a more progressive distribution of income/wealth; and improving material environments and public services, particularly for deprived communities. There is also some support for the idea that the impact of lifestyle-behavioural risks need to be limited by restricting the influence of private sector actors with financial interests in health-damaging products (alcohol, tobacco, etc). Interestingly, however, the two-stage survey also demonstrates that researchers tend to provide rather different responses when they are asked which policy proposals to reduce health inequalities they believe are likely to be effective based purely on their expert opinion and which proposals they believe to be strongly supported by available research evidence.<sup>27</sup> When asked to focus on expert opinion, researchers tended to support the kinds of 'upstream' policy proposals listed in Box I but when asked to focus on policy proposals that they believed to be strongly supported by available evidence, the survey found that researchers were more likely to support policy proposals intended to reduce lifestyle-behavioural risks (albeit in relatively upstream ways). The feedback from survey participants in 'free-text' sections indicated that this disconnection reflected a willingness among researchers to draw on a wide range of knowledge when asked to respond based on their personal expertise but a tendency to restrict themselves to particular kinds of academic work (e.g. the findings from intervention-orientated, evaluative research and systematic reviews) when asked to make a judgement that is specifically about the strength of the available evidence.

### **BOX I. THE 10 MOST POPULAR POLICY PROPOSALS AMONG 92 SURVEYED RESEARCHERS, WHEN ASKED WHICH POLICIES THEY FELT WOULD BE LIKELY TO HAVE THE GREATEST IMPACT ON REDUCING HEALTH INEQUALITIES IN THE UK<sup>12</sup>**

1. Review and implement more progressive systems of taxation, benefits, pensions and tax credits that provide greater support for people at the lower end of the social gradient and do more to reduce inequalities in wealth
2. Develop and implement a minimum income for healthy living
3. Increase the proportion of overall government expenditure allocated to the early years and ensure this expenditure is focused progressively across the social gradient
4. Increase social protection for those on the lowest incomes and provide more flexible income and welfare support for those moving in and out of work ('flexicurity')
5. Support an enhanced home building program and invest in decent social housing to bring down housing costs
6. Invest more resources in state-funded education, with additional investments for schools serving more deprived communities
7. Introduce policies which intensively focus on improving literacy among primary school children in deprived areas through one-to-one teaching for those with low reading scores
8. Invest more resources in active labour market programmes to reduce long-term unemployment
9. Invest more resources in support for vulnerable populations, by providing better homeless services, mental health services, etc
10. Implement measures to protect the policy process and decision-making from interference by relevant commercial sector interests (e.g. alcohol, tobacco and ultra-processed food manufacturers and retailers).

These survey findings have important implications for how those committed to reducing health inequalities think about policymaking and the potential role of evidence within policy. First, they suggest that a strong focus on achieving evidence-based policies may inadvertently contribute to what has been widely described as 'lifestyle drift' within health inequalities, whereby there is a persistent shift in focus from 'upstream' social determinants (the types of factors highlighted in Box I) to a much narrower focus on individual risk factors (trying to get people to change their behaviours with regards to smoking, diet, etc).<sup>28</sup> Second, the results suggest that there does appear to be a fairly clear consensus among health inequality researchers in the UK that upstream, socio-economic policies are likely to have the greatest impact on reducing health inequalities. Notably, the proposal to

'review and implement more progressive systems of taxation, benefits, pensions and tax credits' was the most frequently endorsed proposal when researchers were asked to answer based on their personal, expert opinion and on the strength of available evidence. Such policies stretch well beyond the remit of departments of health and have implications for a variety of other public and political debates. Indeed, questions about the fair distribution of resources are inherently value-based and are unlikely to be answerable through research alone. Both of these findings highlight the limitations of trying to resolve health inequalities via evidence driven debates alone, further reinforcing the necessity of taking the public and political aspects of policymaking seriously.

### **The need for 'advocacy' to reduce health inequalities?**

In the context of the failure of policy efforts in the UK to employ evidence-informed policies to reduce health inequalities, some researchers have called for more 'advocacy' to achieve greater public and political support for the kinds of policies that researchers think are likely to reduce health inequalities.<sup>3,4,8</sup> These calls reflect an awareness of the political and democratic nature of policymaking outlined above. However, 'advocacy' is rarely discussed or taught within public health<sup>29</sup> and it seems unclear that it is something with which researchers ought to be proactively engaged.

Perspectives on this question are likely to be informed by both interpretations of 'advocacy' and beliefs about the 'appropriate' roles of researchers. There are, however, few clear definitions of health advocacy. The World Health Organization defines it as 'a combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support for a particular health goal or programme'.<sup>30</sup> In itself, this definition does not appear particularly controversial. Indeed, this way of thinking about 'advocacy' overlaps with other (perhaps more widely accepted) concepts, such as 'knowledge brokerage', 'knowledge exchange', 'research impact' and 'social marketing'. Other definitions, however, point to activities which may be considered beyond the remit of public health researchers. For example, what Carlisle<sup>31</sup> terms 'facilitational' advocacy involves working collaboratively with organisations representing public and local community interests and supporting community-led action.<sup>32</sup> Carlisle's notion of 'representational' advocacy involves strategically 'selling' public health objectives to a range of non-academic audiences.<sup>29</sup> In these cases, 'advocacy' clearly involves more than simply undertaking public health research and tensions may arise for researchers if community preferences appear out of harmony with research or if, in 'selling' public health objectives, researchers feel compelled to make statements that go beyond the available research.

### **Who is responsible for advocacy to reduce health inequalities?**

For some in public health, the tensions outlined above suggest 'advocacy' is (or ought to be) beyond the remit of researchers. This raises the question of who else might be involved in advocacy to reduce health inequalities. This question is important in light of reports that the effectiveness of public health advocacy often depends on the involvement of broad coalitions of actors from multiple professions and sectors. Currently, there does not appear to be any clear 'advocacy coalition'<sup>23</sup> to reduce health inequalities in the UK. Indeed, Smith notes that almost none of her 141 interviewees (researchers, civil servants, politicians and policy advisors) were able to identify any organisations that they perceived to be actively working to address (let alone prioritise) health inequalities.<sup>4</sup> As one politician in this study reflected, 'there's no big lobby for tackling inequality'.<sup>4</sup> Nonetheless, there are a range of organisations and individuals beyond academia and central government who have at least some interest in health inequalities. These include:

- Local organisations, activists and/or practitioners working in communities that are particularly affected by health inequalities
- Commercial interests (e.g. pharmaceutical companies, such as Pfizer, which co-sponsored a round-table discussion on reducing health inequalities with the *New Statesman* in November 2005)
- Journalists with an interest in public health and/or social inequalities
- Knowledge-brokerage organisations with a public health/inequalities focus (e.g. the UCL Institute for Health Equity and The Equality Trust)
- Non-governmental organisations representing communities affected by health inequalities or health issues for which inequalities are known to exist
- Organisations representing health professionals (e.g. the British Medical Association, the Faculty of Public Health and the Royal Colleges)
- Researchers working beyond academia (e.g. in think tanks, the NHS, the civil service and the wider public sector)

The absence of strong coalitions around health inequalities at least partly reflects the diverse interests within and across different professional communities. For example, while some tobacco control campaigning organisations highlight the links between health inequalities and smoking, they tend to do so in ways which promote tobacco control interventions as a means of reducing health inequalities<sup>33</sup> rather than promoting reductions in 'upstream' inequalities as a means of sustainably reducing smoking-related inequalities. Indeed, very few of the actors listed above are primarily concerned with reducing health inequalities

via the kinds of long-term, upstream mechanisms that most researchers regard as important.<sup>27</sup> In this context, building a functioning advocacy-coalition<sup>23</sup> is likely to be extremely difficult.

So where does this leave researchers committed to reducing health inequalities? Simply continuing to promote the instrumental use of research evidence in policy seems futile given the evident failure of this approach so far.<sup>18</sup> Improvements in the provision and communication of policy-relevant research may help somewhat but, given the innately political nature of policymaking,<sup>34</sup> the idea that such information needs to be accompanied by effective advocacy to achieve the necessary public and political support seems persuasive.

### *Health inequalities researchers as advocates?*

In the absence of other organisations prioritising health inequalities, some researchers in this field are arguing that it is the duty of the research community to become more involved in advocacy to reduce health inequalities.<sup>14</sup> Other researchers, however, have raised concerns that involvement in advocacy may lead to the partial (or biased) use of research.<sup>14</sup> The dearth of studies examining public health advocacy, and researchers' involvement with it, means it is difficult to empirically assess the extent to which such concerns are justified. Existing literature does, however, highlight some of the perceived risks of researchers engaging in public health advocacy and consider potential means of managing these risks.

#### *What are the risks of researcher engagement in public health advocacy?*

The available literature points to at least five risks perceived by researchers in relation to public health advocacy. First, like all outward-facing, non-traditional academic activities, advocacy can be extremely time-consuming.<sup>35</sup> Where rewards revolve around more traditional kinds of academic work, this may impact on an individual's career or their ability to achieve a healthy work-life balance.<sup>4</sup> Second, viable advocacy campaigns often focus on 'winnable issues'. This may mean putting more effort into issues which appear 'feasible', and less on those that seem too challenging for the current policy context.<sup>36</sup> From a health inequalities perspective, it is easy to see how this could reinforce a research and policy focus on downstream, behavioural interventions and not the kind of 'upstream', larger-scale policy changes researchers in the UK tend to support.<sup>27</sup> Third, once a researcher has spent time developing and expressing a clear policy position, it may be difficult to consider (or acknowledge) other points of view, even as the research evidence evolves.<sup>37</sup> Likewise, it has been suggested that advocates 'tend to cite only the data supporting their position, while ignoring or actively disparaging contradictory evidence'.<sup>38</sup> It is perhaps for

this reason, above others, that academics who adopt public media profiles on particular issues risk criticism from academic colleagues.<sup>4</sup> As academics' influence within policy circles is often closely linked to their perceived academic credibility,<sup>4,39</sup> this third risk can lead to a fourth, which is that, through the very act of trying to influence policy, academics become perceived as somehow less credible.<sup>4</sup> This, in turn, may limit their ability to influence policy and public debates. Finally, adopting a clear policy position on a research issue can implicitly or explicitly suggest that the available evidence is sufficient. This may require a researcher to downplay the uncertainty in their findings and may limit researchers' ability to make a case for the need for further research on a particular issue.<sup>39</sup>

In addition to the risks facing researchers themselves, there are also perceived risks to the causes for which researchers might be advocating. First, as Rychetnik and Wise point out, researchers may not have the right skill-sets for advocacy-orientated work and, where they do not, their efforts may be damaging rather than helpful.<sup>39</sup> Second, attracting public attention to research findings might not always be the most effective way to influence policymakers.<sup>40,41</sup> Rock and colleagues, for example, explain how a media campaign concerning food instability among poorer Canadian families resulted in an unexpectedly negative public response.<sup>41</sup> This kind of situation may mean policymakers feel constrained (rather than enabled) to take research-informed action. Third, as noted above, the process of advocacy is likely to require researchers to adopt and promote a clear set of policy proposals. Trying to decide what these should be may reveal (or deepen) divisions across the various actors with an interest in the issue.<sup>36,37</sup> Finally, if researchers lose, or damage, their own credibility by engaging in advocacy work, then any campaigns associated with those researchers may also be damaged.<sup>40</sup>

#### *Is it possible to manage the risks involved in advocacy?*

While public health researchers clearly perceive risks in becoming involved in advocacy, it seems possible that at least some of these risks are manageable. For example, researchers could ensure that there is a strong empirical basis for any advocacy work they undertake. Alternatively, further research may be a necessary first step in a longer-term advocacy process (i.e. research might, in some contexts, be considered a strand of advocacy). Advocacy may be less risky for researchers who have already developed strong academic careers than for earlier career researchers and researchers can ensure that they are not 'lone voices' by working to build coalitions with other researchers and actors who share a (research-informed) belief in a particular public health objective/goal. Finally, health inequality researchers could support calls for more advocacy-focused training within public health.<sup>29</sup>

## CONCLUSION

### Improving the influence of health inequalities research

If we acknowledge the political and democratic nature of policymaking, then it seems likely that advocacy is needed to achieve the public and political support required for the kinds of policy responses that many health inequalities researchers support. In this context, there may be opportunities to learn from more successful examples of public health advocacy, including

aspects of tobacco control.<sup>29</sup> However, the complex, fractured and often deeply political nature of health inequalities debates means that there are also likely to be some specific challenges associated with advocacy to reduce health inequalities. For one thing, there is a noticeable lack of third sector organisations prioritising reductions in health inequalities compared to the plethora of such organisations promoting tobacco control policies and interventions.<sup>4</sup> This is likely to make it more difficult for health inequalities researchers to engage in advocacy; yet it perhaps also makes it more important that they do..

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