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Reframing inequality? The health inequalities turn as a dangerous frame shift

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ABSTRACT

Background Politicians in many countries have embraced the notion that health inequalities derive from socioeconomic inequalities, but European governments have for the most part failed to enact policies that would reduce underlying social inequalities.

Methods Data are drawn from 84 in-depth interviews with policy-makers in four European countries between 2012 and 2015, qualitative content analysis of recent health inequalities policy documents, and secondary literature on the barriers to implementing evidence-based health inequalities policies.

Results Institutional and political barriers are important barriers to effective policy. Both policy-making institutions and the ideas and practices associated with neoliberalism reinforce medical-individualist models of health, strengthen actors with material interests opposed to policies that would increase equity, and undermine policy action to tackle the fundamental causes of social (including health) inequalities.

Conclusions Medicalizing inequality is more appealing to most politicians than tackling income and wage inequality head-on, but it results in framing the problem of social inequality in a way that makes it technically quite difficult to solve. Policy-makers should consider adopting more traditional programs of taxation, redistribution and labor market regulation in order to reduce both health inequalities and the underlying social inequalities.

Keywords health policy, health inequalities, medicalization, social determinants

Introduction

Growing recognition of socioeconomic inequalities in health in the rich western democracies presents politicians with an apparent opportunity: by embracing health inequalities as a political problem, they can proclaim their attachment to the issue of equity while at the same time avoiding direct discussion of contentious issues like redistribution of income and wealth. Framing the problem of social inequality in health terms may be safer for politicians than speaking directly about inequalities in the fundamental causes of health;[1] but, I argue, it reshapes the policy-making environment surrounding social inequality in ways that make it more difficult to reduce both social inequality *and* health inequalities. Political and institutional factors associated with shifting from a social inequality to a health inequality frame pose substantial barriers to reducing inequality, bringing into play institutions that act to reinforce medical, behavioral and neoliberal policy approaches.

To show how reframing social inequality in health terms may make it harder to reduce both forms of inequality, I draw on a variety of sources and methods. These include 84 in-depth interviews with health policy experts and policy-makers in England, Finland, France, Belgium and at the WHO Regional Office for Europe; qualitative content analysis of recent government reports and plans and process-tracing reviews of the secondary literature on policy responses to health inequalities in (see Table 1 for details).

The health inequality problem frame and its policy outputs

Epidemiologists and policy actors have long been aware of the link between social inequality and health inequalities.[2–4] In the modern era, the 1980 Black Report in the UK[5] set in motion a process of linking health and social inequality in political discourse (see Table 2)—most visibly in the 1997 national election campaign in Britain, in which the Labour party

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Table 1 Sources and methods

Context	*Number of interviews conducted*	*Dates*
(a) *Interviews*		
Belgium	24	May–June 2013
Finland	13	March 2015
France	41	June 2011, July 2013 and June 2014
United Kingdom	6	July–October 2014
European Union	2	May 2013 and July 2014
WHO Regional Office for Europe	3	March 2015

Topics covered in interviews: history of political and policy attention to health inequalities; political context of policy-making on health inequalities; inventory of health policy apparatus and outputs; major schools of thought and network analysis of scholarly research community working on health inequalities; relationship between scholarly and policy communities working on health inequalities.

Context	*Date*	*Title*
(b) *Recent policy documents consulted*		
Belgium	2010	*Les inégalités sociales de santé en Belgique* [Social inequalities in health in Belgium]
	2007	*Recommandations politiques—inégalités en santé* [Political recommendations: health inequalities]
Denmark	2013	*Ulighed i sundhed* [Inequality in health]
	2011	Inequality in health: causes and interventions
Finland	2008	National action plan to reduce health inequalities 2008–2011
France	2011	*Les inégalités sociales de santé: déterminants sociaux et modèles d'action* [Social inequalities in health: social determinants and models for action]
	2009	*Les inégalités sociales de santé: sortir de la fatalité* [Social inequalities in health: escape from fatalism]
Norway	2007	National strategy to reduce social inequalities in health
	2005	The challenge of the gradient
United	2010	Healthy lives, healthy people
Kingdom	2010	Fair society, healthy lives: the Marmot review
	2009	Tackling health inequalities: 10 years on
	2008	Health inequalities: progress and next steps
Sweden	2010	Public health of the future–Everyone's responsibility. A summary of the Swedish public health policy report 2010
	2005	*Folkhälsopolitisk rapport 2005* [Public health policy report 2005]
European	2011	European Parliament resolution of 8 March 2011 on reducing health inequalities in the EU
Union	2009	Commission communication Solidarity in health: reducing health inequalities in the EU
WHO	2013	Health 2020: a European policy framework and strategy for the 21st century
	2013	Review of social determinants and the health divide in the WHO European Region: final report

Documents coded for: causal theories of health inequalities (biomedical, behavioral, downstream social determinants, upstream social determinants, fundamental causation), with special attention to causal force attributed to income/earnings *inequality* versus poverty/low income; attribution of treatment responsibility (individuals, communities, society, market actors, local government, national government); proposed concrete actions to reduce income/earnings inequality; use of diagrams, models and concepts derived from WHO materials; references to other major government or scholarly reports.

successfully used the issue of health inequalities to 'kick the Tories' (UK4), highlighting the failure of the incumbent Conservative government's health and economic policies.

Scholars and international organizations have helped to define the policy problem of health inequalities in a way that is closely linked to social inequality more broadly. The dominant definition of health inequalities, articulated by Whitehead[6] and echoed in the final report of the WHO Commission on the Social Determinants of Health (CSDH),[7] invokes social inequality as the driver of health inequalities and recommends redistributive policies to combat these inequalities. Key policy statements such as the CSDH report and the Lancet-University of Oslo Commission report[8] say little about 'whose resources, and how and through what instruments' ought to be redistributed.[9–12] But despite this lack of a roadmap for producing a more equal distribution of the upstream social determinants of health, the health inequalities problem frame has disseminated throughout Europe via scholarly networks like the Eurothine

Table 2 Political motivations for and difficulties with health inequalities as a political strategy

Interview code[a]	*Year of interview*	*Quotation*
UK4	2014	'The way we kicked the Tories was to say that they were literally killing people. Labour absolutely loved the early health inequalities [research] because it said you are child killers, your trickle-down isn't working'.
UK3	2014	'The Labour government didn't want to explicitly address income inequality. They would *never* have framed what they were doing in terms of reducing the gap between the rich and the poor. That would be political suicide.'
UK5	2014	'[Labour] are keen to talk about health inequalities providing they don't have to talk about income and wealth inequalities. … They are terrified of being labeled as a tax-raising party.'
FI12	2015	'The issue of equality is such an important value in Nordic public debate, and for the right it's easier to emphasize their pro-equality position by talking about health inequalities, because it doesn't concern distributing income, which is a more difficult for them.'
FI5	2015	'Health is such an easy issue for politics because everyone agrees, and it can be used by all political parties. But when you come to the determinants of health, then the controversies and differences of interest come out immediately. … [I]f you understand that this may require redistribution of resources, then we are in a hot political area. And this link remains somehow untouched if possible because it is too difficult.'
FR10	2011	'Talking about SES health inequalities is still kind of taboo because there is such a restricted range of options for reducing SES inequalities in health unless you're going to address the underlying social disparities. And the French don't even like to talk about inequalities (fair or not) in earnings. They are still sitting on a social volcano when it comes to talking about class inequalities in France.'
FR34	2014	'The social inequalities in health framing is window dressing. The global context is a strong contraction of the budget, including within health insurance. This is not a politically popular agenda! The politicians needed to affirm that they have some big plan for reforming health without spending any money. The social inequalities in health framing allows them to show political will without actually spending any money.'
BE16	2013	'To be honest, I wasn't aware that [health inequalities] would be so difficult [politically] – much harder than poverty. Even most right wing parties in Belgium are in favor of programs to combat poverty. These don't involve questioning the system. But health inequalities are much more dangerous because they involve questioning the system, for example income inequalities.'

[a]Interviews were conducted in English and French. Quotations were drawn from verbatim notes and cross-checked against audio recordings of the interviews. Interviewees have been anonymized in accordance with IRB regulations regarding the protection of human subjects. The prefix of the interview reflects the national context about which the interviewee was questioned: BE, Belgium; FI, Finland; FR, France; UK, United Kingdom.

collaboration and through key policy statements of the World Health Organization's Regional Office for Europe[13–15] and the European Union.[16–19]

With the social determinants of health (SDOH) problem framing as a backdrop, some political actors in Europe have followed the example set by the Labour party in 1997 and embraced health inequalities as a political issue. Between May 2012 and March 2015, I conducted interviews with 84 policy experts and policy-makers that touched on motivations for politicizing the issue of health inequalities in their country. Interviews with English policy actors confirmed that the health inequalities problem frame, with its focus on the social determinants of health, allowed center-left policy-makers to reintroduce the possibility of redistributive social policy when the neoliberal consensus of the 1980s and 1990s made consideration of such policies fraught.

Other interviewees, notably in France and Finland, explained that the health inequalities issue was politically useful because it resonated with a longstanding political emphasis on social equality in their countries without directly referencing income inequality or redistribution. Raising the issue of health inequalities was also viewed by French, Finnish and Belgian interviewees as lending legitimacy to policy-makers' attempts to reform other aspects of the health system (e.g. limiting expenditures, controlling providers or insurers, reducing geographical variation in health services consumption or supply). (Other cited rationales for adopting health inequalities as a political issue that were mentioned by multiple respondents were because the issue was 'in vogue' or being promoted by actors at the EU level or within the WHO; because the issue of health inequalities was electorally popular; because it

seemed a topic capable of generating political consensus across levels of government, regions, parties or within center-left parties.)

Since politicians adopt health inequalities as a political problem for different reasons, and with varying degrees of commitment, many aspects of the policy response to health inequalities naturally also differ across countries.[20–24] Nevertheless, the health inequality issue 'package' by now comes with a standard set of widely publicized policy recommendations from the WHO: coordinated, multisectoral action, led by national governments, that reaches beyond the health sector to reduce or eliminate the inequalities in the upstream social determinants of health. It is therefore surprising that policy in countries where health inequality is on the political agenda is not more consistent with this problem frame.

Even when key national policy documents regarding health inequalities pay lip service to the social determinants of health, government policies to reduce health inequalities often rely on medicalized understandings of primary care and prevention[25–27] and health promotion policies enacted with an eye to reducing health inequalities tend to target individuals and their behaviors rather than the structures within which these behaviors take place.[28] Furthermore, systematic efforts to reduce inequalities in the 'fundamental causes'[1] of health have been vanishingly rare. Actions against poverty and marginalization have played a role in health inequalities plans from England to France to Finland, but to date only Norway among the European countries has a national health inequalities reduction program that highlights reducing income inequality as a means to reduce health inequalities.[29,30]

Increasing political attention to health inequalities has not been accompanied by substantial reductions in health inequalities.[15,31,32] If measured against the increase in underlying social inequality, some health inequalities reduction plans may be counted as successes merely because they have prevented health inequalities from growing. Nevertheless, it seems noteworthy that political attention to health inequalities has not produced policies that are consonant with the dominant paradigm that shapes thinking about health inequalities in European countries. To the extent that the recommended policy strategy of acting on the fundamental causes, upstream social determinants, or causes of the causes would in fact reduce health inequalities, explaining why these policies have not become more common after the 'health inequalities turn' can help us understand why political attention to health inequalities may undermine attempts to reduce inequality.

Why the health inequalities frame makes it harder to reduce health inequalities

Public health scholars have advanced a number of explanations for the failure of government policy meaningfully to reduce health inequalities. Many analysts cite a lack of data about health inequalities or a lack of evidence about what works as a major obstacle to creating policies that are adapted to reducing health inequalities.[33] Some skepticism still exists concerning the central causal claim of the dominant health inequalities problem frame that socioeconomic inequality is the primary cause of health inequalities.[34–36] Nevertheless, the epidemiological literature is replete with macro-level evidence that would support the CSDHs recommendation to focus on the 'causes of the causes' of health.[7,37–43] If policy responses do not correspond to the health inequality frame's hypothesized causal processes, it is likely due less to a lack of evidence than to a lack of evidence-based policy-making.[28,44,45] Why has policy-making not followed the standard health inequalities prescription?

One reason may be that reframing social inequality as a problem of health medicalizes the problem of inequality, making it seem less amenable to systemic or structural solutions. As several scholars have noted, a belief in individualism links neoliberalism and the medical model of health, and makes the two meta-frames especially compatible.[9,28,46] This resonance may allow neoliberal ideas to influence policy styles, particularly in institutional settings like health ministries that are dominated by actors who have a medicalized understanding of health, or among public health professionals whose training and outlook is primarily biomedical rather than social.[47] The medicalization of health inequalities policy can also occur as a result of more subtle forms of institutional filtering.[45,48] Even when actors understand the social determinants paradigm and are committed to reducing health inequalities, the power of medical actors in the health field, the disease- and issue-based 'silos' between and within departments, and historical decisions to prioritize certain health problems may explain why some ideas within the dominant health inequalities frame are translated more or less intact into policy, while others—like the need to act on the upstream determinants of health—are transformed or ignored.[45]

Beyond medicalization, framing the issue of social inequality as a problem of health inequalities may make the problem seem more difficult to solve. One reason is that health inequalities are the result of multiple, interacting and distal causes. The standard policy remedy, multisectoral policy-making, is in fact extremely difficult, requiring clarity about goals; capacities for joint action; relationships on which to base cooperative action; well-conceived policies that can be

implemented and evaluated; clear roles and responsibilities; and plans to monitor and sustain outcomes.[49] Barriers to cross-sectoral action include coordination problems, issues of sustainability, political power-plays and the need to negotiate the roles and resources of (public) health versus medical actors and health versus other sectors.[50,51] Interviewees reported that officials in non-health policy sectors could be resistant to the very language of 'Health in All Policies,' which suggested an imperialism of the health sector (FI5, FI6, BE8, EU1, WHO1 and WHO2). Indeed, in the arena of health inequalities policy, cross-sectoral policy-making can work, but often it does not.[52]

The difficulty of cross-sectoral policy action is only one result of framing the issue of social inequality in terms that foreground complex causation. Many analysts of health inequalities policy-making understand health inequalities as a 'wicked problem'.[33,49,53–56] Such problems involve disputes over the definition of the public good and have no definitive solutions; evidence about how to solve the problem is often missing or uncertain; and there are numerous possible intervention points, the consequences of which are hard to foresee. Together, these characteristics create problems that are surrounded by uncertainty, and likely to seem insoluble using policy approaches within the current repertoire of policy-makers.

The health inequalities problem frame spotlights many of these troubling characteristics. The social determinants causal interpretation and the cross-sectoral treatment recommendation highlight the complexity of causation and the multiple systems that must be recruited into the solution. A focus on inequalities operating over the life-course implies that outcomes of interventions are bound to be distal. Furthermore, the moral evaluation inherent to the health inequalities problem frame—exonerating individuals and blaming market inequalities and government policies for health inequalities—brings into focus how value-laden are both the definition of and the solutions to the problem of health inequalities. By highlighting the 'wickedness' of inequality, the health inequalities policy framing renders the problem of social inequality impossible to solve.

If health inequalities are wickedly complex, with a relatively weak evidence base to attest to the effectiveness of specific interventions, it should not be surprising that even governments that are committed to reducing health inequalities might find it difficult to enact these policies. Of course the wider political environment can also influence decisions about the policies that ought to be enacted in order to address the problem of health inequalities. In democratic settings, we might expect demand for policies, in the form of public beliefs, to play a role. Baum and Fisher[28] argue that the behavior-based policy frame that is the main alternative to the SDOH model is resilient partly because public beliefs support it. But while some researchers have found that members of the public are not prone to think about health inequalities or generally understand disease as an outcome of lifestyle or healthcare factors,[28,57,58] other studies find greater public understanding of the link between social deprivation and ill health.[59–63] Further, framing the issue of health inequalities in terms of social-structural factors or fairness, rather than individual responsibility, can prompt the public to support policies aimed at reducing health inequalities.[64–66] Public opinion is probably not a decisive obstacle to enacting policies that would reduce health inequalities, then. However, other aspects of the political environment may well be.

One important component of the wider political environment is the dominant neoliberal economic policy paradigm, which much research has shown erects obstacles to reducing health inequalities.[67–71] Many of the policy professionals I interviewed described neoliberal practices and policies that reinforce health inequalities and prevent effective government actions to redress them. Key examples of such practices included campaign contributions and direct lobbying pressure on policy-makers for open markets from purveyors of health-harming products and trade agreements that enforced privatization of health services.

Constraints on macroeconomic policy deriving from domestic and international financial markets or international financial institutions could also contribute to reticence about implementing bold redistributive policies designed to reduce inequalities in the upstream determinants of health. In all but the most extreme cases of financial bailouts, however, the motive force here lies in ideas and anticipated reactions, rather than in direct conditionality. Given the status of neoliberalism as an epistemically privileged master-narrative,[72] it is plausible that neoliberal ideas might have their own motive force. However, as Berman points out, to understand how neoliberal (or other) ideas come to influence policy, we need to see 'how ideas become embedded in particular groups, organizations, or structures, thereby outlasting the initial conditions shaping their emergence.'[73] It is clear that the main articulators of the health inequalities problem frame, epidemiologists and public health professionals are simply not as well-integrated into policy-making in most countries as are medical actors, central banks or lobbyists for multinational corporations; and policy-making structures tend to be organized around an ecology dominated by medical, rather than the social determinants of health. Both of these conditions make it more likely that policies will match the dominant neoliberal meta-frame rather than the social determinants health inequalities frame.[74]

Conclusion

Health inequalities may be a politically appealing problem frame, making palatable certain proposals to reduce inequality that would be politically infeasible if posed baldly as redistribution. But health inequality is also a complicated, perhaps even 'wicked,' problem, and reframing social inequality as a problem of health inequality introduces a great deal of complexity. It implies a need for difficult coordination across policy sectors, and makes the problem at hand seem unamenable to policy intervention, all of which makes it more difficult to combat the power of neoliberal ideas and actors already present within the policy-making arena. The health inequalities problem frame contributes to medicalizing policy-making around the issue of social inequality, recruiting into the inequality policy space actors whose worldviews, expertize and institutional power bases may clash with or overwhelm those of other policy actors whose top priority is social equality more broadly. All these institutional and political obstacles help to explain why, even when policy-makers adopt and promote the problem of health inequalities in part in order to address the underlying inequalities, this problem frame can fail to produce a policy response that would redress either health inequalities or the fundamental causes of these inequalities.

Where does this leave political actors who might have hoped to use the health inequalities frame strategically, as a way to reintroduce redistributive policy after three decades of neoliberal hegemony? Policy-makers interested in reducing *either* social inequalities *or* health inequalities would do well to eschew the health inequalities problem frame and instead adopt a more 'traditional' plan for reducing social inequality consisting of taxation, redistribution and labor market regulation. These policies may seem too politically risky to consider, and near impossible to enact in a neoliberal era; but they have the benefit of being relatively straightforward to imagine and to implement by a single ministry.

The movement for social equity faces a difficult task of political navigation. On one side lurks the shoal of Scylla, a health inequality frame that is politically attractive but makes policy-making technically difficult. On the other swirls Charybdis, redistributive social policies that threaten to drown supporters of equity in the ire of powerful market actors. Scylla, I would contend, is ultimately the more dangerous of the two obstacles. Getting around Charybdis safely will require political ingenuity and favorable winds; but the passage is ultimately made easier by the presence of policy tools like taxation and labor market regulation that are relatively straightforward and within the range of technical feasibility for economic policy-makers.

Supplementary data

Supplementary data are available at the *Journal of Public Health* online.

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