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Getting evidence into policy and practice to address health inequalities

Reducing inequalities in health between and within countries remains one of the most important challenges for all involved in health promotion into the 21st century. It is a challenge recognized in countries all over the world, even though the roots of inequality and the potential solutions may vary from country to country, and community to community (Evans *et al*., 2001).

Among the developed nations in Europe, countries such as Sweden and the Netherlands have a long record of policy commitment to social justice, and to addressing the health consequences of social and economic inequities (Swedish National Committee for Public Health, 2000; Mackenbach and Stronks, 2002).

The United Kingdom too pioneered many of the social policy reforms that established a modern welfare state in that country, for example by introducing the National Health Service and a series of social safety provisions for its citizens in the years following the Second World War. Despite these pioneering policies, the gap in health status between the wealthiest and poorest in the UK has grown consistently during the past 50 years, and many of the social policy structures were wound back, particularly in the two decades from 1980.

A newly elected Government in 1997 embarked upon a series of actions to gather evidence and set policy to address this growing public health problem. In 2002, uniquely, the UK Department of Health worked with the Treasury to develop a joint report on tackling health inequalities (HM Treasury/Department of Health, 2002). The review brought together Ministers and officials from across government departments, together with academic experts, to consider how better to match existing resources to health need, and to develop a long term strategy to narrow the health gap. The report recognized that inequalities in health produced by differences in opportunity, access and resources are both 'avoidable and unjust'. The involvement of the Treasury meant that the report ultimately identified a series of options for public spending and investment to both reduce the causes and mitigate the effects of health inequalities for the 2003–2006 period.

The differences in opportunity, access and resources, and their impact on health status are complex, difficult to explain and rarely suggest simple actions to rectify. This complexity has often led to 'analysis paralysis' for academics and policymakers, leading to continuous examination and debate about the nature of the problem, but little effective action to tackle it.

For example, the UK Treasury report (above) highlights the existence of a high volume of research describing the problem of health inequalities, but relatively little intervention research that helps to identify practical responses. Further, the report identifies an inverse relationship between the volume and quality of available research, and the potential effectiveness of the interventions researched. For example, the greater volume of evidence on potential interventions comes from studies designed to modify individual behavioural risks. This research in itself has often been conducted with specially selected populations that are not always representative of the social groups that need to be reached to reduce health inequalities. In contrast, there is relatively little research funded or conducted to assess the effectiveness of interventions to tackle some of the wider social, economic and environmental determinants of

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health. There is very little evidence of any kind to examine the relative costs and benefits of different policy options.

These deficits in evidence, and the uncertainties that come with them, present real dilemmas for governments (Macintyre, 2003). As a consequence, it is tempting for governments to do nothing until more convincing evidence is obtained, or to restrict its attention only to interventions for which there is good evidence of effect, leading to a narrowly defined set of responses. This latter response has been advocated in the UK (Macintyre *et al*., 2001) and adopted in the Netherlands (Mackenbach and Stronks, 2002).

Others have criticized such a narrowly defined interpretation of evidence and corresponding restrictions on policy-making. For example, Black has pointed out that public health policy decisions are inevitably (and properly) guided by political considerations alongside available scientific evidence (Black, 2001). Davey-Smith and colleagues highlight how evidence-based assessments are invariably restricted to individual behavioural and medical interventions, and risk obtaining what Davey-Smith refers to as 'the right answer to the wrong question' (Davey-Smith *et al*., 2001).

The 2002 UK Treasury review described above recognized this problem. It attempted to identify a balanced mix of interventions, across and within departments and service, using good evidence where it was available and giving high priority to those areas with the strongest evidence base. At the same time, scientific and political judgements were used in areas where good quantitative evidence on the success of interventions is weaker but there is good qualitative material (HM Treasury/Department of Health, 2002). These 'judgements' formed the basis for an ambitious *Programme for Action* to tackle health inequalities described in the foreword by British Prime Minister Tony Blair as 'a whole series of cross-departmental actions [that] will address the root causes of poor health and inequalities' (Department of Health, 2003).

This case study from England provides a good example of the debate and dilemmas that arise when available evidence to guide health interventions is either lacking or relatively weak—a dilemma that is particularly acute in considering action to address health inequalities. The experience in England also illustrates some of the complexities that are inherent in the use of evidence to guide decisions in a political environment. Those who are interested in achieving greater success in the transfer of research evidence into policy and practice can learn a great deal through critical observation of the processes that lead to the development of policies like the UK government's *Programme for Action*.

LESSONS FROM THE UK EXAMPLE

This experience highlights the fact that policy-making is rarely an 'event', or even an explicit set of decisions derived from an appraisal of evidence and following a pre-planned course. Policy tends to evolve through an iterative process, subject to continuous review and incremental change. This was the case with the UK *Programme for Action*, which was the culmination of a series of reviews and analyses, each of which refined the definition of the problem of inequalities in health in England and offered different perspectives on how it might be solved. These included a 'scientific' inquiry chaired by Sir Donald Acheson (Department of Health, 1998), a 'public' consultation focused on gathering practical experience of how to tackle inequalities (Department of Health, 2002), and the largely 'economic' review described above (HM Treasury/Department of Health, 2002).

Policy-making is an inherently 'political' process, and the timing of decisions is usually dictated as much by political considerations as the state of the evidence (Black, 2001). In this context, policy is most likely to be evidence-based if scientifically plausible evidence is available and accessible at the time it is needed, the evidence fits with the political vision of the Government of the day (or can be made to fit), the evidence points to actions for which powers and resources are (or could be) available, and the systems, structures and capacity for action exist (practical to implement) (Nutbeam, 2003).

In this example, relevant evidence from the Acheson Inquiry was available and accessible at the time it was needed, and was presented in a way that clearly fitted with the political vision of the day (Department of Health, 1998). The subsequent public consultation by the Department of Health identified working examples of successful programmes to tackle the causes and effects of health inequalities, which improved understanding of how to take practical action in local

communities. This consultation also helped establish confidence that the capacity and structures existed to sustain this action (Department of Health, 2002). The three basic conditions described above had been met: the recommended action was scientifically plausible, it fitted the political vision and was practical for implementation.

CHALLENGES FOR THE FUTURE

The experience from the UK highlights several challenges facing the public health community in its efforts to ensure that policy development and professional practice are informed by available evidence. First, to improve the quality of evidence that informs policy will require research that is more overtly directed towards informing policy. In turn, this will require investment in research that is focused on testing interventions and that improves our understanding of how effective interventions should be implemented. The paper in this volume of *Health Promotion International* by Dzewaltowski and colleagues provides an important reminder of the fact that too little published research contains vital information on the process of implementation and on the representativeness of the study population, providing key information that can inform decision-makers about the potential for replication of the intervention, and replication of the results that are reported (Dzewaltowski *et al*., 2004).

The second challenge is to find ways of ensuring that evidence forms part of an inherently fluid political decision-making process. This is both a responsibility of those who generate evidence and advocate its use, as well as those who use it. For those who generate evidence (researchers) and those who wish to see it used (health practitioners and advocates), the challenge is to provide timely access to information, and to employ improved techniques for communicating and managing the inevitable uncertainties concerning the replication of actions and predictability of results. For the public servants who use evidence in policy-making, there is the challenge to develop skills in the critical appraisal of evidence, and to judge how to achieve the best 'fit' between available evidence, current political priorities and practical actions to achieve the desired outcomes.

The article in this volume by Lucie Rychetnik and Marilyn Wise considers both the availability and relevance of evidence to support health promotion practice, and to inform policy decisions. Recognizing that the connection between research, policy and practice is far from seamless, they offer an original 'evidence agenda map' to improve the link between desired health outcomes and available evidence on effective interventions (Rychetnik and Wise, 2004).

Further progress will require public health researchers and practitioners to recognize the obvious political nature of the policy-making process and to engage more fully in that process. This will include making relevant information available when needed in a form most likely to influence decisions in the political climate of the day. In this more complex environment, the development of networks and cultivation of relationships with public servants and politicians will often provide more adaptable and durable opportunities to influence the policy process (Nutbeam, 2003).

The current volume of *Health Promotion International* contains other articles and original research that add to our knowledge of inequalities and illustrate the complexity of evaluation design needed to assess the effectiveness of interventions to reduce inequalities in health. The paper by Abbema and colleagues from the Netherlands illustrates some of the methodological complexities involved in the evaluation of an intervention designed to improve health in a disadvantaged community. These complexities often hinder progress in the development of our understanding of how to tackle the root causes of inequalities, and the authors propose an innovative method for constructing individual effect evaluation within a comprehensive community program (Abbema *et al*., 2004). The paper by Fukuda and colleagues from Japan identifies a range of social and economic factors that are associated with variations in mortality in Japan. Their data indicate that even in one of the most advanced economies in the world, with the highest life expectancy, important differences in health status persist between populations. Those who are poorer, less educated and have less access to public services and a quality environment, suffer worse health than the population as a whole (Fukuda *et al*., 2004).

For those who seek to tackle health inequalities, finding and implementing effective ways to achieve more equitable opportunity, access to services and access to resources remain one of the most difficult public health challenges in this new century. It will require real commitment from governments of the

type that is apparent from the UK example, complemented by the skilled execution of effective interventions. The articles in this edition of the journal contribute several original ideas on how to provide high quality, timely and relevant research to inform both policy development and professional practice.

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REFERENCES

Abbema, E. A., van Assema, P., Kok, G. J., De Leeuw, E. and De Vries, N. K. (2004) Effect evaluation of a comprehensive community intervention aimed at reducing socioeconomic inequalities in the Netherlands. *Health Promotion International*, **19**, 141–156.

Black, N. (2001) Evidence-based policy: proceed with care. *British Medical Journal*, **323**, 275–279.

Davey-Smith, G., Ebrahim, S. and Frankel, S. (2001) How policy informs the evidence. *British Medical Journal*, **322**, 184–185.

Department of Health (1998) *Inequalities in Health: Report of an Independent Inquiry Chaired by Sir Donald Acheson* [The Acheson Inquiry Report]. Stationery Office, London.

Department of Health (2002) *Tackling Health Inequalities: the Results of the Consultation Exercise*. Department of Health, London (http://www.doh.gov.uk/ healthinequalities).

Department of Health (2003) *Tackling Health Inequalities: a Programme for Action*. Department of Health, London (http://www.doh.gov.uk/ healthinequalities).

Dzewaltowski, D. A., Estabrooks, P. A., Klesges, L. M., Bull, S. and Glasgow, R. E. (2004) Behaviour change intervention in community settings: how generalisable are the results? *Health Promotion International*, **19**, 235–245.

Evans, T., Whitehead, M., Diderichsen *et al*. (eds) (2001) *Challenging Inequities in Health: From Ethics to Action*. Oxford University Press, Oxford.

Fukuda, Y., Nakamura, K. and Takano, T. (2004) Wide range of socioeconomic factors associated with mortality among cities in Japan. *Health Promotion International*, **19**, 177–187.

HM Treasury/Department of Health (2002) *Tackling Health Inequalities: Summary of the 2002 Cross Cutting Review*. Department of Health, London (http://www.doh.gov.uk/ health inequalities/ccsrsummaryreport).

Macintyre, S. (2003) Evidence-based policy making. *British Medical Journal*, **326**, 5–6.

Macintyre, S., Chalmers, I., Horton, R. and Smith, R. (2001) Using evidence to inform health policy. *British Medical Journal*, **322**, 184–185.

Mackenbach, J. and Stronks, K. (2002) A strategy for tackling health inequalities in the Netherlands. *British Medical Journal*, **325**, 1029–1032.

Nutbeam, D. (2003) How does evidence influence public health policy—tackling health inequalities in England. *Health Promotion Journal of Australia*, **14**, 154–158.

Rychetnik, L. and Wise, M. (2004) Advocating evidence-based health promotion: reflections and a way forward. *Health Promotion International*, **19**, 247–257.

Swedish National Committee for Public Health (2000) *Health on Equal Terms: National Goals for Public Health*. Government Official Reports (91), Stockholm.