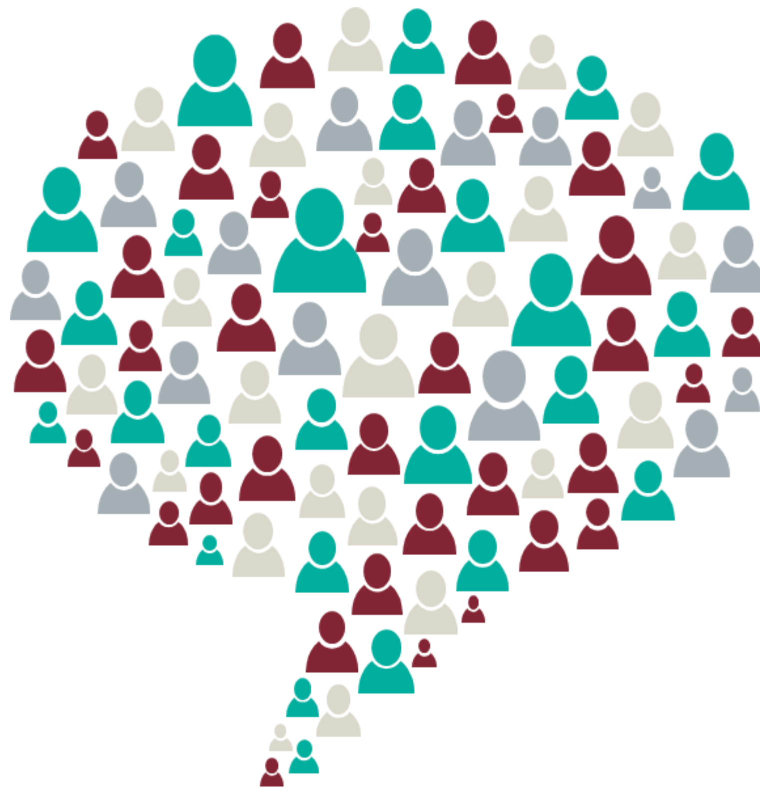
Public Health
England

# Health inequalities: starting the conversation

A toolkit to support local conversations aimed at understanding and reducing health inequalities



# About Public Health England

Public Health England's mission is to protect and improve the nation's health and to address inequalities through working with national and local government, the NHS, industry and the voluntary and community sector. PHE is an operationally autonomous executive agency of the Department of Health.

Public Health England
Wellington House
133-155 Waterloo Road
London SE1 8UG
Tel: 020 7654 8000
www.gov.uk/phe
Twitter: @PHE_uk
Facebook: www.facebook.com/PublicHealthEngland

Prepared by:  TNS BMRB and PHE

© Crown copyright 2014
You may re-use this information (excluding logos) free of charge in any format or medium, under the terms of the Open Government Licence v2.0. To view this licence, visit OGL or email psi@nationalarchives.gsi.gov.uk. Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

Published June 2014
PHE publications gateway number: 2014139

This document is available in other formats on request. Please call 020 7654 8000

# Contents

About Public Health England 2
A little context to the conversation 4
Public dialogue around health inequalities: the key principles 9

# A little context to the conversation

Inequalities in health are widespread across the country and can be entrenched for some parts of our society. Public Health England's (PHE) role is to protect and improve the public's health. In addition, action by PHE on inequalities in health is mandated through the new Duty established in the Health and Social Care Act 2012 to "have regard to the need to reduce inequalities between the people of England".

With the move of responsibility for public health from the NHS into local authorities there is a new opportunity for the public health system to work more effectively with local colleagues and leaders to act on those health inequalities, which may be caused by the wider determinants of health – such as housing, employment, education – rather than lifestyle alone.

As a new national body, PHE seeks to understand what people consider to be the greatest influences on their health and is keen to support local partners who have wide experience of the highly complex work involved in community engagement (NICE LGB16).

To do this, The National Conversation on Health Inequalities is a programme by PHE to engage with the public in a dialogue about health inequalities and about solutions. Questions include: "Do people recognise and understand health inequalities in the same way that professionals do?" and if not, "How do they describe the things that affect their ability to live a healthy life?". Through this work, PHE aims to develop a common language and understanding around health inequalities and, with local partners, encourage and empower local communities to act on health inequalities.

This work will inform the way PHE and others describe health inequalities and it will feed into PHE's programme of action on health inequalities. Knowledge gained from the National Conversation will inform PHE's evidence reviews and advice and will be fed into its Health and Wellbeing Framework.

## Why engage the public around health inequalities?

PHE sees this public engagement on health inequalities as crucial both to understanding the public's perception of what it is that affects their health and in encouraging local action to reduce those causes. Learning and sharing through the conversation is a vital part of creating mainstream understanding of health inequalities and what works to reduce them. As Bolam (2004) reports, if a community is going to successfully participate in action to tackle health inequalities, then we need to understand the subjective perceptions of the lay community about these issues.

The concept of health inequalities and their causes can be difficult to convey. It is easy to focus just on behavioural risk change with communities as simple messages, but there remain more complex reasons for poor health due to interconnected social, economic and structural reasons as set out in the Marmot review (2010). Professional leaders may be familiar with these more complex causes but, for us to be successful in reducing health inequalities, it is necessary to find better hooks upon which communities can engage and discuss the issues that they see as impacting on their ability to lead a healthy life.

PHE commissioned TNS BMRB to undertake research with local communities to understand how the general public identify and describe health inequalities and to identify potential opportunities for innovation in communication and action. This research, which involved interviews with stakeholders (including Directors of Public Health and local authority councillors) and workshops with members of the public , helped identify the challenges of engaging the public in this dialogue as well as some key principles to consider.

## Challenges to engaging members of the public on health inequalities

*"For health inequality do you class someone who's say got a mental health problem or someone who's got a physical disability so they can't even help their situation, so I mean is that classed as inequality?"*

*"[Is it] the choice that the, the national health have to make between treating a person with certain illness against another person with certain illness? If you are in that group that is not going to get treated, because that group is going to get treated you are going to feel that you are not equal. That is [health] inequality."*

*"I think that sort of it's blindingly obvious in some ways, you know. If you're from a disadvantaged background then you're going to have more problems than people who aren't from a disadvantaged background."*

The quotes above were from participants involved in workshops undertaken by TNS BMRB exploring the public understanding of health inequalities. Through these workshops, involving people from a wide variety of socio-demographic backgrounds, it was apparent that conversations around health inequality involve overcoming a number of key challenges.

1. **Members of the public struggle to engage with the concept of 'health inequality':** There is recognition, and even acceptance, that some members of society are more disadvantaged than others. This is seen as a fact of life, and one which is linked to quality of life and of opportunity rather than health outcomes. The evidence of health inequalities is stark to policy makers and others with a 'birds eye' view, but it isn't obvious to members of the public. People rarely contrast their situation with that of others from different parts of their community, and where they do this does not involve making comparisons around health. Furthermore, inequality is associated with things being done to you (for example inequality in terms of employment opportunities, inequality of access to services, inequality in relation to gender or racial discrimination): things that are outside of your control. The choices people make in terms of their lifestyle are seen to be within their control and therefore not related to inequality.

   People do not see the impact of health inequality in a tangible way. While people do make the connection between wider socio-economic influences and health impacts, particularly in relation to wellbeing and lifestyle behaviours, maintaining this link when thinking about addressing health issues is difficult. If you ask people to think about health they think about health services: their funding, effectiveness and equity of access.

   The challenge for public health stakeholders is to approach public dialogue leaving the health inequalities language and evidence base at the door, being willing to support discussion around wider issues that impact on people's quality of life and wellbeing, and helping people to make connections between the health issues in their community, and the causes and solutions to these.

2. **Clarity of purpose:** In undertaking dialogue around a wide range of social issues (ultimately to unpick key local influencers of health outcomes) there is a danger that the purpose of the dialogue becomes unclear. This in turn can lead to perceptions that the process is a talking shop - or worse, a tokenistic exercise - through which no decisions or actions will arise, reinforcing a sense of fatalism and disempowerment.

   There needs to be balance in the discussion. It is important for there to be clarity on the purpose of the dialogue – to improve health and wellbeing outcomes – but to ensure that the dialogue encompasses the wide range of issues which contribute to these outcomes.

3. **Overriding issues may set the local agenda:** In every area there will be one or two key issues which dominate the discussion in relation to the impact they have on people's quality of life. While these may be locality specific, they may also be influenced by the

demographics of the people involved in the process, each of whom bring their own experiences to the dialogue.

Again, strive for balance in the dialogue. Allowing people the space to highlight and focus on those issues which are prominent in their area, but enabling people to also consider other factors which may have an influence on health and wellbeing.

4. **The issues are emotive and highly personal:** Dialogue around health inequalities necessarily touches on a wide range of issues including income, education, housing, employment, ethnicity and the list goes on. Different issues will resonate with different people and public dialogue may involve people with very different needs, aspirations, experiences and agendas. The issues being discussed may be very personal, with people holding fixed opinions cemented through lasting experiences of issues which have not changed, or have become worse over time. In these circumstances people may feel that the impact of these issues on health and wellbeing are obvious and are therefore not reflected on in any detail.

   It is important here to help people to identify how changes made to wider socio-economic influences could directly or indirectly impact on their health and wellbeing, and that of others.

5. **The perceived ability to affect change:** One of the key issues which effects people's ability and willingness to engage in both public dialogue and in making changes to their lives and their communities is a lack of empowerment. There can be a sense of fatalism about addressing the root causes of health inequality resulting from a more general feeling of disempowerment and dependency. Communities are believed to be increasingly fragmented leading to a lack of any collective identity and limited awareness of local assets (and how these could then be leveraged to address factors contributing to health inequality). This can be reinforced by a sense that decisions are taken at both a local and national level - with very real impacts on people's lives and sense of wellbeing - over which they have very little control. People may be used to having things done for them or to them, not with them.

   These are major barriers to engaging people in public dialogue around not just health inequalities but all social issues. Because health inequalities are essentially the resulting outcome of the interaction - and cumulative effect - of other social inequalities this can make discussions around effecting change feel futile.

6. **Supporting, not leading:** Providing opportunities to learn, discuss and debate are integral to effective public dialogue. This is especially the case when the dialogue is around social issues, including health and wellbeing, where experiences and understanding of the issues may vary considerably. Those organising, facilitating and supporting the dialogue process are in the position of power.

   It is important therefore to redress the power imbalance, ensuring that materials, activities and expert stakeholders used to support discussion do not exclude people or bias discussion.

# Public dialogue around health inequalities: the key principles

## What is public dialogue?

Public dialogue is an opportunity for members of the public and, potentially, policy makers and expert stakeholders, to meet and learn from each other and share views on particular issues. It can increase understanding of the needs and aspirations of individuals and communities, inform decision making (and increase acceptability of those decisions), and demonstrate accountability.

Everyone is a stakeholder in their local community; some have an expert or professional view, others report their lived experience. However, in order to distinguish between the two groups, in this toolkit, we refer to the latter as members of the public or participants and to the former as stakeholders.

## When to engage in public dialogue

Public dialogue is an opportunity for decision makers to listen to and take account of the views of members of the public in order to develop a more informed understanding of an issue. According to Popay et al (1998), the lay perspective is a vitally important but neglected perspective on the relationship between social context and the experience of health and illness at both individual and population level. It can be invaluable to work with partners across local authorities, public health and the voluntary and community sector to draw on the wide experience of public engagement that already exists. Dialogue with the public can be used at any point in the policy cycle: agenda setting, policy design, policy implementation and policy evaluation. Dialogue is particularly important around health inequalities because of the complexity of the issues involved and the differences that exist in understanding, experience, values and behaviours between people.

## Seven principles of public dialogue around health inequalities

In the context of the challenges identified in undertaking public dialogue with the aim of addressing health inequalities, there are a number of key principles and associated practical considerations which can help support effective public dialogue. These include:

1. Ensuring transparency of purpose, objectives and intended outcomes
2. Using language and narrative which resonates with people
3. Supporting safe, active, equal and informed discussion among all participants
4. Involving stakeholders
5. Incorporating an asset based approach in the dialogue
6. Continuing the conversation
7. Reviewing and improving the process

## 1. Ensuring transparency of purpose, objectives and intended outcomes

If a public dialogue is to be effective there needs to be a commonly agreed and understood purpose. The integrity and openness of both those running the dialogue and those participating is key to its success. This involves:

- ensuring that public dialogue takes place at the right point in the decision making process; that is before decisions have been taken
- ensuring that people are clear the dialogue is aiming to understand what could improve the quality of life of people in their local area or community, ultimately to impact on their health and wellbeing. This should be clear in the invitation to participate and in any introduction to the process
- setting out what will be done with the information, and what decisions this will influence.
- allowing for an open discussion of the key issues influencing health and wellbeing at the beginning of the dialogue to gain consensus on the objectives of the dialogue process

## 2. Using language and narrative which resonates with people

There is no single right way to frame the public dialogue. However, it is important to use language and information which the public are able to relate to. Therefore it is better to avoid describing it as a dialogue about addressing health inequalities, but rather one about people's current lived experience. As Gamsu (2013) says, it is important to recognise that the starting point is not health and wellbeing or health inequalities but more fundamental questions usually focused on equity, fairness or sustainability. Care should also be taken to avoid discussion being dominated by top-of-mind local issues. In practical terms this involves:

- not bringing inequality into the dialogue process, instead starting with the current lived experience of people, focusing on quality of life in order to encourage open discussion around the range of macro and micro influences on health and wellbeing. For example this might involve asking people to reflect on what factors promote or detract from their quality of life and why
- encouraging members of the public to consider issues from both a personal and wider community perspective in order to identify differences in quality of life and the reasons underlying this. This could be achieved through involving people from across the community or through providing information around the key issues affecting communities
- ensuring that the dialogue allows time for discussion of the most conspicuous local issues as well as wider factors which may underlie or contribute towards them. This requires a degree of facilitation and pre-planning to encourage people to make links between different issues

### 3. Supporting active, equal and informed discussion among all participants

The primary focus of public dialogue is the discussion between members of the public. In facilitating (that is, supporting) public dialogue, it is necessary to foster an environment in which everyone has the opportunity to engage. In practice this means:

- using plain English not just when discussing health issues but more widely in how questions are phrased to ensure clarity among all participants
- giving members of the public the time and space to get to know one another during the process. This builds trust, understanding and inclusivity which leads to a shared language and more valuable discussions. This can be as easy as ensuring there is opportunity for general introductions to begin with and refreshment breaks during the dialogue
- considering the composition of the group both in terms of stakeholders and members of the public. This might include actively looking for representation from particular socio-demographic or under-represented groups where a wide cross section is desired (for example for one-off or larger-scale dialogue events)
- forewarned is forearmed. Getting people to consider an issue (even to do a small piece of homework) before the dialogue means they may feel more comfortable about getting involved in the discussion as everyone can have a view. For example, this might involve getting people to identify what factors promote or detract from their quality of life and why
- providing opportunities during the discussion for people to learn from others and consider what is available locally so that they are able to build on and use this information. This could be achieved through encouraging discussion between stakeholders and participants, and through the provision of information which is easily understandable to a lay audience

- giving people a range of opportunities to express their views including through discussions and activities, individually and collectively. Those organising and facilitating dialogue sessions should consider how discussion could best be supported (for example through smaller-group work or task based activities) and how all views can be captured (for example through individual feedback forms)
- considering the emotional wellbeing of participants. Given the potential sensitivity of the topics being discussed, organisers have a duty of care toward those participating. This means recognising and respecting personal sensitivities in dialogue, allowing people the opportunity to express their views freely and managing the process in a way that inspires confidence
- there should be an opportunity for some form of validation, potentially within a plenary session, where members of the public or facilitators feed-back on key points discussed

## 4. Involving stakeholders

The dialogue process should give priority to public debate. However, local stakeholders (for example practitioners, decision-makers, policy-makers) can play an important role in helping to stimulate and support public dialogue. Stakeholder involvement lends credibility by demonstrating a commitment to engage with the public and to respect their contribution. Importantly, local stakeholders also bring valuable local knowledge of the issues and assets of a community, potentially from a more holistic perspective. This is a resource that can be drawn on to facilitate discussion on assets that could be leveraged beyond those which are top of mind (ie health related services). Organisers of the dialogue should:

- consider the number and role of stakeholders involved in the process, and at what points their involvement is most useful. Stakeholders should ideally be in the minority during any dialogue and it is helpful to involve stakeholders at both operational and strategic levels, from the statutory and voluntary sector, and from across different policy/practice areas (ie not just health). A diversity of stakeholders can help reduce potential bias of interests
- ensure there is clarity around the needs and interests of different stakeholder groups before the dialogue process to ensure that these are managed accordingly
- recognise the power imbalance that can be introduced through stakeholder involvement, and minimise this by ensuring there is a clear understanding that their role is to help support discussion, not to lead or direct it. All stakeholders should be fully briefed before the dialogue process

## 5. Incorporating an asset based approach in the dialogue

Historically the approach taken to promote public health has been based on a deficit model that defines communities in negative terms, disregards what is working well and restricts people's views of what can effect change to health services alone. An asset based model, whereby members of the public explore how key assets within a community could be maximised to promote public health, helps to empower communities, promoting a more positive and holistic approach to action. To do this:

- facilitate discussions of wider lifestyle issues and their causes which contribute to health outcomes. Support participants to make links between socio-economic factors, lifestyles, quality of life, wellbeing and health outcomes. This can be done through activities and discussions to promote these connections and mutual understanding
- draw on the knowledge of local stakeholders and/or provide sufficient support or information to facilitate discussion of wide-ranging assets available within communities. This requires advance consideration of potential assets in order to encourage people to think how these might support the health and wellbeing of communities
- having a focus on what the future might look like – don't limit ideals because of current challenges or constraints. Challenge people to explore the potential uses of assets by looking forward rather than getting stuck on current experiences as this can lead to a negative frame of mind colouring the discussion

For further information about asset based working, see a Glass Half Full by Jane Foot with Trevor Hopkins and the follow up by Jane Foot: What makes us healthy?

## 6. Continuing the conversation

While public dialogue may be ad-hoc or ongoing it is important that there is full transparency in the process and the intended outcomes of the process. The dialogue itself, by involving people in meaningful discussion and clearly outlining how their views will be taken into account, can stimulate interest and encourage ongoing engagement with the issue. Building on the initial dialogue will involve:

- providing clear information on how people's views will be used and what decisions their views will influence
- considering how the public dialogue may be built upon (and interest harnessed). For example this may through instigating longer term dialogue platforms, or local action groups
- circulating summaries of participants views (anonymised to maintain confidentiality) and providing links to any published reports
- giving participants any information that could help them to stay involved in the issue (for example a list of local voluntary and statutory services linked to wider issues impacting on health)

Continuing the conversation applies equally to 'expert' stakeholders. Should a range of stakeholders be engaged in the dialogue process, or benefit from the outcomes of the process, it is important to consider how they could work together to take findings forward. This is particularly important in relation to health inequalities, where co-ordination between services is crucial.

## 7. Reviewing and improving the process

The final principle is a commitment to review the dialogue process, reflecting on the success of the process to identify those elements which were seen to work well and less well, and what impact that had on the quality of the discussion. This can provide a degree of accountability and quality assurance to the process, as well as informing the design of any subsequent dialogue processes. In practice this means:

- determining an appropriate means of collecting feedback from stakeholders and members of the public. This could involve anything from self-assessments through to more comprehensive internal or external evaluations pre and post dialogue
- sharing learning among peers to enable the dissemination of good practice
- altering future dialogue processes to account for lessons learned

## References

Bolam, BL. (2005) Public participation in tackling health inequalities: implications from recent qualitative research. European Journal of Public Health; 15, 5,447. OUP

Foot, J. and Hopkins, T. (2009) A glass half full; how an asset approach can improve community health and wellbeing; IDeA

Foot, J. (2012) What Makes us Healthy? The asset approach in practice: evidence, action and evaluation

Gamsu (2013 Asking the difficult questions; making the difficult decisions - Exploring the role of commissions in developing powerful locally owned evidence based commissioning; YPHO and Leeds Metropolitan University

Marmot, M. (2010) Fair Society, Healthy Lives. Strategic Review of Health Inequalities in England post-2010

NICE (2014) Community engagement to improve health NICE local government briefings. http://publications.nice.org.uk/community-engagement-to-improve-health-lgb16/

Popay J,Williams G, Thomas C, Gatrell T. Theorising Inequalities in Health: The Place of Lay Knowledge. Sociology of Health and Illness. 1998;20(5):619-644

## Further Reading

O'Mara-Eves, A., Brunton, G., McDaid, G., Oliver, S, Kavanagh, J., Jamal, F., Matosevic, T., Harden, A. and Thomas, J. (2013) ‘Community engagement to reduce inequalities in health: a systematic review, meta-analysis and economic analysis’, *Public Health Research*, 1(4) (doi:10.3310/phr01040). http://www.journalslibrary.nihr.ac.uk/phr/volume-1/issue-4

Popay, J., Bennett, S., Thomas, C., Williams, G., Gatrell, A. and Bostock, L. (2003) Beyond "beer, fags, egg and chips"? : exploring lay understandings of social inequalities in health. Sociology of Health and Illness, 25 (1). pp. 1-23. ISSN 0141-9889

South J. and Phillips G. Theory and methods: Evaluating community engagement as part of the public health system J Epidemiol Community Health jech-2013-203742. Published Online First: 26 March 2014

## Further Information

There are additional approaches to engaging communities in  improving health. Some examples and organisations are given below, but this selection is by no means exhaustive.

**Altogether Better:** The Altogether Better health champion programme recruits people who are willing to work voluntarily around health issues in their community and gives them support to develop local groups and activities. More information at: http://www.altogetherbetter.org.uk/. See also Woodall, J., White, J. South, J. (2013) Improving health and well-being through

community health champions: a thematic evaluation of a programme in Yorkshire and Humber. Perspectives in Public Health 133, 2, 96-103.

**Connected Care**: Connected Care trains community researchers, often recruited from groups where there are high levels of need, who undertake a local audit of what people want from health, housing and social care services, and feed that into commissioning and service design. See also Turning Point. Connected Care. Impacts and Outcomes. 2012. Turning Point. http://www.turning-point.co.uk/media/147934/connected__care_impact_report_summary.pdf

**Growing communities inside out:** Growing communities inside out piloted an asset based approach to the JSNA in two deprived communities in Wakefield. The public health team worked through local community organisations and used World café and digital photography methods to gather data with residents. See also Greetham, J. 2011. Piloting an asset based approach to JSNAs within the Wakefield District: Methods and findings. Wakefield: Local Government Association, NHS Wakefield District, Wakefield Council. Available: http://www.local.gov.uk/c/document_library/get_file?uuid=679e8e67-6d41-49a9-a8e1-452959f4f564&groupId=10180

**Health Empowerment Leverage Project:** Originally fund through the Department of Health to explore linking community development and the NHS, the HELP approach uses a seven step model that brings residents and services together in a partnership to develop action plans together and then follows through to local improvements http://www.healthempowerment.co.uk/ See also Fisher, B. (2011) Community development in health – a literature review. HELP.

**INVOLVE**: INVOLVE is a national advisory group that supports greater public involvement in NHS, public health and social care research. INVOLVE is funded by and part of the National Institute of Health Research (NIHR). http://www.invo.org.uk/