How do social, economic and health policymakers consider systematic variations in population health?

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A doctoral thesis of 97,978 words
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December 2024

This thesis is the result of the author's original research. It has been composed by the author and has not been previously submitted for examination which has led to the award of a degree.

Signed: 

Date: **19/12/2024**

Abstract

Systematic and unfair variations in population health have increased in the UK over the last decade, due to factors such as economic austerity, Covid-19 and inflation. Policy approaches to reduce such health inequalities have long faced significant challenges, including the tendency for policy to drift towards individual-level solutions, and difficulties collaborating for 'Health in All Policies'. Research tends to focus on health policy approaches, but inequalities in health are largely shaped by inequalities in social and economic determinants.

Therefore, this thesis explores social, economic and health policy approaches to health inequality. It uses two methods: firstly, a frame analysis (a deductive analysis of text according to five categories constituting a 'policy frame') of thirty policy strategy documents; then, semi-structured interviews with thirty-three policy actors. Texts and participants were selected from two devolved sub-state polities: Greater Manchester Combined Authority (GMCA) and the Scottish Government (SG).

Documentary analysis and interviews found that health inequalities were framed instrumentally in policy texts by GMCA as part of political dialogue with national government concerning devolution. Further, three 'health inequality' policy frames were identified as existing across the devolved policy settings; two of which were achieving high levels of political prioritisation. Social and economic policy actors often used 'health' as shorthand for illness, or for health policy. This latter use surfaced tensions between policy teams that were likely to inhibit collaboration. In contrast, the term 'wellbeing' was widely supported as aligning closer to the social model of health than 'health', and because it was unaffiliated with any specific policy team.

These findings imply a need for further research on how and where the term 'health' may have counter-productive policy impacts; and whether alternative conceptualisations may facilitate more effective policy approaches to population health.

Acknowledgements

This is the section where I am expected to thank the individuals who have helped me most over the last four years. I will do, in a moment. First, in the spirit of considering how social forces shape individual outcomes, let me acknowledge that I am enormously fortunate to have been born into a middle-class family; to wonderful parents; able-bodied; into the ethnic majority group of my country; and as a male. These accidents of birth gave me gale-force tailwinds.

Next I must acknowledge the most proximate cause of this research reaching completion: my primary supervisor Kat Smith. I was told repeatedly before I started this PhD how important it was to have a good supervisor: I could not have asked for better. Kat has always had my back, supporting me through minor struggles and a few not-so-minor, and giving me opportunities to develop my skills and experience. She has also continually challenged me to think again, or to think deeper, to improve my work. Again, I feel enormously fortunate to have had Kat guide my way through this.

Alongside Kat I have had four fantastic co-supervisors. That was not the plan, but maternity made it so. Thank you to Clemmie Hill O'Connor, Anna Macintyre, Gillian Fergie and Lisa Garnham. It's been a pleasure to work with you all, and you all really helped me to think further: I can see the huge difference between my early writings and what I write now. I must also thank Petra Meier, the PI of the SIPHER Consortium, which funded this research. I have learned so much from Kat, Clemmie, Anna, Gillian, Lisa and Petra, and I hope to work with and learn from you all again.

Closer to home, all my thanks, forever, go to Leila, the love of my life. We met one year into this PhD: we fell in love, I moved to your town, to your home, with your child, and our dog. You have put up with all my preoccupations, my irritating criticality, my saying 'no' to family days out because I had to work. I promise I can say 'yes' to more fun now, my love.

Finally, I must take a lifecourse perspective, and give huge thanks to my parents, Colin and Florence, and my sister Emma, for supporting me through all the hard times, again, and again. There's been a few. Last but not least: thanks to Sabine, my bone marrow donor, who underwent a painful procedure under anaesthetic to save a distant stranger's life. My viva will take place almost exactly 25 years to the day. You gave me all of that, and this, too.

Table of Contents

Chapter 1 - Introduction

1.1 Introduction to thesis

New Labour's 1997 election manifesto did not promise to address health inequality. But just two months after the party's landslide electoral victory, the new government commissioned an Independent Inquiry into Inequalities in Health (Acheson, 1998), which was followed by an Action Report (Department of Health, 1999a), national health inequality targets (Department of Health, 2000), and a cross-governmental strategy for England: Tackling Health Inequalities: A Programme for Action (Department for Health, 2003). Alas, despite an unprecedented long-term national commitment, by the end of the New Labour era the targets were reported to have been missed (Department of Health, 2008; Marmot et al., 2010).

Following this apparent failure, researchers who had spent years uncovering overwhelming evidence for the effects of social and economic forces on health faced a dispiriting question with a seemingly negative answer: "Can we reduce health inequalities?" (Mackenbach, 2011). For "*the vast majority*" of the health inequality research and policy community interviewed by Smith and Garthwaite (2015, p83), New Labour's efforts to reduce health inequalities had produced disappointing outcomes. Yet, with the benefit of better data, a systematic review more than a decade after the end of the strategy seemed to answer differently: Holdroyd et al.'s 2022 analysis showed that strategic targets aimed at inequalities in life expectancy and infant mortality had in fact been met, at least partly.

In the meantime, New Labour had not been rewarded by the electorate for the unknown successes of their strategy. Instead, a succession of Conservative-led governments had taken power, with less interest in reducing health inequalities. Moreover, the Conservative-era economic austerity agenda, followed by the Covid-19 pandemic and a rapid rise in inflation, all contributed to widening inequalities (Bambra et al., 2021; McCartney, 2022; Richardson et al., 2023). At the time of writing in late 2024, a new Labour government has won a landslide electoral victory, this time with a manifesto commitment to reducing healthy life expectancy gaps in England. So, is a new national, long-term, cross-governmental strategy required? Or are there alternative agendas and policy settings which might better contribute to reducing systematic variations in population health?

In this thesis, I aim to investigate these possibilities. There are several agendas that purport to reduce the socio-economic inequalities that generate inequalities in health: inclusive growth, levelling up, wellbeing economy, tackling child poverty, foundational economy, and more. But which of them might overcome their practical and political challenges? Further, devolution processes have created new policy settings across the United Kingdom: but each of these has unique contexts and limitations to consider. In this thesis I will explore how social, economic and health policy actors consider health inequalities, while developing such socio-economic agendas, at regional and devolved national levels in the UK.

At the age of seven I discovered that life was not fair because illness could happen to people who had done nothing to deserve it. As an adult I learned that factors outwith individual control – but within collective control - in fact influenced a great proportion of ill-health suffering, and much more so for some people than for others. It is the sense of unfairness behind this that motivates my research, and presumably that of others in this field.

So in this chapter, I shall first turn to the task of identifying that unfairness, clarifying what is meant by 'health inequalities', and consider why it is challenging to understand them. Then, in the next chapter, I will review the literature to discuss further some of the specific issues around health inequality policy development, such as 'lifestyle drift' and potential framing effects of the word 'health'. Therefore, this first chapter shall broadly set the scene, and the next chapter shall analyse deeper what the academic literature says about these issues, and what the present research can contribute further.

1.2 Introduction to health inequalities

1.2.1 Defining and identifying health inequalities

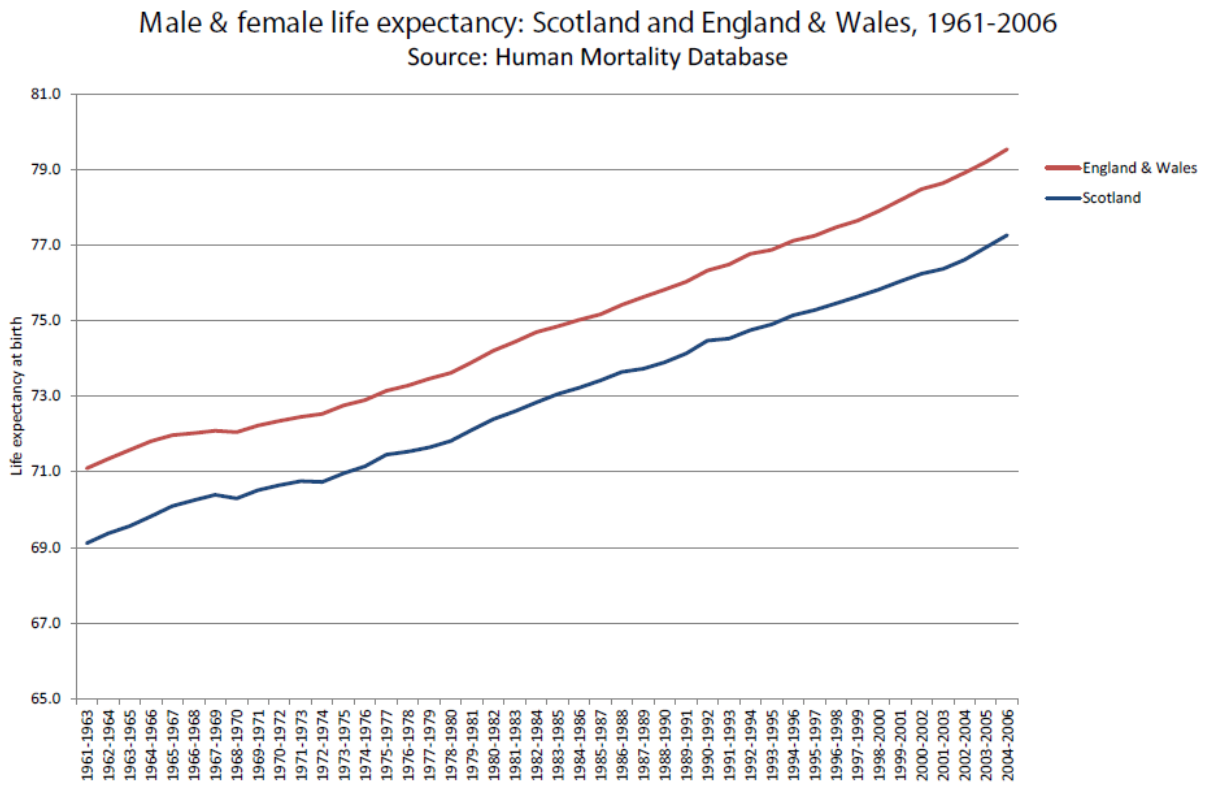
The terms ‘health inequalities’, ‘health disparities’, ‘health variations’ and similar have been debated at length (Braveman, 2006; Ward et al., 2013; McCartney et al., 2019). To a large extent, disagreements over meaning originated geographically, with UK-based researchers preferring the term ‘inequalities’ since its use in the official title of the highly influential Black Report (1980), while US-based researchers used ‘disparities’ to reflect observed gaps in healthcare provision between white and minority ethnic groups (Collyer & Smith, 2020).

At the heart of both concepts is a sense of unfairness about differences in health between different groups. For example, older people have higher rates of disease and of mortality than younger people, but this is rarely considered unfair because it is inherent to the ageing process. Similarly, women tend to live longer than men, but to a large extent, this too is considered to have a biological basis (Austad & Fischer, 2016) so is perceived as natural or inherent rather than unfair.

Therefore, ‘health inequalities’ is an umbrella term for observed associations of different health outcomes between different social or geographical groups or along a social gradient that may be unfair or unjust. Following the definition by McCartney et al. (2019), the unfairness stems from the extent to which the difference is neither random nor inevitable, but systematically produced, and therefore systematically preventable. The ‘systems’ referred to are otherwise known as the social determinants of health (SDoH) - power, poverty, living standards, discrimination, and more – and as these are socially constructed, they can be socially constructed in different ways (CSDH, 2008). Here, the normative assumption behind most work on ‘health inequalities’ becomes clear: if disease or death is preventable, there is a moral obligation to make efforts to prevent it, falling on those in positions of power whose decisions shape the systems.

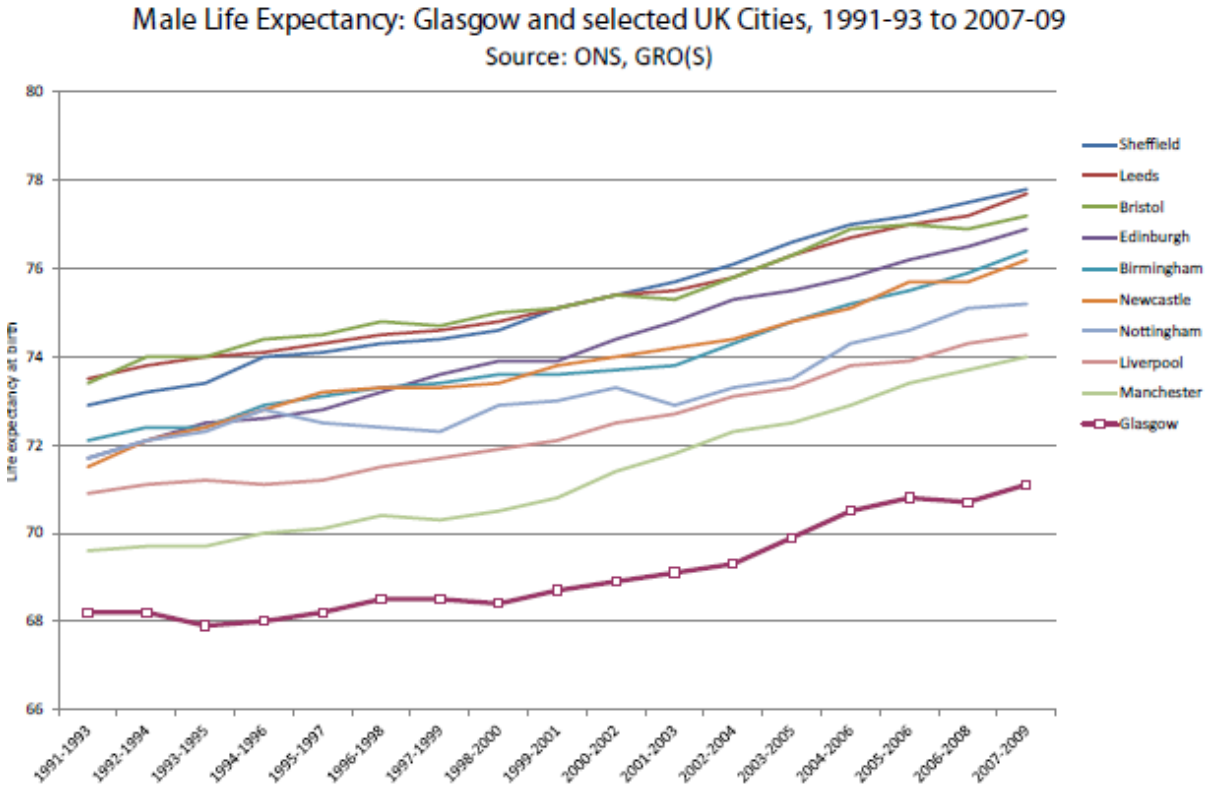
Estimates of life expectancy and healthy life expectancy are frequently used to measure health in groups. Three longitudinal graphs from overlapping time periods can show how life expectancy measures reveal persistent health inequalities between different groups. Firstly, Figure 1a (below) shows that overall life expectancy grew over the latter part of the 20th century in Great Britain, but that the gap between the lower Scottish line and the upper England and Wales line has remained consistent, representing a long-term trend for Scottish lives to end around two years earlier on average. Other evidence shows that Scottish life expectancy has been relatively low since around 1950 (McCartney et al., 2012).

Fig. 1a Male & female LE 1961-2006 in UK from Walsh et al. (2016, p26)



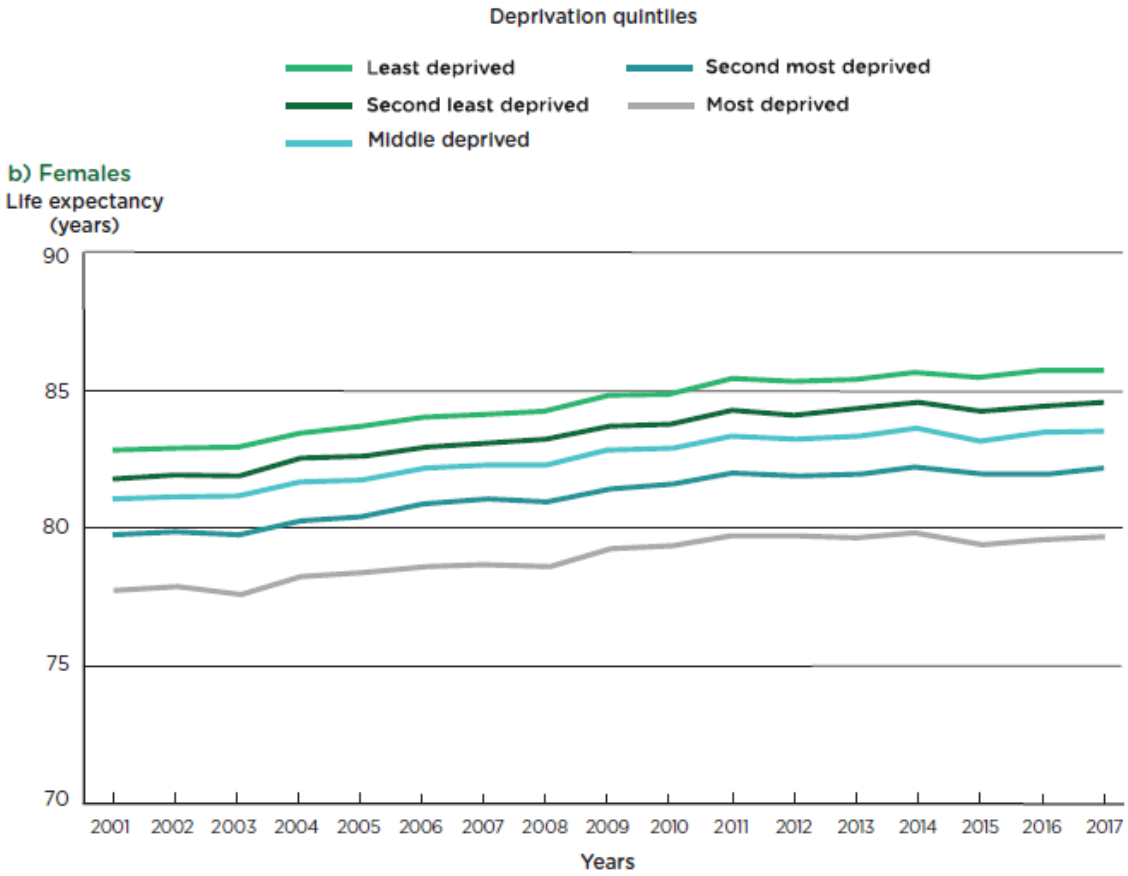
But the national-level difference implied by Figure 1a can be given more nuance by Figure 1b (below), which shows male life expectancies by British city from the early 1990s until the late 2000s. Again, the gaps between lines show that men in Glasgow have consistently had much lower life expectancies than men in any other British city; and life expectancies for men in Manchester remain lower than for men in any other English city. Life expectancies in both cities compare unfavourably with life expectancy in Edinburgh; therefore, the choice of comparison group influences perceptions of unfairness. While the data presented in Figure 1a implies unfairness against residents of Edinburgh, Figure 1b shows that residents of Manchester and several other English cities face more preventable mortality than the relatively advantaged residents of Edinburgh.

Fig. 1b Male LE UK Cities 1991-2009 from Walsh et al. (2016, p26)



Finally, Figure 1c (below) shows twenty-first century gaps between female life expectancies in England according to area-based socio-economic deprivation. Similar data showing negative health impacts of deprivation are abundant in health inequality literature (see e.g. Marmot et al., 2010; Cairns et al., 2017; Miall et al., 2022). These data inform our understanding of Figures 1a and 1b above: an important part of any explanation for systematic variations in health between nations or cities must relate to different levels of socio-economic deprivation (Carstairs & Morris, 1989; Seaman et al., 2015; cf. Walsh et al., 2010).

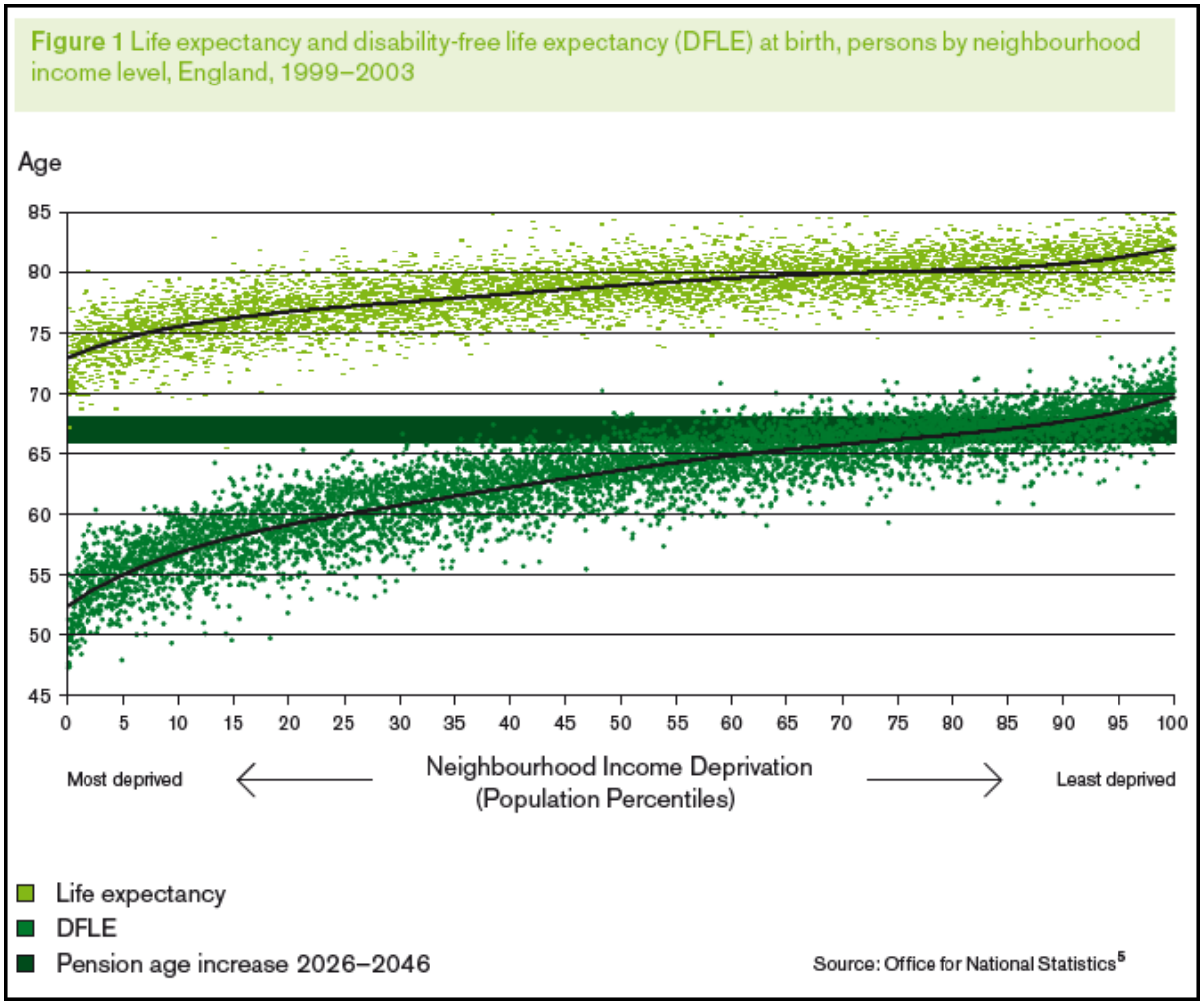
Fig. 1c Female LE by deprivation quintile 2001-2017 from Marmot et al., (2020, p17)



Source: Calculated by Bajekal M using ONS data (2019) (24)

The role of deprivation is clearly shown again on the 'Marmot curve' (Fig. 1d, below) (Marmot et al., 2010), which is a snapshot of data gathered at the turn of the century, not a trend over time as in Figures 1a-c above. Figure 1d shows both life expectancy (light green) and disability-free life expectancy (dark green) for neighbourhoods in England and Wales arranged on the x-axis by average income. According to these data, life expectancy and disability-free life expectancy increase as area-level income increases across the whole of society: there is a social gradient in health. Further, only people in the least deprived neighbourhoods can expect to reach pension age (the horizontal green bar) without a disability. Therefore, despite health inequalities often being conceptualised as 'health gaps' (Marmot, 2015) or as 'health disadvantages' suffered by those living in poverty (Graham, 2004b), the gradient in health shown by the Marmot curve shows health inequality to be a much broader social issue.

Fig. 1d The Marmot Curve from *Fair Society, Healthy Lives*, Marmot et al. (2010, p17)



1.2.2 Explaining health inequalities

Figures 1c and 1d above show that socio-economic deprivation is strongly implicated in patterns of health inequality. But exactly how deprivation and other social forces get 'under the skin' to create differential health outcomes requires further explanation. There are several major theories that attempt to explain the causal pathways between social forces and health outcomes. The Black Report (1980) categorised explanations as artefactual, reflecting natural or social selection, reflecting cultural or behavioural differences between groups, or reflecting material differences between groups; and found little evidence to support the former three explanations. On the other hand, materialist explanations which connect health outcomes to wealth were strongly supported: material resources fundamentally affect whether individuals are able to access health-promoting goods or services, or avoid risks to health, whatever those beneficial or harmful exposures may be. Materialist explanations are now supported by abundant evidence (see e.g. Link and Phelan, 1995; CSDH, 2008; Phelan et al., 2010).

A second type of explanation to emerge following the Black Report is known as 'psychosocial'. In these accounts, there are damaging psychological impacts of having a lower position in a hierarchical society, which may harm both mental and physical health (Wilkinson, 1996; Wilkinson & Pickett, 2009, 2020). While materialist explanations lead some to conclude that poverty underlies health inequality, psychosocial explanations broaden attention to the structure of the whole society, highlighting the role of affluence in generating stress, anxiety and discrimination, including in those not living in material poverty.

A further group of explanations focuses on the 'life-course' of individuals: either the accumulation over life of harms or protections to health, or the impacts of experiences at key periods, such as early childhood (Davey Smith, 2003). Other explanations connect elements of materialist or psychosocial theories to power, or to capitalism: for example, political economic accounts that emphasise the political choices of powerful elites (e.g. Navarro et al., 2003; McCartney, 2022); or the commercial determinants of health (CDoH) lens which focuses on those who profit from health-harming products and practices (Kickbusch et al., 2016; Diderichsen et al., 2021).

While each of these explanatory models may be applied to socioeconomic inequalities in health, other social patterns of health may require additional explanations. For example,

inequalities in health by ethnicity may partly reflect socioeconomic inequalities, but they may also be partly attributed to racism (Phelan and Link, 2015); place-based inequalities in health may partly reflect place-specific vulnerabilities, as in the case of Glasgow (Walsh et al., 2016; Garnham, 2017); and inequalities in health by gender can be linked to other gender patterns, including inequalities in employment and social norms about caring responsibilities (Arber and Thomas, 2001).

In trying to provide evidence to illuminate any causal theories, the gold standard method of evidence-generation in medical science – the randomised controlled trial – is rarely amenable to assessing the social determinants of health in a population. When the exposure of interest is far 'upstream' (as social determinants of health are), or when the setting is the real social world with all its uncontrollable additional exposures, identifying the causal effects of social exposures is extremely challenging (Kaufman, 2019).

In medical epidemiology, the Bradford Hill criteria[1] are often used to infer causation from association. Pickett and Wilkinson (2015) applied this criteria to the literature associating income inequality and health and concluded that higher income inequality must cause poorer health. However, this was a selective review; an umbrella review of nine systematic reviews by Naik et al. (2019) found an equivocal literature. For example: Macinko et al. (2003) found 33 analyses that associated income inequality with poorer health, but also some "*sophisticated*" studies with negative findings; Ngamaba et al. (2018) found an association with subjective well-being that was non-significant; and Kim (2017) found no association between income inequality and most health outcomes, with the exception of child and infant mortality.

These evidential nuances and theoretical doubts provide plenty of scope for moral and political interpretation (Carlisle, 2001; Parkhurst, 2016). Pickett and Wilkinson's findings have huge policy and political implications for those who would accept them. Therefore, those with conflicting interests can choose their own preferred evidence to highlight and shape into preferred ideas (Smith, 2013a). Ultimately, the standard of proof required for a decision to be made is at the discretion of the decision-makers. This means that

[1] In his work investigating strong associations between smoking and lung cancer, Sir Austin Bradford-Hill (1965) described nine criteria for inferring causation from observed associations, including how consistent the associations are, whether the effect follows the putative cause, whether there are alternative explanations, whether causation is biologically plausible, and so on. See Thygesen et al.'s (2005) philosophical analysis.

assumptions about the primacy of evidence in any policymaking process must be kept in check: powerful institutional, corporate and political interests, the personal career interests of public health professionals, academics and policy actors, and prevalent assumptions about health or about inequalities also play important roles in the policy process (Bartley, 1992; Mackenzie et al., 2006; Collin & Hill, 2015; Douglas, 2015).

1.2.3 The pre-history of UK policy attention to health inequalities

Although differences in health outcomes between different social groups have been observed in the UK since at least the mid-19th century (Macintyre, 1997), the social problem of health inequality has been addressed only sporadically since then. Reports written a century apart by Edwin Chadwick (1842) and William Beveridge (1942) had major impacts on national policy: the former led to the Public Health Act 1848 which enacted many of Chadwick's recommendations for improvements in hygiene and sanitary conditions; and the latter led to the post-war creation of the welfare state, including the National Health Service (Abel-Smith, 1992). Both reports were published under Conservative governments but acted upon by successor Whig and Labour governments.

Observations of socioeconomic patterns in health outcomes have long prompted debate about causation and about the level of causation at which the state may intervene: at distal, upstream, social or economic levels, or at more proximal, downstream levels closer to individuals. The post-war creation of the welfare state and NHS were seen as major systematic innovations that would have such an impact on poverty and access to healthcare that health inequalities may be 'resolved' as a social problem (Oliver, 2010). As the decades passed, this did not transpire.

In 1977, the Labour government established a working group to report on health inequalities, but the report was not finalised and published until after the election of a Conservative government led by Margaret Thatcher. As described above, the Black Report (1980) discussed and rejected the arguments that health inequalities could be due to artefact or social selection, instead highlighting the convincing social and economic explanations and recommending significant policy action be taken on them. The Black Report inspired further research which went on to strengthen the evidence-base behind upstream, social and economic explanations for health inequalities (Dahlgren & Whitehead, 1991), including confirming the existence of a social gradient in health outcomes affecting the whole of society (Marmot et al., 1991).

However, the new government of the time did not receive the report kindly and rejected its findings (Macintyre, 1997). Instead, the Conservative governments of Thatcher (1979-1990) and Major (1990-1997) preferred to emphasise the individual responsibility of citizens for their health (Kriznik, 2015), consistent with neoliberal economic ideologies (Schrecker & Bambra, 2015). Thatcher's economic programme led to worsening poverty and unemployment and increasing economic inequalities, with associated increases in health inequalities (Scott-Samuel et al., 2014). While income inequality stabilised at a historically high level under the Major government (Lakin, 2002), socioeconomic inequalities in premature mortality continued to increase throughout the 1990s (Davey Smith et al., 2002).

Eventually, the research evidence was acknowledged in two reports published by the government led by John Major: *The Health of the Nation* (Department of Health, 1992) and *Variations in Health* (Department of Health, 1995). Although these acknowledgements were not acted upon by central government, the gradual political problematization of health inequalities was supported by the state-funded ESRC commissioning of a 26-project Health Variations research programme from 1996 (Graham, 1998).

1.3 New Labour's national strategy to reduce health inequalities in England

1.3.1 Initial focus on social determinants of health inequality

In 1997 New Labour were elected promising both an evidence-based approach to policy and a concerted focus on addressing health inequalities (Macintyre et al., 2001). Just a month after taking office, the new government commissioned a new independent inquiry into health inequalities led by former Chief Medical Officer Sir Donald Acheson, which reported the following year (Acheson, 1998).

This new report broadly mirrored the explanations and subsequent recommendations of the Black Report, but importantly was released into a much more welcoming political environment (Exworthy, 2003). Both reports made close to 40 recommendations; recommendations described as "*remarkably similar*" by Birch (1999, p301), and both reports emphasised that poverty should be reduced and children's health prioritised, reflecting the importance of taking a lifecourse perspective. The Acheson Report further

recommended that all government policies that may directly or indirectly affect health should be formally evaluated for their potential impact on inequalities in health (Acheson, 1998). This 'health equity in all policies' priority, along with the fact that 36 of its 39 main recommendations were aimed outwith the NHS, was reflective of the two decades of research since the Black Report that had confirmed the social and economic roots of health inequalities, rather than the individual or clinical.

Due to its similarity to the Black Report, the government that had commissioned the Acheson Report (led by Prime Minister Tony Blair) said it was already implementing its recommendations upon publication (Exworthy, 2003). Indeed, in 1997 the new government had announced its Sure Start initiative, aiming to provide a variety of extra support services for children and families in deprived areas (Gidley, 2007). Also in 1997, twenty-six areas suffering poor health and deprivation became designated Health Action Zones, receiving further investment to facilitate local partnership work to address health inequalities. Further, while taxes were not raised, new welfare benefits and raised levels aimed to reduce child poverty by a quarter by 2004, and tax credits for employed adults aimed to incentivise people into work (Exworthy et al., 2003).

In 2002, the New Labour government set itself two national health inequalities targets: to reduce by at least 10% by 2010 the gaps in life expectancy between the most disadvantaged quintile of local authorities and the population as a whole; and the gaps in infant mortality between routine and manual occupation groups and the population as a whole (Department of Health, 2002). It further published a cross-cutting review and a programme for action (Department of Health, 2003), the latter elaborating a further 12 national 'indicators' (for example, fruit and vegetable consumption, flu vaccination uptake and child poverty rate) and 82 departmental commitments, which comprised specific policies for various governmental departments to support the strategy.

Child poverty and pensioner poverty were substantially reduced by New Labour's economic agenda, while income inequality nudged upwards slightly (Joyce & Sibieta, 2013). This increase was mostly driven by high earners, particularly the ongoing surge in income share of the top 1% of earners that had begun in the early 1980s under Thatcher's government (Joyce & Xu, 2019).

1.3.2 The downstream drift of New Labour's approach

Despite this attempt to focus on social and economic policy, Exworthy (2003, p17) notes that while multiple subsequent health department documents referred favourably to the Acheson Report, it was "*less widely referenced in documents from other government departments*". Department of Health policymaker Don Nutbeam (2003b) characterised the government's response to Acheson as being framed by two key documents: the white paper Our Healthier Nation (Department of Health, 1999b), and the NHS Plan (Department of Health, 2000). The latter contextualised the health inequality policy challenge as one for the NHS and included the first commitment to national health inequality targets, which became part of the Department of Health's Public Service Agreement (Nutbeam, 2003b). Similar targets based on reducing area-based gaps were introduced for mortality by cancer, heart disease and stroke (Bambra et al., 2023). Therefore, despite the initial focus on social determinants of health inequality, responsibility for meeting the national targets was given to the Department of Health and the NHS.

According to Smith et al.'s analysis (2009, p229), "*something of a watershed*" occurred in English, Scottish and Welsh health policy around 2003-04, as responsibility for health inequalities shifted from a range of social and economic policy teams at central government level, towards local NHS bodies, and individuals, who were encouraged to pay more attention to their 'lifestyle' health behaviours. This tendency in health inequalities policy was later characterised as 'lifestyle drift' (Popay et al., 2010), and was also noted to have occurred in New Zealand, Canada and the US (Graham, 2009)[2].

The English white paper Choosing Health (Department of Health, 2004) exemplified the "*major change of policy direction*" (Dowler & Spencer, 2007, p234), both in its title and in quotes such as: "*in our survey, 88% of respondents agreed that individuals are responsible for their own health*" (p12). Kriznik (2015, p152) called Choosing Health *"an anomaly in terms of New Labour's policies on public health and health inequalities"*; but it may appear

[2] Although the term 'lifestyle drift' is now widely used in health inequality literature, it seems to exclude the similar and often co-occurring policy drift towards healthcare-based solutions. Therefore, I prefer the broader term 'downstream drift' when describing a change in attention from population-level problems to individual-level solutions, including both healthcare and 'lifestyle' or behavioural interventions; while 'lifestyle drift' implies a policy drift towards behavioural interventions only.

less anomalous when seen in the context of parallel NHS agendas promoting patient empowerment and choice (Greener, 2003, Veitch, 2010).

1.3.3 Disappointment after New Labour's strategy

Initially, both of New Labour's national health inequality targets were reported as being missed (Marmot et al., 2010; Thomas et al., 2010). Based on this, Mackenbach assessed the apparent failure of New Labour to reduce health inequalities after 13 years of committed effort, concluding that there was insufficient evidence of effectiveness for interventions; that the scale of intervention required was bigger than was politically feasible; and that it was extremely difficult to evaluate health outcomes that take decades to materialise, contributing to the first two problems (Mackenbach, 2010). In 2015, surveys of UK-based health inequalities researchers found consensus views that more progressive economic redistribution was necessary, as was more investment in services, especially those used by disadvantaged people, and more regulation on health-harming products (Smith & Kandlik Eltanani, 2015). However, a report from a symposium of health inequalities researchers identified concerns about a lack of clear policy solutions, difficulties generating evidence for upstream interventions, and reluctance to act politically (Garthwaite et al., 2016).

However, as Schrecker (2017) highlighted, the positive health outcomes associated with New Labour's substantial reduction of child poverty could take many years to manifest or become measurable. Further, positive effects may be undone by policies of subsequent governments or other major events. Similarly, Smith et al. (2015, p15) suggested that not enough time may have passed to enable a full assessment of the strategy. Therefore, reliably reporting the health inequalities benefits of upstream policy actions presents a major challenge

Indeed, research later in the 2010s began to show more positive outcomes coinciding with the strategy's aims and duration. Buck and Maguire (2015) found that the social gradient in life expectancy had improved during the 2000s. Then, Barr et al. (2017) found that both relative and absolute inequalities in life expectancy had decreased during New Labour's government, having increased before it, and resumed increasing afterwards. A more recent systematic review of studies analysing New Labour's health inequality strategy found that both absolute and relative measures of life expectancy and infant mortality inequalities improved through the strategy period (Holdroyd et al., 2022). Therefore, the strategy appears to have been at least partially successful on the two specific measures initially

targeted. But evidence to support this conclusion was not available until many years after the strategy ended, by which time the UK government had been replaced by one with little national-level interest in reducing health inequalities.

1.4 Devolved national policy interest in health inequalities

New Labour's 1997 manifesto also contained a commitment to hold referendums in Scotland and Wales on the creation of a parliament with law-making powers for the former, and an assembly with secondary powers for the latter. Referendums were held and passed in 1997, and both a Scottish Parliament and a Welsh Assembly became operational in 1999. Northern Ireland also gained an Assembly with devolved powers following the Good Friday Agreement in 1998.

The Scottish Parliament was given primary legislative powers over a variety of policy areas potentially influential on health inequalities, such as health, economic development, education and training, environment, local government and transport (MacKinnon, 2013). However, other issues with important impacts on health inequalities, such as taxation, welfare provision and drug policy, were initially kept fully within Westminster control[3]. The National Assembly for Wales was initially founded without primary legislative powers, but was later given more powers in similar areas to Scotland (MacKinnon, 2013).

Devolved policy settings such as Scotland, Wales and the English city-regions (Lupton et al., 2018) provide unique opportunities to explore policy approaches to health inequality. While the creation of new powers may be assumed to generate policy divergence, there may also be strong forces towards convergence (Smith et al., 2009; Morphet & Clifford, 2014). The limited set of policy levers available to each devolved polity, and aspects of the devolution process itself, may also create new inter-group dynamics around, within and between policy settings (Keating, 2010, Ch4; Swenden & McEwen, 2014). These various differences may shape policy approaches to health inequality in important ways.

[3] The Scotland Acts of 2012 and 2016 gave further tax-adjusting and social security powers to the Scottish Parliament. Devolved and reserved matters are listed here: https://www.parliament.scot/about/how-parliament-works/devolved-and-reserved-powers [accessed 28/10/2024]

1.4.1 Devolved Labour Party approaches to health inequality

Smith et al. (2009) assessed the extent to which health inequalities policy differed across the devolved national governments of the UK between 1997 and 2007, finding the approaches described within health policy texts to be "*remarkably similar*" for England, Scotland and Wales (p233). This can at least partly be attributed to Labour Party dominance in all three legislatures and the limited powers of the devolved administrations. There were differences regarding targets, where Scotland followed the English national targets described in 1.3.1 (above) by setting targets to improve the health of people in the most deprived areas, while Wales avoided specific, quantified targets. Targets may help policymakers focus on and commit to achieving important outcomes and may facilitate better monitoring; but they may also focus policy on specific groups and short-term outcomes, which discourages long-term, upstream intervention (Blackman et al., 2009). For example, short-term mortality targets encourage downstream interventions such as increasing access to nicotine replacement patches for smokers and statins for those already with heart disease (Blackman, 2007).

Smith et al.'s (2009) analysis also found that the Scottish, Welsh and English governments all conceptualised health inequalities as a problem of ill health in disadvantaged communities, rather than as a gradient of differing health outcomes affecting the whole of society. As with the setting of targets, this simplified framing of the problem may facilitate performance assessment processes, leading to extra attention and 'quick wins' on specific issues (Blackman et al., 2009). A gradient-based conceptualisation would require a much more sophisticated approach to measurement and evaluation (Bauld et al., 2008). But the disadvantage framing also tends to lead to policy solutions aimed at specific minorities and their health behaviours, rather than upstream solutions that may benefit everyone on the gradient (Graham, 2004b).

Wales has continued to be politically led by Labour and now has devolved powers in twenty areas, including several of critical importance to health inequalities. However, it also remains the poorest nation of the UK, with a Gross Value Added per head just 71% of England's (ONS, 2018). The Welsh government has struggled to address the causes of poverty: partly due to its lack of power on tax or welfare (Davies & Parken, 2017) and partly due to its focus on increasing employment, which is not necessarily sufficient to escape poverty (Evans, 2019). In 2015 Wales passed the Wellbeing of Future Generations Act,

which requires public bodies to consider the long-term impacts of their decisions, including impacts on health and inequalities (Future Generations Commissioner for Wales, 2015). The Welsh government has also legislated to increase the use of Health Impact Assessments (HIA), which is hoped to improve decision-making across policy teams with regards to social and economic determinants of health inequalities (Green et al., 2020).

1.4.2 Scottish National Party interest in health inequality

While Labour have continued to lead in Wales, the Scottish National Party (SNP) have led the Scottish government since May 2007. Since this time, many aspects of social and economic policy have appeared to diverge from English and UK-wide reserved policy matters, which have been led by the Conservatives since 2010. Like New Labour - but unlike the Conservatives – the SNP took an immediate interest in the challenge of reducing health inequality.

Shortly after forming the new Scottish government, the SNP Minister for Public Health Shona Robison established a Scottish Ministerial Task Force on Health Inequalities, which produced a strategy called Equally Well the following year (Scottish Government, 2008). In it, the then-Cabinet Secretary for Health and Wellbeing, Nicola Sturgeon, said: "*We have made tackling health inequalities our top priority*" (p9). The strategy was described as "a *bold break*" from previous efforts, "*focusing on the social determinants of health*" and "*ranging further outside the health sector*" in a later NHS Health Scotland review (Beeston et al., 2013, p21).

However, two further reviews by the Task Force (Scottish Government, 2010, 2014) and the NHS Health Scotland review (Beeston et al., 2013) explained a number of shortcomings with implementation. The 2010 review highlighted the challenging financial climate of the time, reinforced the need to focus on individuals' environments rather than their behaviours, and asked for a more collaborative approach among public service and third sector organisations. The 2013 NHS Health Scotland review also judged that collaborative work across sectors had not been sufficient, and added that actions had indeed been too focused on behaviours such as smoking and alcohol misuse, rather than the underlying causes of health inequality. Finally, the 2014 Task Force review conceded that lifestyle drift had occurred, and that health gaps in Scotland had not reduced. Similarly to New Labour's health inequality strategy for England, a policy approach that had began with a focus on

social determinants of health inequality had 'drifted' towards individuals and their health behaviours.

1.5 The de-problematisation of health inequalities

Following the perceived failures of both New Labour's health inequality strategy and the SNP's Equally Well strategy, health inequality became less of a policy priority in both England and Scotland. In the former, this occurred alongside the change in governing party following the general election in 2010; in the latter, it is better contextualised by the SNP's firm focus on the 2014 independence referendum. In this short sub-section, I shall first describe how English policy attention remained on health behaviours; then I shall describe how Scottish policy focus moved to public health reform and regulation within the referendum context.

1.5.1 From 'Choosing Health' to "healthy choices" in England

After thirteen years in power at Westminster, New Labour left office in May 2010 to be replaced by the Conservatives in coalition with the Liberal Democrats. In contrast with Thatcher's government response to the Black Report, the new coalition government (2010-2015) publicly welcomed a new report on health inequalities that outgoing Prime Minister Gordon Brown had commissioned (Marmot et al., 2010) and indicated acceptance of five of its six key principles for policy. However, neither that coalition government, nor the successor Conservative majority governments of Cameron (2015-2016), May (2016-2019), Johnson (2019-2022), Truss (2022) or Sunak (2022-2024), created a health inequalities plan to update the one that expired in 2010. As shall be described in the next section, many of their policies contradicted the Marmot Review's recommendations (Marmot et al., 2020a).

Meanwhile, English public health policy continued to be framed around individual behaviours, influenced more by *Nudge*-based ideas than by either of the Marmot-led reports. Continuity in the language used by central government to describe the focus on individual health behaviours can be seen stretching from 2004 until the present. While Tony Blair's foreword to the New Labour paper Choosing Health had said its aim was to "*help shape the … environment we live in so that it is easier to choose a healthy lifestyle*", the coalition government's Healthy Lives, Healthy People (Department of Health, 2010) repeatedly proposed "*adapting the environment to make healthy choices easier*" (p6, p23, p29). Fifteen years after Choosing Health, the Conservative green paper Advancing Our

Health: Prevention in the 2020s indicated a continuing health policy focus on individual choice, saying: "*our focus must be on making healthier choices easier [by] reshaping the environment*" (Department of Health and Social Care, 2019, p28).

1.5.2 From 'Equally Well' to public health reform in Scotland

The final Ministerial Task Force for Health Inequalities review of Equally Well declined to make further recommendations, instead specifying new areas of priority: the development of social capital; support for community planning partnerships; a focus on the 15-44 age group; and support for the implementation of a place standard (Scottish Government, 2014). However, the Scottish government soon began a new process of establishing its own national public health agency and a new set of clear priorities (Scottish Government, 2016). As part of a wider programme of public health reform, the Scottish government published a new set of Public Health Priorities in 2018, and launched a new agency - Public Health Scotland - to lead the co-ordination and delivery of public health functions in April 2020. Unfortunately this timing coincided with the outbreak of the Covid-19 pandemic, which immediately became a top priority for the new agency.

In the meantime, Scottish First Minister Alex Salmond's second government became focused on campaigning for Scottish independence ahead of the 2014 referendum, which it did partly on anti-austerity credentials (Camp-Pietrain, 2017). The SNP's white paper promoting independence, Scotland's Future (Scottish Government, 2013), highlighted that Scottish life expectancy was lower than in the rest of the UK, associated this with Westminster government policy choices, and claimed that independence would provide greater powers to improve the nation's health. It also boasted of some of the public health achievements of devolution, particularly being the first UK nation to implement legislation to ban smoking in enclosed workplaces and public spaces (Smith & Collin, 2013).

After the unsuccessful referendum, new First Minister Nicola Sturgeon announced her intention to pursue an inclusive economic growth agenda (Scottish Government, 2015) and launched several separate initiatives to deal with poverty and inequality (Poverty and Inequality Commission, 2019). High-profile universalist policies such as extended free childcare provision and free baby boxes provide early years support likely to be beneficial to lower-income families, in keeping with recommendations for 'proportionate universalism' (Marmot et al., 2010). The Scottish government also implemented a minimum

unit price on alcohol to reduce the availability of high-strength, low-cost drinks (Mooney & Carlin, 2019).

1.6 Health inequalities resume widening

Recent data from England and Scotland suggest that health inequalities have widened over the last ten to fifteen years. In England, inequalities in life expectancy have increased since 2010, particularly for women; regional inequalities are growing; and life expectancies have decreased for both men and women in many of the most deprived neighbourhoods (Marmot et al., 2020a). In Scotland, life expectancy trends that were improving between 2000 and 2012 have since stalled or worsened (Miall et al., 2022), while the gap in premature mortality between the most and least deprived areas became bigger in 2021 than any time since measurement began in 1997 (Scottish Government, 2023c). This short sub-section shall describe the key causes of widening health inequality: the UK government's economic austerity agenda; and the Covid-19 pandemic and following 'cost of living crisis', the outcomes of which are not yet reflected in many statistics.

1.6.1 Economic austerity

The coalition government's austerity-based response to the global financial crash of 2008 were framed to be part of "*Britain's unavoidable deficit reduction plan*", announced as part of the "*emergency Budget*" one month after the 2010 election (HM Treasury, 2010, p1). The Budget aimed to "*rebalance the economy*" with £32 billion of annual spending reductions, around a third of which would be "*welfare reform savings*" (HM Treasury, 2010, p2). These economic policy decisions are highly relevant for health inequalities because they concern key economic and social determinants of health (Bambra et al., 2015; Marmot et al., 2020a).

Most of the spending reductions were in local authority budgets. The National Audit Office reported that local authority spending power reduced 28.6% in real terms between 2010 and 2018 (National Audit Office, 2020). In 2019, the Local Government Association (LGA) estimated there would be a funding gap of £949 million for children's services by 2020, tripling to over £3 billion by 2025 (Leighton, 2019). This includes funding cuts of around two-thirds to Sure Start centres, at least 500 of which had to close (Cattan et al., 2019).

The LGA analysis also estimated a local authority funding gap of nearly £500 million for public health services. Two years after the beginning of austerity policies, responsibility for public health was moved to local authorities by the Health and Social Care Act 2012. But the increasing demand for social care meant that funding cuts to local authority budgets had particularly severe effects public health services (National Audit Office, 2020).

Further, austerity policies of the coalition government led to relatively bigger local authority budget cuts in areas with poor health and deprivation, compared to areas with better health (Taylor-Robinson et al., 2013). This disproportionate reduction of investment from poorer areas would be expected to increase inequalities, including health inequalities.

In addition to local authority cuts, the coalition government made spending reductions by adjusting welfare entitlements. Payments to welfare claimants were reduced by almost £14.5 billion per year (Beatty & Fothergill, 2018). Around half of that total came from changes to eligibility and payment rates for child tax credits, working tax credits, and child benefit. Therefore, Browne & Elming (2015) found that lower-income households lost the most proportionally, particularly those with dependent children. Beatty & Forthergill (2018, p963) concur that "*by and large it is the poorest places that have been hit hardest*", because losses were concentrated in areas with more welfare claimants.

Therefore, in both local authority budgets and in welfare provision, austerity-era spending reductions reduced investments most in more deprived areas, and reduced support most for children's services and families with children. These policies, while not forming any part of a public health or health inequalities plan, must be expected to have important long-term impacts on both, given that reducing poverty and supporting children have been key policy recommendations to reduce health inequalities since the Black report (Acheson, 1998; Marmot et al., 2010). Research collated by Bambra (2019) used ethnographic and epidemiological methods to assess the harmful impacts of austerity on residents of one English town; while McCartney's doctoral thesis gathered detailed evidence to show that austerity policies "*have substantial negative impacts on mortality*" (2022, p237).

1.6.2 The Covid-19 pandemic and aftermath

The novel coronavirus pandemic that spread through the UK in the early months of 2020 was quickly recognised as posing unequal threats (Bambra et al., 2020; Marmot & Allen,

2020). Unfortunately, some aspects of the policy response that sought to protect overall population health may also have produced unequal outcomes (Bambra et al., 2021).

For example, key workers – disproportionally female, ethnic minority and low-paid - continued to work in higher-risk collective spaces, while well-paid professionals were told to work safely from home (Gustafsson & McCurdy, 2020); while schools were closed to contain the spread of the virus, inequalities in access to learning resources meant many children could not adequately continue their education (Montacute & Cullinane, 2021); and a 'colour-blind' approach to vaccination was taken despite evidence of worse Covid-19 outcomes and higher vaccine hesitancy among black, Asian and minority ethnic (BAME) groups (Osama et al., 2021).

The rapid and radical policy response to Covid-19, including confining the public in their homes and forcing the closure of businesses and schools, seemed to demonstrate that seemingly infeasible policy interventions were in fact viable with public support in the face of an urgent threat. This provided a moment of hope that politicians might pursue approaches to 'build back fairer' (Marmot et al., 2020b), or to otherwise take a stronger approach to addressing inequality as a major population health hazard (McCartney, Leyland, et al., 2021). But no such stronger policy approach was apparent in a post-pandemic period marked by political instability and a sharp and prolonged increase in inflation that worsened economic inequalities further (Wernham et al., 2024).

This prolonged inflation, popularly known as the 'cost of living crisis', created a 'second health emergency' (Meadows et al., 2024). Between 2021 and 2024, consumer prices increased by over 20%, which was attributed variously to pandemic-related interruptions in supply chains, the invasion of Ukraine by Russia, and profiteering (Jung & Hayes, 2023; Francis-Devine et al., 2024). This inevitably spread and deepened economic hardship, including food and fuel poverty, and was expected to worsen population health significantly across the whole social gradient and particularly for more deprived groups (Broadbent et al., 2023).

1.7 Policy approaches to health inequalities elsewhere

Just as UK policy attention first turned to health inequality in the late 1970s with the commissioning of the Black Report, the World Health Organization (WHO) also launched its

Health For All agenda at a similar time (WHO, 1979). By the mid-1980s, all 33 countries of the WHO European Region had agreed to work to reduce health inequalities when agreeing the Targets for Health For All strategy (WHO, 1984). However, European countries varied significantly in the extent to which they proceeded to take action (Whitehead, 1998).

Several northern European high-income countries have developed national strategies to address health inequalities. A Swedish White Paper identified health inequalities as a social problem in 1984, acknowledged the social gradient of health outcomes, and explained the causes in terms of living conditions and behaviour (Vallgårda, 2007). In Denmark, health inequalities were not officially recognised until 1998 and were then conceptualised as originating in poor health behaviours (Vallgårda, 2007). Despite these differences in timing and conceptualisation, both countries published detailed strategies to tackle health inequalities in 2000 (Mackenbach & Bakker, 2003). The Netherlands began systematically researching the nature and determinants of its health inequalities in 1989, followed by a six-year program to evaluate various intervention options and develop a strategy by 2001 (Mackenbach & Stronks, 2004). Norway's governing Labour party published an ambitious national plan to reduce health inequalities in 2007, and reinforced it with a Public Health Act in 2012 that sought to implement a cross-sectoral Health in All Policies approach (see 1.6.1) at local, regional and national levels (Dahl & van der Wel, 2015).

In both Sweden and Denmark, relative inequalities in mortality by education have continued to increase during the first part of this century, though absolute inequalities appear stable (Mackenbach et al., 2018). The same pattern held for income-based inequalities in life expectancy in Denmark, except for a sharp increase in life expectancy for low-earning women, possibly due to Danish labour market policies (Bronnum-Hansen & Baadsgaard, 2012). In the Netherlands, Gheorghe et al. (2016) reported that relative inequalities by education in both quality-adjusted and unadjusted life expectancy widened between 2001-2011. The ambitious Norwegian plan "*produced few tangible results*" (Arntzen et al., 2019), and while work is ongoing to improve implementation of the HiAP aspect of the Public Health Act, the newly elected centre-right coalition government has been less supportive (Bekken et al., 2017).

The above countries form a small group, with the UK and few others, that have made a significant effort to reduce health inequalities on a national scale. But it is often a temporary one, as successor political parties may change direction. Globally, the dominance of neoliberal economic ideologies, which promote the primacy of the free market and individual responsibility for issues such as health, employment and poverty, holds policy windows for effective upstream interventions closed (Collins et al., 2015; Schrecker & Bambra, 2015).

1.8 What other policy approaches have been proposed to address health inequalities?

Evidently it remains extremely difficult to successfully reduce health inequalities. Even for governing parties who wish to act, the continuing practical difficulties of successfully tackling health inequalities must be discouraging. An analysis of five global examples of when health inequality has successfully been reduced – the post-war establishment of social democratic welfare states in Scandinavia; the War on Poverty and Civil Rights Acts in 1960s USA; Brazil's democratisation in the 1980s; the reunification of East and West Germany in the 1990s; and New Labour's English health inequalities strategy, described above – indicate the scale of sustained political action required (Bambra, 2021).

In this sub-section, I shall introduce two important suggestions for more suitable policy approaches: new procedural approaches to ensuring that health is considered in all relevant policymaking; and entirely new approaches to economic policy. Both approaches are discussed in more depth in the next chapter, the literature review.

1.8.1 Health in All Policies

As described above, social and economic policy determine health outcomes on a far grander scale than narrowly defined 'health' policy can on its own (McLaren & Dutton, 2020), but the broadening of institutional responsibility for health has proved difficult to operationalise. There are good reasons why policymaking organisations require specialised departments: so that staff can focus their knowledge and skills, build team relationships, and have clear vertical lines of accountability (Pollitt, 2003). Unfortunately, internal

boundaries can make horizontal collaboration across departments challenging (Smith, 2013b). Attempts to foster 'joined-up government' for cross-cutting issues such as health inequalities have been long-term challenges, in many settings (World Health Organization, 1978; Exworthy & Hunter, 2011; de Leeuw, 2017).

One of the key proposed solutions to this challenge is Health in All Policies (HiAP), "*an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies and avoids harmful health impacts, in order to improve population health and health equity*" (World Health Organization, 2012). Both the Acheson Report (1998) and Marmot Review (2010) recommended a version of this general idea, but implementation has varied internationally.

In South Australia and in English local government, public health experts collaborate with social and economic policymakers to look at policies 'through a health lens', without forgetting the social and economic policy objectives (Lawless et al., 2012; LGA, 2016). In California and Finland, policy organisations have created interdepartmental bodies to facilitate co-ordination on cross-cutting priorities (Greer, 2012). In the US, Hall & Jacobson (2018) found broadly positive responses to HiAP from policymakers, including a common view that it focused their attention to health inequality issues.

A related approach is to mandate the completion of a Health Impact Assessment (HIA) (Kemm, 2001) for each proposed policy, ideally with an equity focus; such an approach was the first key recommendation of the Acheson Report (1998). A Scottish Health and Inequalities Impact Assessment Network (SHIIAN) has promoted the use of HIAs in Scottish policy for more than twenty years (Douglas & Oldcorn, 2023), with members producing work on affordable homes (Higgins et al., 2017), road space reallocation (Douglas et al., 2023) and other topics.

However, as with other approaches to co-ordinate collaboration between sectors, HiAP approaches have faced multiple challenges to successful implementation. For example, legislation in Norway to embed HiAP processes in all national, regional and local authorities was insufficient to persuade all stakeholders to fully engage with the processes (Greszczuk, 2019). Issues of leadership, ownership and accountability are persistent difficulties when trying to deal with complex and cross-cutting issues such as health inequalities (Guglielmin et al., 2018). A workshop held in Scotland to discuss how local government approaches HiAP found mixed experiences, with extra resources required for stakeholders to have the

capacity and time to build relationships across departments (Douglas, 2020). In England, while local governments are increasingly developing HiAP approaches, they have not been supported to do so by central government (LGA, 2020b).

There are also questions about the framing of HiAP. Researchers in Australia have found that health equity can be subordinated to health in HiAP agendas (Van Eyk et al., 2017), which was characterised as 'equity drift' (Baum et al., 2019b). Kottke (2016) argues that 'Wellbeing in All Policies' would more successfully win public, political and stakeholder support than the narrower concept of 'health'; this proposal was also discussed by participants in the local government workshop on HiAP in Scotland (Douglas, 2020).

1.8.2 Inclusive Economic Growth

More recently, there has been consideration of a further alternative approach that involves rethinking macroeconomic strategy, as the economic conditions of a place are important determinants of its population's health. The famous 'Preston curve' shows a robust positive relationship between a country's average national income and its average life expectancy, which is much stronger at lower levels of income, and greatly diminishes for rich countries such as the UK (Preston, 1975). At least some of the variance in high-average-income countries is explained by inequalities in the distribution of income, because the social problems and psychological effects caused by inequalities have a myriad of health impacts (Wilkinson & Pickett, 2009, 2020).

However, in recent decades many countries have pursued macroeconomic policies aimed squarely at improving average national income, usually expressed as Gross Domestic Product (GDP) per capita. This strategy assumes that wealth generated anywhere within a society will "trickle down" to where it is not generated, as the wealth is consumed and distributed through a society (Akinci, 2018). But this has proved not to be the case. Instead, the wealthy have accumulated more wealth, facilitated by neoliberal macroeconomic policies that have globalised trade and deregulated markets, including financial markets (Piketty, 2013). These policies also contributed to the global financial crisis in 2008. Despite this disastrous outcome, and the global inequalities that continue to worsen, there has not yet been a paradigm shift in macroeconomic logic (Blyth, 2013).

Recently, new economic policy agendas have emerged claiming to shift the focus of economics in a more social direction. Inclusive growth "*refers both to the pace and pattern of [economic] growth, which are considered interlinked, and therefore in need to be addressed together*" (World Bank, 2009, p2). Definitions and elaborations are still actively debated, but at the core is a repudiation of the 'trickle down' assumption, meaning that the distribution of economic benefit must be built into economic planning. Naik et al. (2020) elaborate five features of inclusive growth compared to conventional economic policy: it prioritises bottom-up, locally rooted development, rather than top-down or external investment; it is concerned with various goals, including those of wellbeing, rather than profit only; it is led by local collaboration and priority-setting; it creatively uses a range of policy tools to shape markets; and it ensures that people and places are not forgotten or excluded.

The first economic strategy of the Scottish government after the referendum defeat in 2014 (Scottish Government, 2015) made inclusive growth one of its four broad priority areas, alongside investment, innovation, and internationalisation. Several UK cities and newly devolved city-regional authorities have also indicated interest in developing inclusive growth approaches, including Belfast City Council, Cardiff Council, the West Midlands Combined Authority, and the Greater Manchester Combined Authority (IGN, 2024). The unique set of devolution deals for the latter - which includes public services, transport, housing, policing, and responsibilities for health and social care (Sandford, 2024) - makes it a particularly intriguing new setting for combined interests in inclusive growth and health inequality at the city-region scale (McKenna, 2016).

In addition to ongoing debates over the specific detail and functioning of inclusive economic growth policies, the foundational concept of economic growth itself has been challenged. Proponents of sustainable development have argued that growth is not sustainable as it cannot be infinitely achieved on a planet with finite resources (Jackson, 2016). This line of thought has been developed into 'doughnut economics', which envisions an economic system balancing human needs and planetary boundaries (Raworth, 2017). A related concept is 'degrowth' (Cosme et al., 2017), which advocates the reduction of economic activity in developed countries to promote global social equity and

environmental sustainability. These debates have led some to prefer 'inclusive economics' to 'inclusive growth' to step around uncertainties around the viability of growth itself.

1.8.3 What further research might help inform policy approaches to health inequalities?

One of the main explanations for the disappointing outcomes of New Labour's health inequalities strategy was a lack of sufficient evidence for the effectiveness of specific policies and interventions (Bambra et al., 2010; Mackenbach, 2010, 2011). Therefore, further evaluative evidence may be useful to the further design and funding of policies and interventions. However, a focus on evaluability may push policies and interventions downstream, as individual- or behaviour-based interventions are perceived as easier to evaluate (Garthwaite et al., 2016). Further, insisting on evidence meeting a very high standard of proof may, deliberately or otherwise, lead to policy inertia, as has long been evident with climate change policy (Oreskes & Conway, 2011). As described in 1.2.2, inferring causation from upstream policy interventions can be extremely difficult and subject to challenge from parties motivated to challenge it. Evidence must always be interpreted by individuals and institutions with both micro- and macro-political motives (Parkhurst, 2016).

For that reason, many health inequalities researchers have turned to more political theorizing, including discussion of how researchers can advocate appropriately for policy action (Smith & Stewart, 2017) and research elaborating how public sentiment about health inequalities can be better understood and supported to promote stronger political action (Baum et al., 2020). Qualitative research does not suggest that public understanding of social determinants of health is lacking; however, some may reject structural explanations for poor health which diminish the sense of personal agency and are therefore felt as disempowering (Smith & Anderson, 2018). Relatedly, neoliberal discourses may have shaped perceptions that responsibility for health lies with the individual rather than the state (Peacock et al., 2014; Garnham, 2015). Developing further understandings of political processes may ultimately contribute more to moving health inequalities policy forward than more empirical evidence confirming further the existence of such inequalities, or more evaluative evidence of specific intervention outcomes. If the maxim 'where there is a will,

there is a way' is at all meaningful, then it must be a key interest of researchers and advocates to understand the forces that shape political will.

Nevertheless, in the current political environment, where there is little evidence of publics clamouring for political action on health inequalities, inaction remains preferable for many national governing authorities. However, governing takes place in various settings: both horizontally, across departments, and vertically, at national, regional, city and other levels. Much preceding health inequality policy analysis has focused on analysing policy texts or interview data from national health departments, particularly in the UK following New Labour's strategy (Graham, 2009; Baum et al., 2013; Kriznik, 2015; Kriznik et al., 2018; J. Lynch, 2016, 2017, 2020; J. Lynch & Perera, 2017; Maybin, 2015, 2016; Povlsen et al., 2014; Smith, 2007, 2013a; Smith et al., 2009; Vallgårda, 2007, 2008). This is by no means surprising, but given the wide range of policy determinants of health across departments and levels of government, and considering policy commitments at sub-state levels to cross-departmental agendas such as HiAP and IG, a broadening of analysis might usefully illuminate opportunities for effective policy action even during periods of national or health department policy inertia.

This particularly applies to economic departments, which are severely under-represented in health inequalities policy research. The potential for inclusive economic approaches to improve health and reduce health inequalities has now been raised in several quarters (James et al., 2017; LGA, 2018; Malmusi et al., 2018; Naik et al., 2020). In March 2021, Public Health England released a report identifying inclusive and sustainable economic development as a way to reduce health inequalities in the post-Covid context (PHE, 2021). But how social and economic policymakers working on pro-equality agendas consider systematic variations in population health is far from clear.

Therefore, this thesis aims to contribute important new insights to understandings of policy approaches to systematic variations in population health, by broadening the analytic lens to consider how a range of policymakers in devolved policy settings conceptualise 'health', 'inequalities' and 'health inequalities'.

1.9 Research Aims and Questions

My overall aim is to explore how policymakers in different teams within the devolved policy settings of Scotland and Greater Manchester consider systematic variations in population health. Within this broad aim are the following more specific questions:

- RQ1: How is health conceptualised by social, economic and health policy teams in these devolved settings?
- RQ2: How are inequalities conceptualised by social, economic and health policy teams in these devolved settings?
- RQ3: How is 'health inequality' conceptualised in these social, economic and health policy teams in these devolved settings?
- RQ4: What are the implications of these findings for efforts to reduce systematic variations in population health in devolved settings?

1.10 Thesis structure and Outline

This introductory chapter 1 has provided a high-level overview of policy approaches for health inequalities in the UK over the last four decades. In the next chapter, the literature review, I will discuss in more depth the literature regarding some of the specific issues around health inequalities policy development, including: upstream and downstream policies; the 'lifestyle drift'; some known limitations of health department policymaking; policy framing; ideational approaches; and the potential problem with 'health'. Therefore, the purpose of this first chapter has been to set the scene broadly, and the purpose of the second chapter is to analyse what the academic literature says about these issues, and the rationale for the present research to contribute further to it. In the third chapter I shall describe in detail the methods for the original research undertaken for this purpose.

The second half of the thesis describes and contextualises the results from the present research, with analysis of how it enhances the body of knowledge already generated by other researchers. The fourth chapter is a brief results chapter that seeks to clarify the relationship between paradigms, ideas and frames, and to situate these relationships in three examples from my data. Chapters 5 and 6 then explore two key meanings of 'health' within policy settings, while chapter 7 discusses the meanings and uses of 'inequality'. In

the eighth chapter, three competing 'health inequality' policy frames are identified and discussed, with key implications for future policy approaches to systematic variations in population health. Chapter 9 discusses the implications of these findings in more depth, including by discussing alternative potential policy agendas to 'health inequalities'. In the tenth chapter, I synthesize my findings specifically in regard to the research questions, and draw final conclusions about implications for policy, practice and research.

Chapter 2 - Literature Review

2.1 Introduction to Literature Review

The Introduction chapter provided a broad, contextual overview of the main interests and themes of this thesis. Following that breadth, this literature review chapter will now aim to provide more depth. This chapter discusses relevant academic literatures thoroughly, in a sequence that highlights what is understood, and what could be understood better, about policy approaches to health inequalities in the UK.

Firstly, this literature review will outline the policy approaches to health inequality that are implied or recommended by research on health inequality. To deal with the vast scale of research with policy implications for health inequalities, I 'zoomed out' to concentrate on the major landmarks of this literature. In this case, that means focusing on the major health inequality reports introduced in the previous chapters - reports led by Black (1980), Acheson (1998), Marmot (2010), and Marmot again (2020a) – with further discussion of literature influenced by, or cited by, these key texts.

Then, in section 2.3, I take a thematic approach to discussing how policymakers in the UK have approached health inequalities in practice. This is a more limited literature, and therefore I am able to discuss it in more depth. For this section, I analysed around fifty academic texts which empirically or theoretically analyse specific policy approaches to health inequalities in the UK, using qualitative data analysis software to code them thematically. Reflecting the slow problematization of health inequalities described in the first chapter, culminating in New Labour's development of a cross-cutting national strategy to tackle health inequalities in England, all but two of these texts were published after 1997.

As many of the policy approaches proposed by research require policy teams to work in a 'joined-up' way, for section 2.3.5 I conducted a separate thematic review of literature on a key method of collaborative policymaking for health: Health in All Policies (HiAP). As with section 2.2, I primarily reviewed key texts and evidence reviews to understand the contours of the vast HiAP literature and its specific themes discussing operationalisation and relational issues. This section on HiAP is included within 2.3 due to its significant overlap with the 'joined-up government' theme of policy approaches to health inequality, but a key

finding from this literature is that Health in All Policies approaches are concerned with health, and not necessarily with health inequality.

Section 2.4 then looks at alternative approaches to health inequality policy in two distinct sub-sections. Firstly, I 'zoom in' to pay especially close attention to one particular analysis, recently developed by Julia Lynch (2017, 2020), that critiques 'health inequalities' as a framing. As described in the Introduction chapter, policy approaches to health inequalities have had limited success, with both English and Scottish strategies afflicted by a downstream drift from population-level social and economic causes towards individual-level healthcare and behavioural solutions. Further, collaboration across government remains challenging, with researchers identifying 'equity drift' when the focus is on 'health' in all policies (Baum et al., 2019b). Lynch's analysis contributes to understanding these drifts, and so has very important implications for health inequalities policy, and for this thesis. Finally, I review literature about recent 'inclusive' or 'wellbeing' approaches to social and economic policy. This literature is nascent, cross-disciplinary and remains somewhat nebulous. However, in light of recent policy interest in these ideas at devolved and local levels within the UK, and the potential impact of these ideas on policy approaches to health inequality, I considered it important to address. Therefore, I delineated the literature narrowly, reviewing key texts and papers specifically relevant to UK devolved and local contexts. As with HiAP, I found a literature full of good intentions but facing both political and practical challenges.

2.2 What policy approaches to reducing health inequalities are suggested by research?

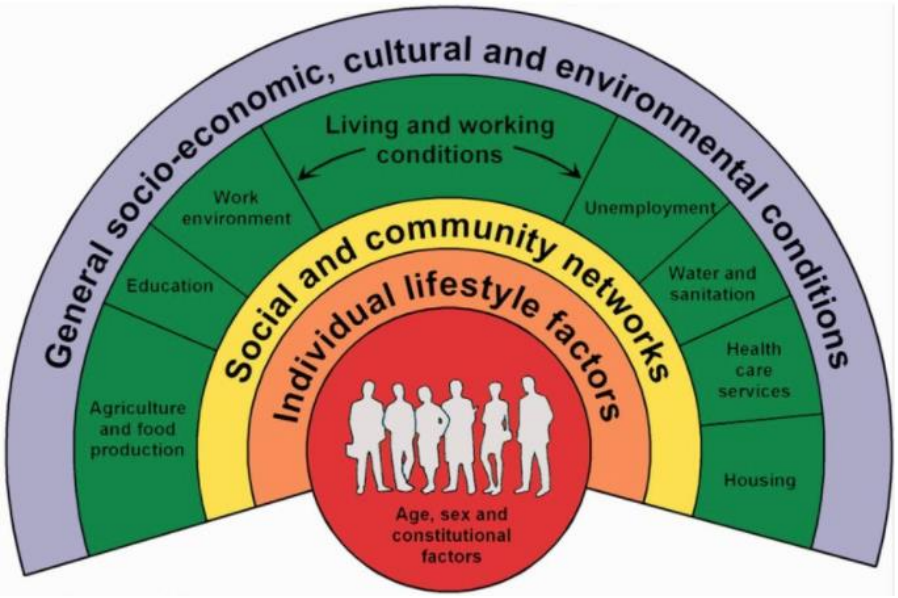
As described above, there is a vast health inequalities literature that could imply particular policy responses. In this section I will use four major UK-based reports – those led by Black (1980), Acheson (1998), Marmot (2010) and Marmot again (2020a) - as 'key texts' to orientate this brief review of research-based proposals for policy responses to health inequalities. These four reports were all briefly introduced in Chapter 1, but this chapter

considers what each says about the developing evidence base and related policy responses in more detail.

Previous reviews of these reports have highlighted the similarities between Black (1980) and Acheson (1998) (Birch, 1999; Marmot, 2001), and Bambra et al. (2011, p404) further comment that the Marmot Review (2010) provides "*remarkably similar*" policy recommendations again, despite the decades of research, policy and political developments between them. Marmot et al. (2020a) strikes a notably pessimistic tone about population health trends and political willingness to address them: unlike the first three reports, each commissioned by a Labour government, Marmot et al. (2020a) was commissioned by a charity (The Health Foundation), following a decade of economic austerity under Conservative-led government. However, by retaining five of Marmot et al.'s (2010) six key principles for policy, it too treads a broadly similar path.

Each of the four reports gathered extensive empirical evidence to construct multi-causal explanations for health inequalities. The Black Report acknowledged some behavioural or healthcare-related impacts on health but emphasised material factors, such as differences in income and access to goods and services. This expansion of health causation to a range of socio-economic determinants of health - supported by a huge amount of further evidence generated afterwards - was the basis of the social model of health adopted in the other reports as fundamental to understanding and addressing health inequalities. A WHO Europe paper for interested policymakers (Dahlgren & Whitehead, 1991) conceptualised different layers of the social determinants of health in a rainbow-style image (Fig.2a, below) that was adopted by Acheson (1998) and remains widely influential. The social model of health that follows from this evidence implies three important policy principles: addressing the social gradient, intervening upstream, and collaborating across sectors.

Fig.2a Rainbow model of Dahlgren & Whitehead (1991)



Firstly, epidemiological evidence consistently shows that inequalities in health outcomes follow a social gradient, meaning that everyone is affected, not only the most disadvantaged (Marmot et al., 2010). Despite this, health inequalities are often framed not as following a gradient but as 'health gaps' (Black, 1980; Marmot, 2015) or 'health divides' (Dahlgren & Whitehead, 1991; Bambra, 2016). The health 'gap', 'divide' or related 'disadvantage' conceptualisations imply targeting intervention at identified high-risk groups, whereas the 'health gradient' framing implies broader intervention (Graham, 2004b). For example, the Black Report recommended tackling health gaps with "*a comprehensive anti-poverty strategy*", arguing that at low levels of income individuals may be exposed to "*multiple deprivation[s] in diet, housing and environmental amenities, leisure activities and at work*" (para 9.3). But the Marmot Review (2010) argued that a disadvantage approach is insufficient as it allows the preventable ill-health of the rest of society: "*what about those just above the bottom or at the median, who have worse health than those above them?*" (p41). Therefore, Marmot et al. (2010) proposed a 'proportionate universalism' approach to policy, which entails universal action "*but with a scale and intensity that is proportionate to the level of disadvantage*" (p16). Marmot and colleagues' ten-year update (2020a) reinforced the need for universalist but proportionate responses to "*be sensitive to the gradient*" (p7) and described the austerity agenda as running counter to that aim.

Secondly, the social model of health implies that addressing causal factors in the outermost arcs of Dahlgren & Whitehead's rainbow (Fig. 2) is likely to be far more effective than addressing inner arcs. A similar conceptualisation is of 'upstream' and 'downstream' factors, originating in McKinlay's (1975) parable about curative healthcare workers rescuing individuals from drowning in a river, while preventive public health looks upstream to prevent them falling in the river in the first place. These models that layer causation can be seen in, for example, the Black Report's discussion of the social patterning of cigarette smoking, which concluded that: "*smoking behaviour cannot be taken as a fundamental cause of ill-health, it is rather an epiphenomenon, a secondary symptom of deeper underlying features of economic society*" (para 6.85). Acheson (1998) recommended both 'upstream' and 'downstream' interventions (p11), while twice noting that the latter are likely to have narrower impacts. The Marmot Review (2010) repeatedly referred to the need to address "*the causes of the causes*" (p39, p60, p140, p148) and Marmot et al. (2020a) also request "*action on the causes of the causes of ill health; focussing only on the downstream effects* [health behaviours] *will be less effective*" (p127).

Further research has facilitated theory development on upstream determinants of health. Link and Phelan (1995) review dozens of medical sociology and social epidemiology studies from the post-Black Report period to highlight that, regardless of the disease or risk factor, socioeconomic advantage is associated with better health outcomes: thus, they conclude, socioeconomic inequality must be a fundamental cause of disease. Since then, Phelan et al. (2010), Hatzenbuehler et al. (2013), and McCartney et al. (2021) have respectively suggested racism, stigma and power as fundamental causes of disease, implying a need for much stronger policy responses to address social hierarchies.

Third, the social model of health that follows from the evidence gathered in and since the Black Report implies that policies not directed at health nevertheless have important health impacts. The Black Report recommended policies to reduce poverty and improve working conditions and housing; the Acheson Report additionally recommended reducing inequalities in income and educational achievement and providing affordable, high-quality public transport. Both Marmot-led reports (2010, 2020a) described "*create fair employment and good work for all"* and "*ensure a healthy standard of living for all"* as key policy objectives. This all implies that health departments cannot reduce health inequalities alone; action is also required from policy departments other than health. Indeed, of

Acheson's 39 main recommendations, only three were healthcare-related (Exworthy, 2003).

How to co-ordinate health and social and economic department policy has been a recurring challenge. The Black Report suggested a "*comprehensive and interlinked*" social and economic strategy (para 9.2) but said little more by way of detail. On the other hand, the Acheson Report's first key recommendation was that "*all policies likely to have an impact on health should be evaluated in terms of their impact on health inequalities*". A review by O'Neil et al. (1997) found that, in the intervening years, a new literature within health promotion had coalesced around the importance of intersectoral health-related action, but had struggled to specify how to achieve it. Subsequently, health impact assessments (HIA) were encouraged (Lock, 2000), ideally with a strong equity perspective (Douglas & Scott-Samuel, 2001), and from this thread emerged the Health in All Policies approach (Stahl et al., 2006). However, Marmot et al. (2010) encouraged a 'whole system' approach led by national government and the Department of Health, similar to that just attempted by New Labour. By 2020, Marmot et al. were unimpressed by the implementation of HiAP, criticising it as comprising "*cumbersome*" and "*time-consuming*" "*tick-box"* assessments, having too much focus on healthcare, and for its tendency to forget about equity (p134). Instead, they advocated health-equity-in-all policies (HEiAP), as Acheson (1998) had done, including required assessments. However, while this may ensure more focus on equity, Marmot et al. (2020a) do not address how their first two criticisms of HiAP can be avoided by HEiAP.

As discussed by Bambra et al. (2011) over a decade ago, the similarities in recommendations between the first three reports suggested both academic consensus and policy inertia. They wrote:

> *"A radical shift in thinking and in actions is needed to ensure that, in 2020 and beyond, the exact same criticisms are not being levelled at official responses to the Marmot Review's recommendations"* (Bambra et al., 2011, p403)

In 2020, Marmot et al. make clear their criticism of official responses: not merely that they represented inertia or ineffectiveness, but that many subsequent policies "*have run counter to the Marmot Review's recommendations*" (p8). Therefore, while Marmot et al. (2020) includes up-to-date epidemiological data and discussion of newly salient topics such as zero-hour contracts, the threat to jobs of automation, and food insecurity, all the broad

recommendation principles in Marmot et al. (2020) are repeated from Marmot et al. (2010): give every child the best start in life; enable all to maximise their capabilities; fair employment and good work for all; healthy standards of living for all; and healthy and sustainable places and communities. Therefore, the "*radical shift in thinking and in actions*" has not occurred; or at least, not in the direction hoped for by Bambra et al. (2011).

What explains the apparent divergence between the strength of the evidence-base for policy to reduce health inequalities and the policy approaches taken? A common explanation in the literature is that the academic consensus *implies* policy responses, but evidence that *demonstrates* the effectiveness of specific policies and interventions is lacking. For example, in their search for evidence to support Acheson's recommendations, MacIntyre et al. (2001, p224) found a "*disappointing*" lack of evidence about the effectiveness of specific policies or strategies in reducing health inequalities. This was also identified by New Labour policy documents (Department of Health, 2002, 2008), in chapters 3 and 4 of the Marmot Review (2010), and was later proposed as a key reason for the apparent failure of New Labour's strategy in two comment pieces (Mackenbach, 2010, 2011). Even when successful historical examples of reducing health inequality are identified, demonstrating which specific policies were key remains challenging (Bambra, 2022). As noted by Acheson (1998, p18), interventions to address upstream policies are more difficult to evaluate with the preferred research methodologies. This was described as an "*inverse relationship*" by Nutbeam (2003a, p156), who had been in charge of developing New Labour's health inequalities strategy.

Therefore, a series of systematic reviews and umbrella reviews (systematic reviews of systematic reviews (Papatheodorou, 2019) have attempted to rigorously analyse intervention evidence with the aim of clarifying policy options. Bambra et al. (2010) conducted an umbrella review of systematic reviews of interventions aimed at the two outermost arcs of Dahlgren & Whitehead's rainbow (Fig.2, above). Illustrating the difficulty of evidencing upstream interventions, the authors were not able to find any reviews of interventions aimed at the outermost arc. However, in thirty systematic reviews they did find suggestive evidence of positive health outcomes from specific housing and work environment interventions. The authors also concluded that the evidence-base was mixed and unclear at this level.

Lorenc et al. (2013) found evidence from just twelve reviews to support the principle that downstream interventions may increase inequalities in health behaviours, while upstream interventions can reduce such inequalities. Therefore, even effective upstream interventions could be undermined by counteracting downstream interventions. Thomson et al.'s (2018) similar umbrella review of public health interventions found many more reviews - twenty-nine – and found several options for interventions that may reduce health inequalities, including taxes on unhealthy foods, regulated tobacco promotion, and water fluoridation.

Naik et al. (2019) conducted a broader umbrella review of sixty-two systematic reviews of relationships between macro-economic exposures and health outcomes. It concluded that evidence provided clear recommendations for the market regulation of health-harming products and for unemployment support and prevention. There was also suggestive evidence of associations between left-of-centre, social democratic and welfare state-based economic approaches and reduced health inequalities. However, while economic conditions are shaped by interventions, many policy actors do not accept the causal links between those interventions and health outcomes.

For some, this point about acceptance is key. Some researchers – described as "*critical materialists*" by Garthwaite et al. (2016, p474) based on discussions at a health inequalities symposium – look to sociology and political theory to understand why powerful actors do not act on the "*undisputed*" evidence connecting social, economic and health inequalities. From this perspective, whether the evidence is insufficient, or indisputable, is a matter of political interpretation.

2.3 How does available evidence assess policy responses to health inequalities in the UK?

In this section, I will synthesise and critically appraise the literature describing how policymakers have attempted to address health inequalities in the UK, based on a thematic analysis of around fifty texts. As described in the first chapter, health inequalities were not addressed as a policy problem by any pre-Black Report UK government, nor by the

subsequent Conservative governments of Thatcher or Major. Therefore, the health inequalities literature was almost entirely descriptive of the problem – and not of policy approaches to it – until the late 1990s.

Most of the literature about policy approaches to health inequalities in the UK is focused on New Labour's national strategy for England that developed in the years after their 1997 election victory. But there are also several important papers, produced by a team led by Tim Blackman, that take a comparative view of the strategies developed by England and the devolved governments of Scotland, Wales and Northern Ireland. This research often finds similarities in the issues faced by each government, and their chosen policy solutions to them.

A closely related literature with specific issues concerns Health in All Policies (HiAP), a form of joined-up governance. In this section I shall review five major themes of the health inequalities policy literature in turn. They are:

2.3.1: lifestyle drift

2.3.2: health disadvantage

2.3.3: performance management

2.3.4: evidence-based policy

2.3.5: joined-up government (and Health in All Policies).

2.3.1 Lifestyle Drift

'Lifestyle drift' is a key critique in the literature about UK policy approaches to health inequalities. As introduced in section 1.3.2, lifestyle drift is the tendency for governments to acknowledge the wider determinants of health inequalities implied by the social model of health, but then favour interventions aimed at individual behaviours based on the medical model of health. A broader term is 'downstream drift': for when upstream population-level problems are followed by downstream individual-level solutions such as healthcare or behaviours. Either way, individual-level interventions are unlikely to successfully reduce health inequalities, and therefore this tendency to drift is a fatal flaw for health inequalities

policy agendas. There are multiple suggested explanations for this; lifestyle drift is a recurring critique throughout this review.

A significant 'shift' is widely observed to have occurred in New Labour's strategy around 2003-2004, from a strategy aimed at upstream determinants of health to a strategy aimed at individual behaviours (Dowler & Spencer, 2007; Smith et al., 2009; Kriznik, 2015). Several authors highlight the 2004 publication of the White Paper 'Choosing Health' as exemplifying this change, but signs of a drift were evident before Choosing Health. Davidson et al. (2003, p545) identified a "*subtle marginalisation*" of health inequalities with the publication of Saving Lives: Our Healthier Nation (Department of Health, 1999b), compared to its predecessor Green Paper, Our Healthier Nation (Department of Health, 1998). Davidson et al. situate this change in a media environment increasingly sceptical of the government's ability to implement its plans, positive about its downstream initiatives, and highly critical of concurrent NHS performance. Blackman et al. (2009, 2012) later found that Welsh targets for health inequalities were side-lined due to media pressures around NHS waiting list targets. Therefore, media focus on short-term healthcare outcomes appears to contribute to downstream drift.

Individualistic conceptualisations of health are tracked by Kriznik's (2015) doctoral thesis, which analyses English public health documents from 1980-2011. Using Carol Bacchi's WPR method of post-structural discourse analysis (Bacchi, 2009), Kriznik's title asks "*what's the problem of 'health inequality' represented to be?*". According to Kriznik, these documents conceptualised health inequalities in three ways which each implied different 'governable subjects': firstly, an 'informational' problematization aimed at individual 'responsible choosers'; then, a 'constraints' problematization with a 'constrained chooser'; then, a 'paternalistic libertarian' problematization with individuals portrayed as 'flawed choosers'.

Kriznik writes that New Labour adopted the social model of health by attempting to co-ordinate a cross-departmental strategy for health inequalities throughout their thirteen years in office (p132-134); and discussed at length the benefits of upstream action on health inequalities, such as on education, employment, and community empowerment (p134-139). Therefore, it appears clear that New Labour did – at least initially - problematize health inequalities according to the evidence that upstream action across policy departments was required.

However, Kriznik finds references to individual choices for health even within New Labour's idealistic first term texts (p134-135). She also finds that the problematizations changed before (from 'informational' to 'constraints') and during (from 'constraints' to 'paternalistic libertarian') New Labour's time in office, which points to deeper individualising forces. Health inequalities researchers have repeatedly highlighted individualising aspects of neoliberal economic regimes, including the promotion of individual responsibility and the medical model of health (Brown & Baker, 2012; Collins et al., 2015; Navarro, 2009; Rushton & Williams, 2012; Schrecker & Bambra, 2015). Some have also described New Labour's economic approach in neoliberal terms (Hay, 2004; Dorling, 2010).

Another individualising force may lie within policy departments. Kriznik's policy text analysis – like those by Smith et al. (2009), Harrington et al. (2009) and Smith & Hellowell (2012) – focuses on texts from national health departments. This may be entirely unsurprising given that national health departments have consistently been given responsibility for reducing health inequalities and have therefore taken a lead on strategy texts. However, Smith (2013a) describes how formal divisions of focus and responsibility between and within policy departments have 'institutionalised' an individualistic medical model of health. Her interviewees consistently suggested that:

> *"the location of responsibility for health inequalities with departments of health functioned to encourage the influence of ideas over which these departments had most control."* (p120)

In this sense, health department-led health inequalities strategies may inevitably produce downstream drift, including lifestyle drift, due to their institutional limitations. If this is the case, then health-department led strategies may inevitably fail to reduce health inequalities. This prompts the question: might efforts to reduce health inequalities be more effective if policy responsibility was situated in a department other than health? By exploring a social or economic inequalities agenda, this thesis aims to inform an answer.

2.3.2 Conceptualisation of 'health disadvantage'

As introduced in section 1.2.1, health inequalities may be conceptualised as reflecting a 'social gradient', consisting of 'health gaps' between groups, or as the particular 'health disadvantage' of deprived groups (Graham, 2004b). Analysis of policy texts found that all

four national governments of the UK conceptualised health inequalities in the same way during the 2000s: as a matter of health disadvantage, rather than an issue affecting the whole social gradient (Smith et al., 2009; Smith & Hellowell, 2012). Blackman et al. (2009, 2010) conducted 130 interviews with senior figures at local NHS, government and partnership level in England, Scotland and Wales and found similarly, with a particular focus on the need to improve the health behaviours of individuals living in deprived areas. Comparing policy texts with Blackman et al.'s interview data, Harrington et al. (2009) found few differences in the ways health inequalities were conceptualised between the countries.

As Graham and Kelly (2004) highlight, conceptualising health inequalities in terms of disadvantage rather than gradient has practical benefits for policymakers, including facilitating performance management processes such as targeting. Two Department of Health policymakers tell us directly in the literature the reasoning for New Labour's English national targets: Nutbeam (2003b, p44) writes that targeting "*is about ensuring that a higher proportion of the gains overall are made by those in poorer circumstances*"; and Earwicker (2007, p23) writes that the national targets announcement in The NHS Plan (Department of Health, 2000) was "*crucial in consolidating health inequalities as a priority across government, within the NHS, and with health and other professionals*". Nutbeam's comment refers to the proportionally larger disease burden suffered by the most disadvantaged groups (Deaton, 2003; Bramley et al., 2019). The disadvantage conceptualisation then facilitates targeting, which Earwicker referred to as a *"crucial"* tool to facilitate joined-up policymaking across departments.

Therefore, there are linked normative and practical justifications for policymakers to conceptualise health inequalities as 'health disadvantage'. However, gradient-based approaches tend to be recommended by researchers as they better reflect the full epidemiological picture of preventable disease burden (Marmot et al., 2010; Beeston et al., 2013; Arntzen et al., 2019). In particular, Marmot et al.'s (2010) aforementioned principle of 'proportionate universalism' encourages policies that are universal but with a scale and intensity proportionate to disadvantage.

Further, conceptualising health inequalities as arising from the poor health behaviours of poor people can obscure the social and economic determinants of those behaviours and the political choices that shape those determinants (J. W. Lynch et al., 1997; Katikireddi et al., 2013; O. Williams & Fullagar, 2019). Blackman et al. (2009, p769) report a "*surprising*

lack of scepticism about lifestyle interventions" among the health inequalities policymakers they interview despite the lack of evidence of their effectiveness. Just as policy documents can often articulate social determination of health but then advocate individual-level intervention ('lifestyle drift'), several researchers have found healthcare and public health professionals articulating social determination while attributing responsibility for health to the individuals they work with (Powell et al., 2017; Babbel et al., 2019; Mackenzie et al., 2020; Mead et al., 2020).

These "*well-meaning*" professionals are nevertheless "*sustaining a 'cargo cult' of health behaviouralism*", according to Scott-Samuel & Smith (2015, abstract), who blame the distorting effect of the neoliberal economic paradigm and its fixation on economic growth. Mackenzie et al. (2020) interviewed doctors in deprived areas of Glasgow and found similar inconsistent discourses of upstream determinants but individual responsibility for health. Echoing Scott-Samuel & Smith, Mackenzie et al. write that "*there is something about the pervasive weight of neoliberal rhetoric and practices that actively creates a cleavage between the social/population perspective and the individual/clinical*" (p7).

As aforementioned, many researchers have highlighted the individualising tendencies of neoliberal economics. Smith (2013) connects the dominant health and economic ideas, finding that both the medical model of health and the overriding priority of economic growth are 'institutionalised ideas' within the English and Scottish public health policy environments of her interviewees. Therefore, this literature suggests that individualised conceptualisations of health remain dominant in various expert public health and policy settings. By exploring social and economic department conceptualisations of health inequalities, this thesis may be able to clarify whether there are policy settings with other conceptualisations of health.

2.3.3 Performance Management

Blackman et al.'s (2006) project begins with a discussion paper that describes English policy's preference for top-down auditing processes as applied to the 'wicked problem' of health inequalities. In theory, only by establishing specific cross-departmental roles and responsibilities can policymakers focus on cross-cutting tasks. Further, in areas of uncertainty, auditing and evaluation processes allow evidence to be gathered about 'what

works'. But unlike 'tame' policy problems like NHS waiting lists, Blackman et al. write, health inequalities are poorly defined, continually evolve, have uncertain solutions, and result from many causal pathways. Therefore, performance management processes are an attempt to clear the "*fog*" (Klein, 2003) of health inequalities policymaking. The conceptualisation of health inequalities in terms of health disadvantage, as discussed above, was partly to facilitate performance management.

A series of further papers by Blackman et al. (2009, 2010, 2012) found a much stronger performance management culture in England than in Scotland or Wales. While Scotland set health inequalities targets in 2004, they were seen as useful rather than vital, and Scottish interviewees often criticised the suitability of targets for highly complex, long-term problems such as health inequalities. Wales also set health inequalities targets in 2004, but they were not quantified, and there was no systematic monitoring to track them (Harrington et al., 2009). On the other hand, England had more internal reporting requirements and interviewees were much more likely to discuss health inequalities in terms of targets.

Despite these differences, according to Blackman et el., (2009, 2012) in all three polities the performance management of health inequalities was distinctly secondary to 'hard' targets, such as financial limits and NHS waiting lists. This was partly because health inequalities was a 'black box' problem - regarded as a long-term concern with complex cause-effect connections - so under less control. It was also partly due to perceptions of media and public demand for the "*quick wins*" of NHS targets (2009, abstract). Welsh interviewees particularly highlighted unfavourable media comparisons with English waiting lists as driving their focus on improving local NHS performance. These findings were consistent with the views of local policymakers interviewed about implementing health inequalities policies from New Labour's central government in Exworthy et al. (2002). They write: "*The de facto relegation of health inequalities in performance management was associated with a distinction between the use of hard and soft targets*" (p79). Therefore, at both local and national level, this body of research suggests that health inequalities targets were always 'soft', partly due to complexity, and partly due to higher priorities.

Blackman's team's research also illuminates how attempts to meet targets for health inequalities led to policy interventions with measurable, short-term effects, rather than the more distant and complex effects of upstream interventions. For example, in Blackman et

al. (2009) policymakers frequently refer to health inequalities in disadvantage-terms while discussing targets and the relatively "*quick wins*" they could achieve with pharmaceutical interventions such as statins and nicotine replacement therapy. Evidence of short-termism associated with targets is also described in Blackman et al. (2010, 2012) and Bauld et al. (2007). In Qureshi's (2013) ethnographic research with New Labour health inequalities policymakers in 2006-07, she is told by two senior civil servants that the national life expectancy targets mean a requirement for "*something that will categorically have an effect*" on "*people who already have disease*" (p7). These examples demonstrate 'lifestyle drift': the policy move from upstream explanation to downstream intervention.

2.3.4 Evidence-based policy

As described in 1.3.2, New Labour publicly claimed to be pursuing a non-ideological agenda based on evidence-based policy (EBP) and 'what works'. Smith & Hellowell's (2012) analysis of policy documents found that Scottish, Welsh and Northern Irish health inequalities strategies also claimed to be based on evidence. As described in 2.1, a lack of evidence of 'what works' in terms of specific interventions for health inequalities has been highlighted as a serious problem for policymakers (Macintyre et al., 2001), and was proposed as one of the key reasons for the perceived failure of New Labour's national strategy (Mackenbach, 2010, 2011).

EBP has its own substantial literature discussing various issues (French, 2019). For example, Mulgan (2005, p224) argues that in democratic systems politicians "*have every right to ignore evidence*", and Cairney (2016, p127) says that we should *"recognise the legitimate role of politics*" in policymaking. Within the health inequalities policy literature, most of the evidence debate is over its nature and use rather than political preferences.

These dilemmas are shown in two residential workshops with health inequality actors hosted by Petticrew et al. (2004) and Whitehead et al. (2004). In the former, seven senior policymakers rejected the "*high concepts*" of EBP in favour of a "*mixed economy*" of different types of evidence (p813). In the latter, researchers thought that "*assembling an evidence jigsaw*" (p819) was helpful to policymakers, also suggesting a diversity of acceptable types of evidence. However, in the former case participants were critical of researchers, for their "*apparent obsession with bias, ambiguity and uncertainty in the*

evidence-base" (p814). Instead, these policymakers wanted timeliness, relevance, clarity, and the presentation of a "*good story*" (p812).

Petticrew et al.'s work was with a small number of health inequalities policymakers, but it chimes with three ethnographic studies in policy departments. Stevens (2011), on placement within an unspecified social policy department of the UK civil service in 2009, observes that there was a "*distaste for uncertainty, complexity and contradiction*" (p247) within his department, the former of which was "*the enemy of policy making*" (p243). Maybin (2016), based on interviews and observing meetings in England's Department of Health between 2009-2011, describes some policymakers as having "*an almost insatiable appetite for numbers and a misplaced faith in their simplicity and certainty*" (p106).

For Maybin, knowledge was partly "*a tool for persuasion*" in the political and social process of policymaking. Stevens' findings specify how 'evidence jigsaws' were assembled for persuasion, with Google searches "*widespread*" (p252) and acceptable evidence including TV dramas and personal experiences. This evidence was used to build narratives to "*sell the policy*" (p242) to senior decision-makers, ideally including highly persuasive "*killer charts*" (p243). In an ethnographic study conducted with New Labour health inequalities policymakers in 2006-07, Qureshi (2013, p9-10) highlights a highly quantified killer chart used "*in all reports and Powerpoint presentations*", as a "*studied instrument of persuasion*" purporting to show the "*bullet-proof*" rigour of EBM. For Qureshi, this was an example of "*policy-based evidence*" (p7), rather than evidence-based policy.

Stevens (2011), Maybin (2016) and Qureshi's (2013) observations paint starker pictures than the self-disclosures of Petticrew et al.'s (2004) workshop participants: evidence in policymaking for health inequalities appears to be primarily selected, whatever its origins, to persuade fellow policy actors. Therefore, political preferences and policy processes must be part of any explanation of the apparent divergence between evidence and action, described above in section 2.2. Equally, the roles played by other policy actors, particularly those with levers over social and economic determinants of health inequality, must be examined.

2.3.5 Joined-up Government and Health in All Policies

2.3.5a Joined-up Government

It is widely agreed that the social model of health implies a policy response that involves social and economic departments. However, as described in section 1.3.4, joined-up government (JUG) has been a hugely challenging "*administrative Holy Grail*" (Peters, 1998, p295) for many years. The focus of this section is the literature on JUG within health inequalities policy agendas, rather than the huge literature on JUG as a general ambition of public administration (see Pollitt, 2003, for an overview).

The literature on JUG in health inequalities is dominated by examples of complexity and continuing difficulty. Exworthy & Hunter's (2011) review of New Labour's strategy identifies two core features of its JUG approach: performance management culture, and cross-departmental units, reviews, and task forces. As described above, New Labour's performance management culture was partly aimed at facilitating joined-up government by attributing roles and responsibilities to multiple departments and monitoring progress (Earwicker, 2007).

Using New Labour's health inequalities strategy as a case study, Exworthy and Powell (2004) argue that successful JUG is achievable when Kingdon's (1984) three streams – the problem, policy and politics streams – align across the vertical (central-local) and both horizontal (at central and local level) dimensions. But this is extremely difficult, they write, due to the inter-dependencies of multiple policy sites and disagreements between them. Exworthy and Powell describe this administrative network as "*the congested state*", and the bewildering array of agencies, committees, partnerships, boards and task forces is indeed a feature of this literature. For example, Barker et al. (2000) identify over 300 task forces and 200 internal policy reviews set up at the beginning of New Labour's tenure.

Later, Exworthy (2008) highlights further layers of policy administration: increasingly, he writes, supra-national organizations such as the EU, WHO, IMF and World Bank are influencing domestic policymaking for health, and decentralisation to devolved governments and cities adds further inter-dependent policy sites. It is not clear from the literature whether the additional inter-dependent policy sites created by devolved national and city-regional authorities have helped, hindered, or had little effect on attempts to co-ordinate cross-sectoral agendas such as health inequalities. How do the different policy levers and resources available to the different actors, and the different political and cultural

contexts affect policy decisions? By analysing cross-sectoral agendas at city-regional and devolved national levels, this thesis aims to clarify how these varying contexts, levels and dependencies impact policymaking.

Smith and Hellowell (2012) found that English, Scottish, Welsh and Northern Irish health inequalities strategies during the 2000s all committed to a JUG approach. But in interviews conducted in 2006, Blackman et al. (2009) reported that Scottish interviewees did not believe joined-up planning extended to health inequalities, with interventions described as short-term and lacking co-ordination. The Scottish government's Permanent Secretary of the time, Sir John Elvidge, then instituted a series of internal reforms, including the abolition of departments in favour of broader 'directorates', in an attempt to create a structure more conducive to JUG to address cross-cutting issues such as health inequalities (Elvidge, 2011). This re-organisation coincided with the creation of a Scottish ministerial task force for health inequalities, and subsequent health inequalities strategy, Equally Well (Scottish Government, 2008). Unfortunately, Beeston et al.'s (2013) review of the strategy reported that "*genuine cross-government linkage around Equally Well has been limited*" (p1). Therefore, Scotland's innovative reorganisation did not appear to be effective for health inequalities policy. Instead, the familiar downstream drift critique applied to Equally Well too, as Beeston and colleagues reported that despite being "*bold*" and "*ambitious*" it had "*primarily been delivered as a health and wellbeing initiative*" (p1).

Exworthy & Hunter (2011) conclude that JUG remains "*an aspiration rather than a reality*" (p210), due to the same fundamental problems that have existed for many years. Cross-cutting issues "*defy easy solutions by departments acting in isolation*" (p210). As far back as 1971, Exworthy & Hunter report, a health-department-led attempt at JUG was "*almost doomed to failure from the start*", partly because of suspicions that the health department was "'*empire-building and trespassing on their territory*" (p202). This type of language, redolent of 'Us vs Them'-type inter-group conflict, recurs both in the JUG literature and, as shall be seen, in the related 'Health in All Policies' literature.

2.3.5b Health in All Policies

As introduced in section 1.8.1, recent years have seen the rise of the Health in All Policies (HiAP) approach, which promotes the systemic integration of health into social and economic policymaking. After responsibility for public health was moved to local authorities in England in 2012, HiAP has become central to many current health inequalities

approaches at local levels in the UK (LGA, 2016, 2020b). However, many of the key texts, existing reviews and critical analyses on the HiAP approach are international. Therefore, rather than limiting my review to UK contexts, in this section I 'zoom out' to take a broader perspective.

Much of the huge international literature on HiAP is in the form of policy entrepreneurs and organisations attempting to clarify and operationalise its principles. Cairney et al.'s (2021) qualitative systematic review of 113 studies identifies five common aims of the HiAP agenda: to consider health as a human right; to seek evidence of social determination of health inequalities; to pursue upstream and evidence-based solutions; to promote intersectoral and collaborative policymaking; and to foster political engagement. According to Cairney et al., these common aims have led to a seven-point HiAP 'playbook' of advice for policymakers: make use of policy learning to push for action and commitment; frame HiAP alongside other government priorities; focus on win-wins to generate intersectoral trust; avoid the impression of 'health imperialism'; support policy entrepreneurs; promote the routine use of health impact assessments (HIAs); and avoid difficult conversations involving cost-benefit analyses.

Much of this is indeed familiar from the scoping review of Guglielmin et al. (2018) and reviews published by organisations, including the WHO (2018), the Local Government Association in England (2014), and the Health Foundation (Greszczuk, 2019). All agree on the importance of the provision of dedicated funding and staff in the long-term; the alignment of values and shared goals across departments; leadership at both the highest level and at departmental levels; the negotiation and agreement of clear responsibilities; and the ongoing monitoring and evaluation of progress. Indeed, Cairney et al. say that "*we have reached a saturation point on practical advice for intersectoral action*" (p24). Therefore, why do "*most country studies report a major, unexpected and disappointing gap between HiAP commitment and outcomes*"? (p13) To answer this, we need to look at another arm of HiAP literature that focuses on empirical accounts of policymaking and political realities.

Available evidence suggests that there are process issues that remain unresolved: for example, with the routine use of HIA. Attendees at a seminar held to discuss Acheson's 'critical' recommendation that all policies should be assessed for their potential impact on health equity concluded that it would best be implemented by making equity a core aspect

of HIA, rather than developing separate health equity impact assessments (HEIA) or similar (Douglas & Scott-Samuel, 2001). However, not creating an assessment explicitly aimed at equity again risks it being considered subordinate to other aims, such as improving health generally. Indeed, a scoping review of HIAs thirteen years later found that they were not adequately addressing health inequalities (Povall et al., 2014), and a review of HIA use in the European Commission described them as a "*tick box exercise*" (Rosenkötter et al., 2013, p11), a criticism echoed by Marmot et al. (2020).

There are also relational difficulties to collaboration. Cairney et al. point to the epistemological contradiction between public health research, which privileges knowledge gained from a hierarchy of evidence intending to minimise personal biases, and intersectoral collaboration, which respects multiple subjectivities and a spirit of mutual co-operation. This may be related to the aforementioned need to "*avoid projecting a sense of 'health imperialism'*"(p10). Challis et al (1988) describe that a health department-led attempt at JUG in 1971 produced "*much suspicion of [Department of Health and Social Science] 'empire-building', linked with sceptical comments about the inflexible application of theory to the untidy variety of the 'real world'*" (p74). But it is difficult to see how an imposition of health-led knowledge claims or values can be avoided with an agenda called 'health in all policies' in which health department actors presuppose health, or health equity, as a common priority across sectors.

In addition, the position of equity within HiAP appears to be confused. Much of the HiAP literature states that equity is a key focus. For example, an infographic from a recent WHO report describes the aim of HiAP as "*to ensure all people have equal opportunities to achieve the highest level of health*" (WHO, 2018). Cairney et al. (2021)'s simplest statement of the meaning of HiAP is "*the pursuit of health equity*" (p1). However, the HiAP literature I reviewed suggests that health equity has frequently been subordinated to other aims. For example, a review of international HiAP case studies highlighted that inequalities were often forgotten (Greszczuk, 2019). This even occurred in South Australia, one of the leaders of the HiAP agenda, where the subordination of equity in its HiAP processes has been described as 'equity drift' (Baum et al., 2019b).

Van Eyk et al.'s (2017) interviews of South Australian HiAP policymakers found that while the processes of intersectoral collaboration had been improved, and social and economic policymaker understandings of the social determinants of health had improved, "*it was*

complicated to take this argument further to the social determinants of health equity" (p19). According to Van Eyk et al.'s participants, health equity was perceived to be a health department value of little interest to social and economic policy actors, and therefore the imperative to build relationships and improve collaborative processes meant social and economic department goals were privileged.

Arguably, this subordination of equity is apparent in the framings of HiAP: 'health" and 'health equity' are distinct aims, but 'health in all policies', 'health impact assessments', and the related 'healthy public policy' all foreground health and not health equity . As Graham (2004a) emphasises, the social determinants of health are important causes of health inequalities to the extent that they impact health differentially, not in-and-of-themselves. Policies which improve health can worsen health inequality (Frohlich & Potvin, 2008; White et al., 2009; Lorenc et al., 2013). Therefore, these aims must not be assumed to be complementary.

Much of the international HiAP literature refers to relational issues: challenges of engagement or buy-in with other sectors (de Leeuw, 2017; Holt et al., 2018; Greszczuk, 2019); the importance of building cross-sectoral trust and relationships (P. Williams, 2002; O'Flynn et al., 2011; Storm et al., 2016); using evidence for persuasion (WHO, 2018); and the importance of leadership and enthusiasm at all levels (S. L. Greer & Lillvis, 2014; Carey & Crammond, 2015). These coercive efforts may not be so essential if the primacy of health equity were as evident to other policymakers as it is to health policymakers.

As the preceding four paragraphs make clear, a significant part of the difficulty of horizontal collaboration – whether by JUG or by HiAP - relates to the management of inter-group relations. There is a vast literature in the field of social psychology on inter-group relations (Fiske, 2002). A recent review by Böhm et al. (2020, p958) describes an "*undisputed assumption*" of the entire field that "*humans readily condition their attitudes and behaviours on markers of group membership*".

Similar observations have been made of research disciplines, including health inequalities. Collyer's (2020) doctoral thesis uses a bibliometric analysis to draw a map of the "*tribes and territories*" (p61) of health inequalities research. By finding eight distinct clusters of researchers, the map "*reveals the presence of silos*" (p160) within a field apparently unified by a common interest. These silos appear to be shaped by disciplinary identities, and geographical, institutional, historical and financial forces. According to one interviewed

health equity researcher, for those attempting to collaborate "*the problem is, of course, it is like different tribes*" (p332).

Within the HiAP literature I reviewed, Synnevåg et al. (2019) was the only paper to address the risk of group discrimination hindering HiAP implementation. After interviewing 31 policymakers with long-term experience of HiAP in Norway, Synnevåg et al. concluded that "*professional identities and the potential risk of identity conflicts need to be considered as potential factors challenging the legitimising process*" of HiAP (p8). The authors also asked if the relative 'dominance' of health departments may make other policy actors "*feel devaluated*" (p7). This implies the possibility that cross-sectoral initiatives led by other departments may meet less resistance to collaboration; a possibility that this thesis aims to explore.

Finally, the HiAP literature describes a lack of political prioritisation for HiAP, even in contexts where it has relatively high prominence, such as South Australia and Finland. Melkas (2013) writes that neoliberal economic policies were implemented in Finland without the application of any HiAP process, and probably counteracted any inequality-reducing effect of Finland's HiAP programme. Van Eyk et al.'s (2017) mixed methods qualitative study in South Australia describes neoliberalism as an institutionalised policy idea, and an important barrier to addressing equity through HiAP. Despite prominent rhetorical support, Baum et al. (2019) report that South Australia's HiAP budget was 0.009% of its health department's budget in 2015-16, reflecting its low prioritisation in practice.

Therefore, despite an abundance of practical advice for implementing HiAP, empirical accounts of HiAP in practice portray a policy approach to health inequalities with severe limitations: it is not usually applied to economic policies, it may be underfunded, it may not incorporate 'health equity', and it may be deeply challenging to achieve due to inter-departmental tensions.

2.4 Alternative approaches to health inequalities policy

2.4.1 A critical analysis of 'health inequalities'

As described by the above literature, approaches to health inequalities policy have faced multiple important challenges and have so far appeared to produce unsatisfactory results. A recent analysis of policy approaches to health inequalities by the American political scientist Julia Lynch (2017, 2020) develops an alternative perspective: by confronting 'health inequalities' as a politically constructed problem, Lynch describes it as a "*dangerous frame shift*" (2017) that misdirects the mind away from effective policy solutions. This section focuses on Lynch's analysis, which brings together and builds on previously scattered insights from the health inequality research literature, and in doing so challenges important assumptions of that research community.

Lynch's argument describes a process of three main steps. First, she argues that the emerging economic paradigm of neoliberalism in the early 1980s deeply challenged the legitimacy of the post-war welfare state as a set of mechanisms to moderate social and economic inequality, leading politicians to impose taboos on themselves against discussing redistributive solutions. Second, left-of-centre politicians adopted the growing research consensus on health inequalities as a political agenda because it allowed them to signal their pro-equality stance without invoking redistribution. Third, the health inequalities framing therefore shifted attention towards a raft of individual-level or highly complex technical solutions aimed at 'health', and away from more straightforward (but taboo) redistributive solutions aimed at 'inequalities'. Therefore, health inequalities agendas have largely failed because the framing directs policy efforts towards ineffective solutions.

In developing this argument, Lynch describes her core method as frame analysis, via process tracing and content analysis of policy documents from England, France, Finland, the WHO and the EU. She first conducted grounded coding of these texts, before categorising her codes into five key elements of policy frames: a definition of a problem, a causal story about the source of the problem; a moral judgement that makes action necessary; an attribution of responsibility to particular actors to take action; and a recommendation of how that action should be taken. Using the codebook and her categorisations she was able to trace the development of framings across policy texts and contexts. She also conducted

sixty-seven in-depth interviews with participants active in health inequalities research, civil service, politics or advocacy across these three countries and internationally.

Lynch's central argument is a persuasive and a compelling one. It is persuasive because it combines an in-depth analysis of existing literature with a thorough documentary analysis process and interview data from distinct national and international settings. Her content analysis process is thoroughly described in an appendix and presented alongside the quantified results (2020). Further, her points of argument are consistent with much of the existing literature on health inequalities policy.

Like Lynch, Smith (2013) connects neoliberal assumptions within policy settings to health inequality policy failure. Ideas play an important role in both analyses. Smith (2013) describes the primacy of economic growth, and the medical model of health, as 'institutionalised ideas' within public health policy settings, meaning that ideas that were inconsistent with them would have to adapt to them or be excluded. In Smith's account (2013, p130-131), policymakers and researchers perceived a public dislike for redistributive policies that made them impossible in the "*political context*", and therefore pitched ideas about health inequality accordingly. But these newly shaped ideas were less likely to stimulate the change required.

Lynch uses a schema of frames, paradigms, and taboo to describe how ideas have shaped health inequalities policy. In Lynch's words, "*policy frames are mental constructs, made of ideas*" (p24), such as the "*stylized facts*" of the social gradient and the upstream-downstream parable. For Lynch, policy frames such as the "*international consensus health inequalities policy frame*" are "*distinct from, and subsidiary to, the neoliberal policy paradigm*" (p17). Therefore, to the extent that the dominant policy paradigm (neoliberalism) made redistributive ideas taboo, the subsidiary policy frame (health inequality) excluded them. In both analyses, individualistic economic and health beliefs are dominant over other economic or health beliefs.

Other connections made by Lynch can be found in previous health inequalities literature, including at least five papers uncited by Lynch. Nazroo (1998, p710) wrote that "*a concern with mechanisms in health inequalities research can lead to a focus on technical interventions along causal pathways, with the roots of health inequalities, social inequalities, being ignored*". Stewart-Brown (2000) asked why public health continued to focus on the outcomes of social inequality while redistribution appeared to be taboo.

Carlisle (2001, p278) wrote that "*individualistic explanations and solutions to health inequalities will probably continue to be highly acceptable to any government"* partly because they were politically "*less costly*" than redistribution. Douglas (2015, p109) critiques "*the emphasis that tends to be placed on 'health' in framing health inequalities*", while also discussing the difficulty of talking about social inequalities. In each of these papers, the pursuit of ineffective policy solutions that Lynch identifies as the outcome of her first two steps is connected to the perceived political costs of openly advocating redistributive solutions.

Most presciently of all, Wainwright (1996) noted that the "*taboo*" on "*class variations in health*" (p67) was already receding in the mid-1990s, because neoliberalism had "*taken on the appearance of an immutable law of nature*" (p70). Therefore, Wainwright wrote that to be considered realistic, policy proposals must fit within the "*narrow parameters*" of neoliberal logic (p72). He offered three potential explanations for the usefulness of a health inequalities agenda to any forthcoming government: to help maintain social order, to maintain a healthy and compliant workforce, or to contain state expenditures. The latter of these explanations is what Lynch later identified as occurring in England under New Labour, and in both France and Finland too.

Lynch's argument is compelling because it takes a constructivist approach to health inequalities policy analysis to build a new grand explanation for the disappointing outcomes of health inequalities policy agendas. By assessing 'health inequalities' as a political framing, Lynch challenges epistemological assumptions about the nature of the policy process. For example, Lynch's description of the "*stylized facts*" that were combined to create the "*international consensus policy frame*" portrays researchers as stylizing, within the policy process, rather than as neutral 'scientists' uncovering 'truths' from outside it. The political role of researchers has long been debated (Smith & Stewart, 2017); it is not a new observation that researchers can be politically influential. However, Lynch's perspective reconstitutes the academic specialism of health inequalities - built on a vastly detailed epidemiological evidence-base collated in lengthy authoritative reports - into the political agenda of 'health inequalities' - constructed and used by internal and external policy actors each with instrumental and expressive motivations.

Therefore, by considering 'health inequalities' as a constructed political framing rather than as a pre-existing object of description, Lynch invites those actors to consider whether

'health inequalities' is the optimal framing for their strategic purposes, or whether an alternative framing may be preferred. The varying descriptive or normative effects of terms such as 'inequalities', 'inequities', 'disparities' and 'variations' have been extensively discussed in the literature (Braveman, 2006; Ward et al., 2013; Arcaya et al., 2015; Kriznik, 2015; Collyer & Smith, 2020). However, the impact of the word 'health' in the 'health inequalities' framing remains unexamined.

Lynch's work implies that the word 'health' itself may be fundamentally problematic for the 'health inequalities' agenda. She writes:

> *"[R]eframing inequality in general as an issue of health inequalities invites medicalization of the issue of inequality, and this may in turn lead – for a variety of institutional and ideational reasons spelled out ably by Asthana et al. (2013), Smith (2013), and others – to the dominance of individualist over structuralist thinking and health sector–focused interventions over actions in further upstream policy domains."* (p223)

As discussed above, Smith (2013) concludes that the medical model of health is an 'institutionalised idea' within public health policy settings. Asthana et al. (2013, p167) criticise the location of policy responsibility for health inequalities within the NHS, which they describe as a "*medicalisation of health inequalities…* [that] *sidelines the macroprocesses of social inequality*". In both cases, it is the influence of 'health' on policy processes that has individualising effects. Implicit in these accounts, and by Lynch's description of the social model of health as a 'policy frame', is the highly limited use and impact of the social model of health compared to the medical model.

Two reports commissioned by the Health Foundation investigated expert, public, media and organisational conceptualisations of 'health' with a view to reframing communications for public health. L'Hôte et al. (2018) interviewed 36 members of the public to identify 'cultural models of thought' that were available for understanding health and its determinants, finding that those within the "*individualistic strain*" was dominant compared to those in the "*ecological strain*" (p14). However, even several of the ecological models facilitated individualistic conclusions: for example, participants acknowledging the socially determined "*behavioural constraints … quickly defaulted back to the deeper, more dominant individualistic cultural models*" (p26). The authors made a series of suggestions for how communicators could adapt their framings to orient public understandings of health closer

to expert understandings; however, notably they were unable to suggest how to counter the "*deeply and implicitly understood*" medical model of health (p18). Levay et al.'s (2018, p22) accompanying analysis of British newspapers found that "*the individualistic strain in media coverage reinforces individualistic thinking among the public*".

This depiction of the word 'health' routinely individualising patterns of thought presents a fundamental challenge to 'health inequalities' agendas. Smith (2013) and Lynch (2020) both describe neoliberal economics as dominant in policy settings: for Smith it is an 'institutionalised idea'; for Lynch a dominant 'policy paradigm'. Similarly, for Smith the medical model of health is another institutionalised idea; for Lynch, the social model of heath is a subservient 'policy frame'. But institutionalised ideas and policy paradigms can change. For example, is it conceivable that newly created devolved policy settings have not yet institutionalised the medical model of health? Could social policy teams work within a paradigmatic framework that includes the social model of health? The questions asked in this research must consider these possibilities.

The linguistic difficulty at the heart of this framing question is subtly present in much of the health inequalities policy literature: phrases such as "*health is created largely outside the health sector*" (de Leeuw, 2017, p329) and "*the medicalisation of health inequalities*" (Asthana et al., 2013, p167) may be widely counter-intuitive, except to health inequalities experts. Perhaps because it makes sense to academics working on health inequalities, the academic literature rarely notices this incongruity. Klein (2003, p57) suggested that social policy interventions that may reduce health inequalities could be justified "*without mentioning the word 'health'*", implying some limitation of the word. Kottke at al. (2016, p2) suggest reframing HiAP as 'well-being in all policies' partly because the association of 'health' with 'healthcare' seems "*impossible to break*". In Smith (2013, p157), two academic interviewees "*went as far as suggesting that health inequalities researchers were restricting efforts to reduce societal inequalities by continually bringing the focus back to 'health' and by a reticence about working to promote broader societal change.*" That suggestion, presented in 2013 as somewhat radical, is supported by the implication of Lynch in 2020: that 'health' just distracts from 'inequalities'.

This distraction appears to have been reported in Scotland almost a decade ago, by a Scottish ministerial task force for health inequalities. In the executive summary of a review of the health inequality programme Equally Well, they wrote:

> "All members of the Task Force were clear that the focus of all our efforts should be on tackling *inequalities*. Moreover, they reflected that by targeting *health* inequalities we may have inadvertently allowed different parts of the public sector to think that this focus did not apply to their organisation, and that responsibility to resolve the problems arising from inequalities lies only with the National Health Service (NHS)." (Scottish Government, 2014, p6, emphasis added)

This apparent framing effect has been under-explored until Lynch's recent work, particularly in the UK and at sub-national levels: just six of Lynch's 67 interviewees were UK-based, just three were policymakers, and none worked at devolved, regional or local levels. Further, all of Lynch's UK interviews occurred in 2014. Therefore, more recent interview data from policymakers in UK devolved polities - as this thesis contributes – can usefully add to or challenge details of her analysis.

For if Lynch's claim that 'health inequalities' represents a "*dangerous frame shift*" is supported by further evidence from these contexts, the next section addresses the vital follow-up question: is there an alternative political agenda that may be better suited to addressing preventable variations in health without focusing on 'health'? As introduced in section 1.8, new economic agendas framed as 'inclusive' or as improving 'wellbeing' may provide an answer.

2.4.2 Economic approaches to reducing health inequalities

In this section, I shall briefly review literature on economic policy approaches currently being pursued in the UK that seek to reduce economic inequalities. By doing so, these approaches may reduce health inequalities too. However, these approaches are being led by economic development departments and policymakers, in conjunction with other policy departments, rather than by health department policymakers. Therefore, these approaches may be able to escape key deficiencies of health-framed approaches described above, such as 'lifestyle drift', resistance to collaboration with health departments, and the repeated de-prioritisation of inequalities within health policy.

<u>Contested conceptualisations</u>

There are currently at least five economic agendas being constructed by UK polities which ostensibly share a concern to reduce socioeconomic inequalities: inclusive growth (IG),

inclusive economy (IE), wellbeing economy (WE), foundational economy (FE), and levelling up (LU). At the time of writing, IG and IE have both been promoted by health inequalities researchers and public health agencies. Further, IG and IE approaches are often used interchangeably. Therefore, this overview will focus on IG and IE approaches.

This literature is difficult to delineate, partly because of the variety of agendas being framed and their significant overlaps, and partly due to the cross-disciplinary nature of these agendas. Included in this analysis are public health-originating texts with an explicit focus on economic development; economic policy texts with a particular focus on inequalities and their social determinants; urban planning and economic development texts with analyses of spatial inequalities; and cross-cutting social policy texts with a focus on inequalities. Many are also now incorporating ideas from the sustainable development literature. Due to the extremely broad nature of these literatures, this review is necessarily selective: I focused attention on papers concerning sub-national UK settings, and those making explicit connections to public health or health inequalities.

In the literature identified, IG and IE are used both interchangeably and as distinct agendas. Lupton and Hughes (2016) for the Inclusive Growth Analysis Unit (IGAU) distinguished between two related models under the IG banner: the 'growth plus' model, which accepts the priority of economic growth but acknowledges the need for better distribution; and the 'inclusive economy' (IE) approach, which prioritises inclusivity and non-growth outcomes such as well-being or sustainability. The RSA Inclusive Growth Commission (2017) also used IG as an umbrella term while including policy initiatives now associated with IE, such as anchor institutions and social value processes. In Regional Studies, Sissons et al. (2019, p444) analysed the devolution agreements of six city-regions in England between 2012-2016 and found some "*relatively weak*" evidence for growth-plus thinking within them, and even less for IE.

On the other hand, two more recent papers from a public health perspective used IE as an umbrella term. Naik et al. (2020) for the Health Foundation provided a framework for policymakers to adopt IE approaches to reduce health inequalities, based on learning from both IG and IE case-studies. In the Journal of Epidemiology and Community Health, Shipton et al. (2021) conducted a rapid literature review to identify the attributes of IE approaches using a combination of both IG and IE literature from a diverse range of global contexts.

Burch and McInroy (2018) for the Centre for Local Economic Studies (CLES) distinguished IG from IE and made a case for preferring the latter, arguing that IG is a vague, business-as-usual "*smokescreen*" that addresses neither environmental sustainability nor the difficulties of achieving growth. Instead, IE has "*an overt focus on economic and social justice and a rejection of market liberalism*" (p8).

The more recent English literature appears to show a movement towards preferring IE, with particular interest in policies focused on community wealth building, via anchor institutions, social value processes and the promotion of the social economy. This may be attributed, at least in part, to the well-publicised success of such approaches in Preston (Chakrabortty, 2018), and other promising case studies promoted by the Local Government Association in England (LGA, 2018, 2020a), Public Health England (PHE, 2021) and recent Marmot-led reviews on health inequalities in England (Marmot et al., 2020a; Marmot et al., 2021).

Environmental sustainability is also a key conceptual question. The more recent movement towards preferring IE may also reflect growing doubts over the sustainability of 'growth'. The RSA Inclusive Growth Commission (2017) made no reference to the environment or sustainability. This seems like an omission compared to more recent UK-based literature; cross-cutting economic or social policy texts now almost universally mention sustainability, and often prominently so. In public health, "*a sustainable, inclusive economy with equality of outcomes for all*" became one of Public Health Scotland's six priorities in 2018; and a Public Health England report (2021) promoted "*inclusive and sustainable economies*" for the explicit purpose of reducing health inequalities. These separated framings imply that 'sustainable' and 'inclusive' are distinct. But this too is uncertain in the wider literature.

Shipton et al.'s (2021) rapid literature review of global IG and IE texts published between 2007-2019 found four key features of "*inclusive economic approaches*" broadly defined: economies designed to deliver inclusion; an equitable distribution of economic benefits (including income, wealth and access to essential services); an equitable distribution of resources for economic participation (including good health and skills); and an economy that operates within planetary boundaries. However, while 52 of the 56 conceptualisations included the equitable distribution of economic benefits, only five referred to planetary boundaries, none prior to 2014. Therefore, it is doubtful whether this aspect is indeed one of four 'key features' of inclusive economic approaches; if it is, then it may be a feature of more recent texts only, or of texts in particular contexts. In European Planning Studies,

Waite et al. (2019) argued that appropriate IG interventions must be highly context-dependent. Therefore, combining conceptualisations from settings as diverse as Iran, Vietnam, and Greater Manchester, as Shipton et al.'s global review did, may inevitably produce inconsistencies.

Political critique of IG and IE agendas

The ongoing conceptualisation debates above are central to a literature that remains more theoretical than empirical. The literature identified is dominated by discussion papers from third-sector think-tanks and policy agencies, illustrative case studies, and guides or frameworks for policymakers. In this sense the literature on IG and IE is reminiscent of the agenda-building arm of the HiAP literature, described in section 2.2. In one of few critical UK-based papers on IG, Lee (2019, p429) in Regional Studies states "*it seems hard-hearted to critique such a well-meaning agenda*". Yet political critique of 'health inequalities' by Lynch (2017, 2020) and of HiAP has illuminated important inadequacies in those well-meaning agendas. Therefore, a critical perspective on the IG agenda might give us important theoretical clues to help deepen our understanding of how such ideas function in policy settings.

Several authors have described the political uses of a vague agenda. In his "*sympathetic*" critique, Lee (2019, p429) describes IG as a 'fuzzy concept' in the sense described by Markusen (2003): "*researchers may believe they are addressing the same phenomena but may actually be targeting quite different ones*". Hill O'Connor et al. (2023) find that IG's malleability helps it to gain support, but that support is then at risk as the idea is operationalised. Similarly, Waite et al. (2019) say that the continuing breadth of IG conceptualisations "*risks spawning anything-goes policymaking*" (p1813) and warning against IG becoming "*old wine in new bottles*" (p1828). Therefore, conceptual confusion makes IG easy to politically manipulate, but difficult to operationalise.

Both Lee (2019) and CLES's Burch and McInroy (2018) allege that IG is being used liberally in new policy texts without evidence of meaningful policy change. Researchers perceive a risk of IG becoming a "*mirage*" (Turok, 2010), a "*placebo*" (Lee, 2019, p431) or no more than an "*agreeable policy label*" (Waite et al., 2019). Similarly, Jenkins (2018) argues that the vagueness of 'wellbeing' is turning it into a 'fuzz-word' (Cornwall, 2007) in the UK, its moral force giving wellbeing-framed policies a discursive shield against scrutiny. Thus, while broad framings of 'inclusive' or 'wellbeing' agendas may win broad political support, several

authors appear sceptical of misuse. On the other hand, Béland and Cox (2016) describe ideas that are both ambiguous and emotionally attractive as "*coalition magnets*", citing 'sustainability', 'solidarity' and 'social inclusion' as examples. From this perspective, conceptual confusion may help the IG agenda achieve support and resources.

Interestingly, Lupton et al.'s (2019) final report for the Greater Manchester-focused IGAU took an agnostic approach to conceptualisation, acknowledging the series of related ideas to IG, including IE, FE and social value, but seeking to focus on specific policies and their implementation, rather than to further debate framings. The Greater Manchester Independent Prosperity Review (Coyle et al., 2019), its One Year Update (Coyle et al., 2020), and Marmot et al.'s Greater Manchester review (2021) all also refrained from choosing a specific framing of their recommendations for more equitable economic development. Therefore, there appears to be a reluctance in Greater Manchester to continue the conceptualisation debate at the level of simple framings.

A related point by Lee and others (e.g. Waite et al., 2019; Deas et al., 2021) ascribes a political appeal to IG similar to that ascribed to 'health inequalities' by Lynch: it "*helps avoid the electoral challenges of taxation and redistribution*" (Lee, 2019, p428) while still signalling progressive intent to the electorate. As Statham and Gunson (2019) describe it, IG is about "*the distribution of prosperity across society before government intervention in the form of tax and transfers*" (p4). To readers of Lynch, this new complex and challenging cross-sectoral agenda to reduce inequalities without redistribution may look wearily familiar.

On the other hand, as several authors note (Green et al., 2017; Lee, 2019; Tonkiss, 2020; Houston et al., 2021), redistributive policy levers are largely unavailable at the local, city and regional levels where IG and IE approaches are most popular. Therefore, it may be unfair to criticise political actors for excluding political actions unavailable to them. It is not only policy levers that are limited at subnational levels. A parallel literature about the severe financial cuts to local authority budgets of the Conservative-led austerity agenda is referred to throughout this UK-based IG and IE literature (Pike et al., 2017; Lee, 2019; Dennett & Russell, 2020; Hughes & Lupton, 2021).

It is for these pragmatic reasons that Lee's (2019) critique is "*sympathetic*": there are political and practical reasons why this "*well-meaning*" agenda with much potential may yet struggle. But as yet, there is little critical analysis of the interaction between inclusive

economic or wellbeing-based economic agendas and policy attention to health inequalities. This thesis aims to contribute to analysis addressing this gap.

2.5 Conclusions

This literature review first described the policy approaches to reducing health inequalities in the UK suggested by research. The Black Report (1980), the Acheson Report (1998) and the Marmot Review (2010) arrived at similar conclusions and policy recommendations (Bambra et al., 2011). More recent Marmot-led reviews (2020, 2021) have maintained similar themes from 2010 while newly suggesting the adoption of inclusive economic growth and social value approaches.

Then, section 2.2 reviewed the literature regarding policy approaches to health inequalities in the UK, with a focus on New Labour's cross-cutting national strategy between 2002-2010. First, I described 'lifestyle drift', an important critique in the literature that describes the downstream drift from upstream policy rhetoric to individual-level policy action. Then, I discussed other important themes of the literature on New Labour's strategy: its focus on performance management and its stated ambition to enact evidence-based policy, both of which were associated with lifestyle drift; and its attempts at joined-up government, which has a long history of intractability. Finally in this section, I reviewed literature about the Health in All Policies (HiAP) agenda, which has become more popular in the years since New Labour left office. Unfortunately, despite much enthusiasm and a wealth of practical advice, empirical accounts of the HiAP approach reveal a number of important limitations.

These disappointing outcomes over two decades have led to alternative approaches being sought. In section 2.3 I focused on a recent critique by one author, Julia Lynch, that highlights the political construction and use of 'health inequalities' as an agenda. This critique, along with the lifestyle drift critique, the repeated de-prioritisation of inequalities within health policy, and the resistance of social and economic departments to collaboration with health departments, implicate important policy impacts of the word 'health'. For this reason, social- or economic-led policy agendas that reduce socioeconomic inequalities may more successfully equalise health outcomes than health-led 'health inequalities' agendas. Therefore, this section concluded with a limited review of literature

about inclusive approaches to economic development, as recently recommended by both Public Health Scotland (2018) and Public Health England (2021).

However, there are important gaps in our understanding here. In particular, Lynch's proposal that the 'health inequalities' agenda has failed due to its framing means reframing may be necessary to produce political solutions that minimise unequal health outcomes. Therefore, how policymakers constructing inclusive or wellbeing-related socio-economic agendas consider unequal health outcomes may crucially lead to a productive reframing. In which contexts might alternative framings aimed at a similar perceived injustice, such as 'wellbeing', be preferred? What may be the different impacts of such alternative framings? How should policymakers interested in reducing health inequalities proceed if the word 'health' is problematic? In this thesis, I will analyse social, economic and health policy documents and interview social, economic and health policymakers to inform answers to questions such as these.

Further, inclusive or wellbeing-based approaches are being explored by various subnational polities in the UK. This means an array of contextual differences may shape agenda construction: decisions will be shaped by the different policy levers and resources available to the different actors, and the different local contexts targeted by each decision. In this thesis, I will analyse discourses from two different polities – a city-region and a devolved national government – to capture how contextual differences may impact policy decision-making in this area.

More broadly, there is a lack of critical analysis of the policymaking realities of inclusive or wellbeing-based agenda-making in the UK. As described in section 2.3, much of the identified literature comprised grey literature discussion papers, case studies, and guides for policymakers. Given the cross-sectoral nature of these inclusive economic agendas, and the limitations of health-led cross-sectoral agendas highlighted by critical analyses, there is a clear need for similar analyses in this context. In this thesis, I will critically analyse how varying conceptualisations across policy teams might interfere with the construction of cross-sectoral agendas to reduce socioeconomic and health inequalities.

Chapter 3 - Methods

3.1 Introduction

As described in the Literature Review, a key interest of my research is to investigate further the claim made by Lynch (2017, 2020) that the health inequalities frame is itself problematic to attempts to reduce health inequalities. Lynch contends that "*policy frames are mental constructs, made of ideas*" (2000, p24). Put another way, frames are constellations of ideas presented by frame constructors, which can shape the beliefs and actions of frame receivers.

This shaping – known as 'framing effects' - has been demonstrated in a series of psychological and survey experiments that show how the presentation of similar information or ideas can produce very different responses (Kahneman, 2011). For example, Rasinski (1989) found that the proportion of Americans believing too little was spent on welfare more than tripled (20% to 65%) when 'welfare' was simply rephrased 'assistance to the poor'. Framing effects like these have been found repeatedly in public opinion research and exert an important influence on political strategizing (Lakoff, 2004; Chong & Druckman, 2007).

For Lynch, the framing effects of 'health inequalities', as constructed by researchers and activists, include both the intended effect of focusing political attention on the health implications of social inequalities, and also the unintended effects of directing political action towards ineffective individual-level solutions. While the constructors of the 'health inequalities' frame have tried to communicate a social determinants-based understanding of health, the receivers seem to persist with more pervasive biomedical understandings of health, which are often individualistic.

Lynch's perspective implies that political action on social and economic inequalities may be more effective at reducing systematic variations in population health than political attention to 'health inequalities' as such. New political agendas that are focused on social and economic inequalities – the 'inclusive-' and 'wellbeing-' economic agendas of interest in this thesis – therefore provide an opportunity to analyse this implication.

Moreover, the understanding of 'health inequalities' as a political framing potentially motivated by a range of instrumental or expressive aims invites further examination of specific framings of health, variations in health outcomes, and of variations in other social or economic outcomes. Might additional expressive or instrumental aims lie behind these framings? From where do they emerge, and to where do they lead? In this research, I hope to gain a deeper understanding of how social and economic policymakers consider and frame health and variations in health, given the centrality of social and economic policy to preventive health policy efforts. My research aim and questions were specified in section 1.9, above.

3.2 Ontology and Epistemology

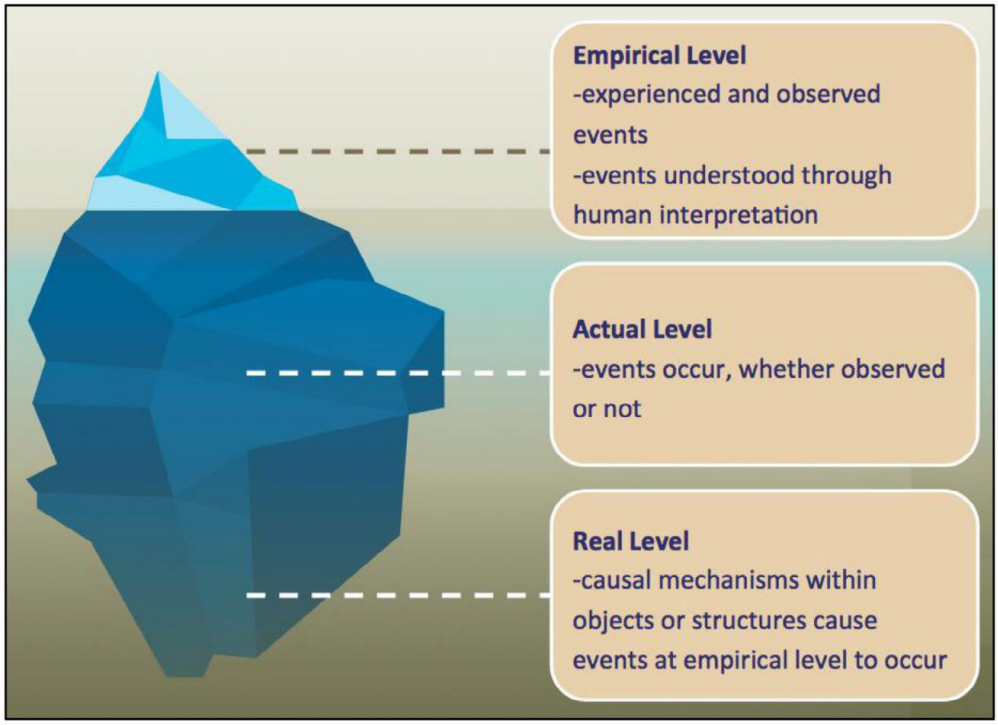
Ontology and epistemology relate to the nature of reality and knowledge respectively. Historically, philosophical debates on the fundamental nature of science have compared objectivist (positivist, deductive, empiricist) and subjectivist (interpretive, inductive, constructionist) positions (Baskarada & Koronios, 2018). Crudely, objectivists believe both that a real world exists and is governed by universal laws that humans can observe and comprehend; subjectivists either deny or ignore the existence of a real world, but either way insist that human knowledge is always constructed by humans and therefore partial, which means 'truth' is impossible to know. In my view, both these stances suffer serious flaws that make them impossible to maintain: the former's denial of the human-mind filter on all knowledge, and the latter's denial of a human-mind-independent real world, both seem like intellectual dead-ends (Lincoln et al., 2011).

Something of a compromise position is most often described as 'critical realist' (CR), following the work of Roy Bhaskar and others (Archer et al., 2013). By combining the realist ontology of objectivism, with the constructivist epistemology of subjectivism, it evades the most significant flaws of objectivist and subjectivist approaches. This describes my ontological and epistemological stance. I assume the existence of a real world; I acknowledge the value of the many pre-existing theoretical stances that influence my work; and I believe in some degree of standards or quality in research. These statements cover three core ideas of CR: ontological realism, epistemological relativism, and judgemental rationality, respectively.

Ontologically, I believe in a real world, existing independently of human conceptions of it. This is not to assume that the real world is simple or homogenous, only that it exists. CR ontology differentiates between the natural world and the social world: the latter emerges from the former. In both worlds, reality contains entities with causal powers: natural entities such as water, which has the power to extinguish flames; and social entities, such as ideas, which have the power to shape action. I am interested in the *considerations* of policymakers and the policy frames they construct: "*the meaning-making activities… that shape action*" (Lincoln & Guba, 2011, p167). Therefore, my research is concerned with subjective creation and perception rather than objective manifestation; that is, the social world, not the natural world.

CR ontology describes three stratified levels of reality, often usefully described metaphorically using the image of an iceberg (see image 3.2, below). The Empirical is what we can capture or measure using our senses – it is the directly observable tip of the iceberg. The Actual is where events happen but are not observable – it is below the surface, but can impact what is observed above it. The third, deepest layer is The Real: its generative conditions, or causal mechanisms, underlie Actual (unobserved) and Empirical (observed) events. A key task of CR research is to posit potential conditions or mechanisms that have effects, despite not being directly observable.

Fig. 3a: An iceberg metaphor for CR ontology (Fletcher, 2017)



By exploring how health, inequality and health inequality are framed within policy documents, and by policy actors, I aim to identify Empirical tendencies, Actual mechanisms, and the Real conditions or contexts which cause them to occur. In Pawson and Tilley's (1997) formulation, context + mechanism = (empirical) outcome.

There is an underlying interest in the causal powers of ideas here: how ideas embedded in policy settings shape the consequent arrangements of ideas within policy frames, which consequently shape policy solutions. Positivist epistemologies are concerned with deterministic causal claims – when *x* happens, the result is *y* – that can be observed in closed systems, such as carefully controlled laboratory experiments involving natural entities. But the social world is an open system that cannot be carefully controlled, and the causal effects of social entities, such as policy frames, cannot be directly measured.

This was referred to in the Introduction chapter: specifying the causal effects of social exposures far upstream to health outcomes has always been challenging, to the detriment of efforts to build a pluralistic evidence-base for tackling health inequalities. Although positivists prefer the quantified determinism of randomised controlled trials and similar experiments involving natural entities, the causal powers of social entities have to be investigated in other ways. While I cannot directly measure or quantify the causal impacts of ideas or frames, I aim to demonstrate in this thesis how they are influential on observable actions or outcomes.

My epistemology is constructivist: scientific knowledge is both relative, and fallible, so it can never achieve a depiction of reality that is complete and true. Epistemological relativism means that our ways of thinking are inherently dependent on our personal histories, which are situated within varying social and cultural contexts. While the real world exists independently of human minds, the social world – including our knowledge claims or beliefs - does not. This is why I shall describe important aspects of my background in the following section: my knowledge claims are necessarily shaped by my personal, social and cultural experiences. The combination of ontological realism and epistemological relativism can be concisely summarised as "*one reality, many theories*" (Lawson, 2003, p166).

A CR approach seeks to "*modify, support or reject existing theories to provide the most accurate explanation of reality*" (Fletcher, 2017, p190). This is what I intend to do: to support, modify or reject Lynch's theory that the 'health inequalities' frame medicalises social inequality detrimentally to the aim of reducing systematic variations in population health through policy. I am also mindful of related theories and concepts in the health inequalities literature described in the literature review – of lifestyle drift, health in all policies, joined-up policymaking, health imperialism, and so on – to which my research and analysis may contribute towards a better understanding.

Attempting to produce an "*accurate explanation of reality"* points to the third key idea of CR referred to above: that of judgemental rationality. Again, this is something of a compromise position between the objectivist or subjectivist positions. Objectivist or positivist views of science take a strictly hierarchical view of evidence validity, placing methods that seek to eliminate human judgement or 'bias' at the top, which leaves qualitative methods somewhere near the bottom (D. Evans, 2003). Subjectivists would take the opposite view: that all methods are humanly formed and replete with judgements, so no form can be impartially judged 'better' than any other. Judgemental rationality means that a research community can reach rationalised agreement on which procedures are suitable for attempting to explain the area of reality of interest. In the natural sciences that may well be methods of careful control to isolate natural entities and observe their causal powers through experimentation; in the social sciences an array of quantitative or qualitative methods may be justifiable to tease out causal mechanisms beyond direct observation.

I intend to create an account that is credible, from which valuable insights may be drawn and considered with reference to other research and other contexts. I do not intend to 'find facts', nor do I claim that my study could be precisely replicated by others, as in a tightly controlled experiment. I do believe that I can contribute to a richer illumination of the Real and Actual mechanisms within policy that impact on observed attempts to reduce health inequalities. I intend to construct a credible account of a portion of social reality, but other constructions may be generated by other researchers asking similar questions.

Judgemental rationality allows for judgements of 'quality' in research, though not so strictly as objectivist hierarchies of evidence. The quality of the work behind and presented in this

thesis can be judged on the rigour of my methods and my transparency about those methods; the criticality of my analysis; and my reflexivity.

As described later in this chapter, I have flexibly created a structured methodology that was suited to my research needs, rather than using universalised methods aligned to the needs of other research (Mason, 2002). Epistemological relativism encourages a methodological plurality: multiple perspectives and methods are necessary to illuminate more fully the unobservable mechanisms of social reality. By being transparent about many of the judgements I have made - particularly in this chapter and in the supporting Appendices - critical readers may judge the plausibility of my claims (Hammersley, 2009). I intend to base my 'findings' upon explanations that are detailed, contextualised, and subjected to questioning; this shall also be open to readers to judge. Finally, in the next section I shall surface for discussion the personal subjectivities I bring to this research, so that my role as an active constructor of the data can be assessed.

3.3 Reflecting on myself: the researcher

A constructivist epistemology implies that my lived experiences and social positions necessarily impact my interpretations and methods. Therefore, reflexivity throughout this process is a key tool to ensure I am always thinking critically about the judgements I make and the data I generate. To assist the reader's judgement of this study, I shall briefly describe some aspects of my lived experience and positionality that may influence the data and my approach to it in this research.

I am a heterosexual, white, a-theistic male in my late-30s, from a middle-class family background. My father was a general practitioner, and my mother was a Diabetes specialist nurse. Although my parents were both medical professionals, I felt no inclination to follow them into medicine because I spent long periods of my childhood and adolescence in medical settings due to a series of cancers. These illnesses, and the medical treatments which saved my life, left various physical and emotional sequelae extending into adulthood.

Having spent much of my life feeling unfairly afflicted by serious illness, in my early 30s I learned about the social determinants of health and health inequalities while studying a master's in public health. I was deeply moved to realise that a great amount of illness may

be preventable by social or political choices, and that these choices foreseeably cause more suffering for some than for others. I was further shocked to learn that my own survival had been more likely than that of other children on my ward due to the lottery of our parental backgrounds (Lightfoot et al., 2012). My belief that these preventable diseases and deaths are deeply unfair lies behind my interest in the topics of this thesis.

Further, my life experiences must influence my underlying assumptions about health and medical matters. On one hand, I have never experienced financial precarity, a damp home, social discrimination, or any other apparent social threat to health. On the other hand, both my parents were medical professionals, and I have an extensive history of hospital attendance. I have received healthcare in seven different countries, delivered by seven different medical specialities. I have had thousands of conversations with my parents about health and medical matters. In the role of an 'expert patient' I once presented, 'A patient perspective of using evidence for shared decision-making' at a conference of the Cochrane Collaboration, an organisation focused on promoting 'evidence-based medicine'.

It is clear that my personal history is steeped in biomedical experiences of health. This must remain within me. It seems obvious to me that biomedical conceptualisations of health dominate over social conceptualisations, when I had so many important experiences rooted in the former, and had never fully reflected on the latter until my 30s. I am deeply aware that everyone is a past, present or future medical subject, and that very many people - including both my parents - are medical professionals too. I suspect this is why I find sociological perspectives so fascinating, as they provide wholly new ways to reflect on my prior experiences and assumptions.

I also suspect this is why I am particularly interested in Lynch's (2017, 2020) work, including her suggestion that 'health inequalities' is a "*dangerous frame shift*". If 'health' medicalises 'inequality', perhaps there are benefits, as well as deficits, of that frame. I consider both that I owe my life to medicine, and that I have been harmed by its side-effects and by errors of medical judgement. As Ballard and Elston (2005) write, the benefits of medicine may be underplayed by largely negative critiques of medicalisation processes. Reflecting on this, I was not truly exercised by social or economic inequalities before learning about health inequalities. For me, 'health inequality' carries an additional moral sting, informed by the deep injustice I felt while experiencing traumatic illnesses and painful treatments, that non-specified 'inequality' does not carry. Perhaps it holds this effect for others too, whether

informed by illness experience or not. Perhaps I would have been more exercised by social or economic disadvantage had I experienced them. Either way, an extra moral sting to 'health inequality' seems to me potentially important for its prospects as a policy agenda.

3.4 Case selection

Critical realism is methodologically inclusive: it does not necessarily privilege some methods over others. As my primary interest is the present *considerations* of policymakers and the policy frames they have recently *constructed*, my interest is in subjective perception and creation. This could plausibly be gathered by survey, but more intensive qualitative methods are preferred because reality is 'multiply determined' at unseen levels (Bhaskar, 1975).

Among research strategies suggested in the social sciences, Yin (2003, p5) suggests case studies to answer 'How' questions (such as my first three research questions); when the researcher is unable to control behavioural events; and when the focus is on contemporary events. Ackroyd (2010, p60) suggests case studies as "*the primary kind of research design in the realist cannon*", as the fixed context allows "*the boundary between mechanism and context [to be] progressively clarified*" so that mechanisms at the Actual level can be identified. By looking at two case studies, I can introduce a comparative element: when the context is no longer fixed, I can explore how context and mechanism may intersect (Yin 2003, p53). However, as the contexts shall differ in multiple ways, I can only describe contextual facilitation or hindering of mechanisms, not causal determination. Time limitations precluded more than two case studies.

This research was funded by the SIPHER Consortium[4]: a multi-disciplinary systems science programme to develop evidence tools and research insights to inform preventive public health policymaking (Meier et al., 2019). SIPHER was developed in partnership with three policy partners: Sheffield City Council, Greater Manchester Combined Authority (GMCA), and the Scottish Government (SG). This research was not limited to focusing on these polities: but their commitment to exploring 'inclusive' or 'wellbeing'-based economic agendas; their interest in reducing health inequalities; and their potential facilitation of

[4] SIPHER is an acronym for Systems science In Public Health and Health Economics Research.

access to policymakers for interviews, made them each excellent candidates for case selection.

I considered alternative options. Although the Conservative-led UK national government promised a potentially similar 'levelling up' agenda as part of its 2019 manifesto, no details of this agenda were available during the early stages of this research project. Further, as explained in section 2.3.5, I was interested in the impacts of devolved policy levels on cross-sectoral policy agendas such as health inequalities. Exworthy and Powell (2004) called the highly complex administrative network with interest in health inequalities at the time "*congested*", and a hindrance to successful collaboration. My interest in exploring this potential issue led me to prefer to analyse policy work at levels other than UK national level.

I selected Greater Manchester Combined Authority (GMCA) as my first polity to research, alongside the Greater Manchester Health and Social Care Partnership (GMHSCP). GMCA is a combined authority comprising one elected councillor from each of the ten local authorities of Greater Manchester, and an elected mayor. It has policy authority in several social and economic policy areas of importance to health and to inequalities – such as transport, housing, and planning - in a region of almost three million people. Greater Manchester also has "*soft devolution*" arrangements over health and social care via GMHSCP (Walshe et al., 2018, p34), which is closely affiliated with GMCA and which provides the GM-based health policy texts and actors for this research. As described in section 1.8.2, this unique devolutionary arrangement provided an especially interesting new setting for policy interests in inclusive growth and health inequality to meet (McKenna, 2016).

At the time of commencing this research, GMCA's most recent overall strategy document, Our People, Our Place (2017), sought to "*create a thriving, inclusive economy*" (p34). Several GMCA policy texts further discussed reducing social, economic and health inequalities. A series of reports commissioned from external actors - including the 'Greater Manchester Independent Prosperity Review' (Coyle et al., 2019), 'The Greater Manchester Independent Inequalities Commission' (Pickett et al., 2021), and 'Building Back Fairer in Greater Manchester: Health Equity and Dignified Lives' (Marmot et al., 2021) - demonstrated a polity with active interest in exploring social, economic and health inequality issues. Therefore, I was confident in my choice of GMCA as an appropriate subject for my research.

Table 3a – Selected Cases

Acronyms: GMHSCP (Greater Manchester Health and Social Care Partnership); TfGM (Transport for Greater Manchester); AGMA (Association of Greater Manchester Authorities).

	Greater Manchester Combined Authority (GMCA)	**Scottish Government**
Area of jurisdiction	Devolved city-region of 493 square miles	Devolved nation of 30,090 square miles
Population	2.8 million	5.4 million
Established by	Localism Act 2011 and Greater Manchester 'City Deal' 2012	Scottish Parliament election 1999 following 1997 referendum
Political composition (as of 2021)	9 Labour members (including the Mayor); 1 Conservative; 1 Liberal Democrat	25 Scottish National Party ministers and 2 Greens ministers
Vertical division	Twelve 'Portfolios' (led by 11 members and a salaried Dep. Mayor for Policing, Crime, Justice & Fire)	49 'Directorates' grouped into eight 'Directorates General' led by (civil servant) Directors General.
Affiliated public bodies	Close affiliations to TfGM, GMHSCP, GM Fire & Rescue and others.	Funds 129 agencies, health boards, public corporations etc.
Competent powers include	Economic Development; Healthcare (with GMHSCP); Housing; Transport (with TfGM); Policing; Environment; Planning (as AGMA); Public Health; Skills	Economic Development; Healthcare; Education & Skills; Transport; Justice; Housing; Policing; Devolved Tax; Devolved Benefits; Public Health; Trade
Incompetent powers include	Taxes; Benefits; Monetary policy; Education; Justice; Defence; International Trade; Foreign Policy	Reserved Tax; Reserved Benefits; Foreign Policy; Energy; Monetary policy; Defence; International Trade

I further selected the Scottish Government as a polity to research, alongside Public Health Scotland. The Scottish Government has extensive policy authority within Scotland on issues of importance to health and to inequalities, including education, transport, housing, healthcare, and some taxation powers. Other important policy areas, including tax and other macroeconomic policy, are reserved by the UK national government. Public Health Scotland is an arms-length public health agency established in 2020 to support the Scottish Government and local authorities with public health evidence and advice.

Inclusive growth has been a priority for the Scottish Government since at least 2015, when 'Scotland's Economic Strategy' made it one of four economic priorities (alongside 'investment', 'innovation', and 'internationalisation'). More recently, the Scottish Government's 2018 iteration of its National Performance Framework named "*sustainable and inclusive economic growth*" as one of its two central purposes, alongside "*increased wellbeing*". In the same year, it was a co-founder of the 'Wellbeing Economy Governments' group (WEGo), as it sought to collaborate to develop the idea of a 'wellbeing economy'. Therefore, I considered the Scottish Government a highly appropriate case to select for research into 'inclusive' or 'wellbeing'-based economic agendas.

I had considered studying the Welsh Government instead of the Scottish Government: Wales is another devolved UK state with strong policy interests in 'wellbeing' and a cross-departmental, preventive approach (Wallace, 2019). However, as a Scot, I had existing contextual knowledge about the political culture of the country; and as a resident of Scotland, I had an ongoing personal interest in the actions of the Scottish Government. I had no such connections to Wales.

Reflecting further on my positionality, I consider myself both Scottish, and British. Perhaps unusually for a Scot highly engaged in politics, I do not have strong feelings for or against Scottish independence, which can polarise opinions for or against the governing Scottish National Party. I was living in South America during the Scottish independence referendum in 2014, so paid little attention to the campaigns. Now, I regularly discuss the issues with pro-independence family – who claim I am a unionist – and anti-independence friends – who see me as a nationalist. I am not aware of any impact my political positions have on my specific analysis of Scottish Government policy texts, except insofar as agreeing with Gorski (2013, p669) that "*the social sciences are not 'value-neutral' [as] they presuppose an*

axiological commitment to human well-being", and in my case, a particular interest in efforts to reduce inequalities in such.

3.5 Analysing Policy Texts

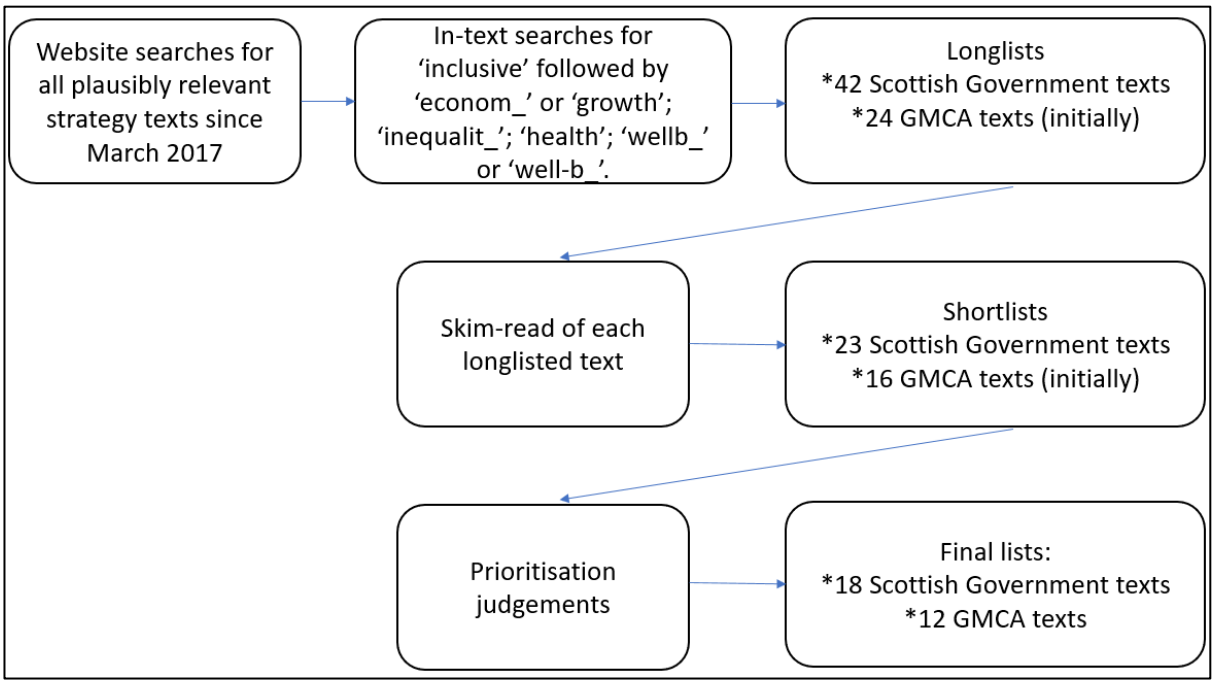
3.5.1 Rationale

I am investigating the approach taken to unequal health outcomes by policymakers constructing 'inclusive' or 'wellbeing' economic agendas. Within health policy texts, socioeconomic variations in health outcomes are often framed as unfair and preventable 'health inequalities'. Within social and economic policy texts, I want to know if the same or a similar injustice is present, and if so, how is it framed? How is health framed, how are inequalities framed, and how are 'health inequalities' framed? Which health outcomes and differences are important, and why? Which axes of inequality are important, and why? What are the suggested solutions? To understand this, I need to analyse framings within social and economic policy texts, and within health policy texts of the same polities.

The analytical process described in this section was developed in late 2021 and conducted through 2022.

3.5.2 Selecting policy texts

Fig. 3b: Flow diagram showing policy text selection process



3.5.2a Longlisting

The selection process for policy texts first involved thorough searches of the websites of the chosen polities for policy strategy texts published since March 2017. This permitted a 5-year period of texts to be included, culminating in March 2022. I searched all texts I found for discussion of 'economic growth' or 'inclusive' economics, of inequalities, health, or wellbeing. The longlists included explicitly economic and health-policy texts, and also texts about housing, transport, the environment, spatial planning, children and young people, Scotland's islands, and a range of others.

3.5.2b Shortlisting

I then undertook a rapid reading of each text to assess its relevance to the inclusive economic policy agendas of each polity. I also checked any other policy texts referred to in these texts against the longlist and added them if appropriate. From rapidly assessing all texts in this way, I created shortlists.

Texts were *included* in the shortlist if they explicitly referred to inclusive or wellbeing economic agendas, *and* to health or wellbeing, at least once. I also included major general population health strategies, whether they referred to economic agendas or not.

Texts were *excluded* from the shortlist if they did not refer explicitly to inclusive or wellbeing economic strategies or to health or wellbeing. I also excluded risk-factor specific health texts (e.g. smoking or alcohol strategies). This latter exclusion was because my aim was to focus on policy documents concerning upstream economic and social determinants of health, rather than downstream determinants.

In specific policy areas where I had more than one text, I chose to include just one. For example, according to my inclusion criteria, my Scottish shortlist could have contained three texts related to environmental or climate concerns. I chose to prioritise the Climate Change Plan 2018-2032, as it made many more references to inclusive economics or growth, wellbeing economics, and inequality, than the others. I also chose the most recent of the annual 'Programme for Scotland' texts – A Fairer, Greener Scotland: Programme for Government 21-22 – rather than including each one.

3.5.2c Prioritising

My initial shortlists included 16 for GM (three of them health-focused), and 23 documents for Scotland (five of them health-focused). To manage workload, I had to further prioritise texts within these shortlists. In judging which texts were 'high priority' on this initial shortlist, I looked for texts with multiple or prominent references to inclusive or wellbeing agendas, key texts for areas central to inclusive or wellbeing agendas (see Table 3b, below), and texts multiply or prominently referring to health inequalities. Texts de-prioritised at this late stage included the GM Infrastructure Framework 2040, which had no references to any inequality or to inclusive economic agendas; and the Scottish Government's National Islands Plan, which made just a few references to either.

Table 3b: Key Policy Areas for 'Inclusive' or 'Wellbeing'-focused Economic Agendas

Key Policy Areas	**Why?**
Equalities	'Inclusive economy' agendas are characterised primarily by their concern for more equal economic and social outcomes (OECD, 2015; RSA, 2017; LGA, 2020a).
Economic Development	Economic development is central to any planned economic agenda (RSA, 2017; Naik et al., 2020; Ferguson, 2020).
Skills	Skills increase economic participation and earnings, so the distribution of skills is a source of economic inequalities (OECD, 2012; Rincon-Aznar et al., 2015; Busemeyer, 2018).
Employment	Unemployment, precarious employment and low wages are also important root sources of economic inequalities (Bambra, 2011; G. Rogers & Richmond, 2016; Pike et al., 2017).
Housing	The distribution of affordable and adequate housing is an important factor of place-based economic and health inequalities (Schifferes & Thorold, 2017; OECD, 2020).

Transport	Spatial mobility, facilitated by public roads and transport, is an important factor in place-based inequalities (Houston et al., 2021; Lupton & Hughes, 2016; Venables et al., 2014).
Spatial Planning	The spatial distributions of job opportunities, residential areas and infrastructure create place-based inequalities, while 'green infrastructure' affects local public wellbeing (Evenhuis et al., 2021; Hughes & Lupton, 2021; LGA, 2020a)
Public Services	Public services provide non-income benefits which proportionally help disadvantaged groups more than advantaged groups(Hermann, 2015; Lupton et al., 2019; PHE, 2021)
Other Relevant Policy Areas	Economic Strategy; Environmental/climate concerns; Public Health; Devolution; Children & Young People

I also conducted approximate word-counts of each text, to help judge workload. In some cases, I was able to select individual chapters or sections that were relevant, while excluding much of the rest, to reduce workload. I considered a text's foreword, executive summary, and introductory chapter to always be relevant to how 'health', 'inequalities' or 'health inequalities' might be framed by the text overall.

After piloting (see section 3.5.3 below), I proceeded to analyse the text one polity at a time, beginning with GMCA. I also periodically searched both polity websites for new texts that may be suitable for inclusion and subsequent analysis. Therefore, the initial longlists and shortlists were added to on an iterative basis over a year or so. I stopped searching for new texts in March 2022 and finalised prioritisation and final lists then.

3.5.2d Texts analysed

Ultimately, I analysed the following twelve GMCA policy texts and eighteen Scottish Government texts:

Table 3c: GMCA texts analysed

Document	**Policy Area**	**Year**
Our People, Our Place: The GM Strategy	Overall Strategy	2017
Children & Young People's Health and Wellbeing Framework	Children & Young People's Health	2018
Taking Charge: the Next 5 Years	Health	2019
Local Industrial Strategy	Economic Development	2019
Housing Strategy	Housing	2019
Children and Young People's Plan	Children & Young People	2019
GM Model for Public Services	Public Services	2019
Transforming the Health of our Population	Health	2019
Transport Strategy 2040	Transport	2021
Local Skills Report & Labour Market Plan	Skills & Employment	2021
AGMA Places for Everyone	Spatial Planning	2021
Good Lives for All: GM Strategy 2021-2031	Overall Strategy	2022

Table 3d: Scottish Government texts analysed

Document	**Policy Area**	**Year**
Mental Health Strategy 2017-2027	Mental Health	2017
Every Child, Every Chance: Tackling Child Poverty Delivery Plan 2018-2022	Equalities / Children	2018
No One Left Behind: Next Steps for Employability Support	Skills / Employment	2018
Public Health Priorities for Scotland	Public Health	2018
National Transport Strategy	Transport	2020
Economic Recovery Implementation Plan: SG Response to Advisory Group on Economic Recovery	Economic Development	2020
Public Health Scotland's Strategic Plan 2020-2023	Public Health	2020
Updated Climate Change Plan 2018-2032	Climate concerns	2020
A Fairer, Greener Scotland: Programme for Government 2021-22 (Non-Health Chapters)	Social and Economic Policy overview	2021
A Fairer, Greener Scotland: Programme for Government 2021-22 (Health Chapter)	Health Policy overview	2021
Scottish Government Vision For Trade	Economic Development	2021

Fair Work Action Plan	Employment / Equalities	2021
Social enterprise Action Plan	Skills / Employment	2021
Public Health Scotland delivery plan 2021-24	Public Health	2021
Housing to 2040	Housing	2021
Covid Recovery Strategy: for a fairer future	Overall Strategy	2021
Scotland 2045: Our Fourth National Planning Framework Draft	Spatial Planning	2021
Delivering Economic Prosperity: National Strategy for Economic Transformation (NSET)	Economic Development	2022

3.5.3 Coding policy texts

3.5.3a Choosing a model of frame analysis

There is no consensus in the literature on policy frames about the constituent parts of a frame. One of the most influential articles in the literature is titled 'Framing: Toward Clarification of a Fractured Paradigm' (Entman, 1993), indicating the lack of consensus. Entman describes four components of a frame, saying that a frame must:

1. Define a problem;
2. Diagnoses cause(s);
3. Make moral judgements; and
4. Suggest remedies.

While Entman's definition is widely admired, it is also frequently adapted. Therefore, I decided to explore a range of conceptual models of frames with the intention of choosing some to pilot on a small selection of relevant policy texts. Since the questioning of the 'health inequalities' frame by Lynch (2020) was a key inspiration for this thesis, I decided Lynch's conceptual model should be a contender for my purposes. Lynch (2020, p16) defines a policy frame as consisting of five key elements (four of which are present in Entman's definition):

1. the definition of a problem;
2. a causal story explaining the origin of the problem;
3. a moral judgement that implies the need for action;
4. an attribution of responsibility to particular actors to solve the problem; and
5. a recommendation for how the problem should be solved

I also returned to the framing literature to investigate whether other models may suit my work better than Lynch's. I compiled Table 3e, below, showing the component parts of several influential models:

Table 3e: Various models of policy 'frames'

Component	Gamson & Lasch 1983	Snow & Benford 1988	Entman 1993	Verloo 2005	Van Gorp 2005	Lynch 2020
Problem definition / diagnosis		**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Causal story	**Yes** ("roots")		**Yes**	**Yes**		**Yes**
Moral judgement	**Yes** ("appeals to principle")		**Yes**		**Yes**	**Yes**
Actors					**Yes**	**Yes**
Proposed solutions / prognosis	**Yes** ("consequences")	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Call to Arms		**Yes**		**Yes**		
Stylistic elements	metaphors, visual images, exemplars, catch-phrases, depictions				metaphors, visual images, lexical choices	

As Table 3e shows, some components are amalgams of similar concepts from different models: for example, I judged 'causal stories' and 'roots' to be similar, as Gamson and Lasch defined 'roots' as having "*causal dynamics*" (1983, p5). I also equivalised 'moral

judgements' and 'appeals to principle'; but not 'call to arms'. As Snow & Benford (1988) describe, the 'call to arms' is an action mobilisation element to motivate social movements. However, within several pages of description, they mention that such calls often include "*moral rationales*" (p203). Had I focused on this element of the description, I may have decided 'call to arms' and 'moral judgement' were sufficiently similar to combine into a component present in all five models. But I decided that 'moral judgements' may not always be motivational, and so these components were different. These subjective decisions illustrate a framing process: the selection and arrangement of some idea-elements together, while others are omitted. In section 4.2 I discuss ideas, frames and framing in more depth; and in section 8.4 I highlight uses of moral language in my data.

I leaned away from piloting the models of Snow & Benford (1988) and Verloo (2005) because of the 'call to arms' element, which I judged more relevant for external advocacy groups than for the policy strategies of governing authorities. I also leaned away from Entman's (1993) conceptualisation, as its four elements were all present within Lynch's model. On the other hand, I considered the 'stylistic' elements captured by Gamson & Lasch (1983) and van Gorp (2005) to be potentially highly meaningful in any text. Therefore, I selected these two models to test alongside Lynch's.

I piloted coding according to these three models on No-One Left Behind, an employability support services document from the Scottish Government from 2018, as the first test document. I chose this document because employability is a good example of an economic policy area that appears key to inclusive economic agendas, and that also could have important distributional impacts on health outcomes. Therefore, it seemed an appropriate choice for piloting possible methodologies.

Using NVivo 12 software, I created 'nodes' for each of the models, and then hierarchies within each node representing the categories of each model. I then read No-One Left Behind closely, looking for opportunities to categorise any of the text in any of the nodes within each model. I also coded aspects of the document that did not fit a category but that seemed important or meaningful to the framing of health or inequalities policy. Extending this view, I decided the best way to know what would be important to capture would be to inductively code a selection of documents. Therefore, I chose three more documents and began inductively coding all four documents.

My initial coding approach involved closely reading each document and categorising any segment of text that I interpreted as potentially meaningful to my research aims and questions. I aimed to categorise in ways that were both true to the text, and abstracted, so that data conveying similar meanings could be categorised together. With these dual aims, I attempted to populate categories of meaning with text, and arrange these categories in hierarchies of abstraction within higher-level 'themes'.

During this piloting phase I also realised that specifically coding for metaphors, visual images, or lexical choices, as suggested by Gamson & Lasch and van Gorp, was becoming an unnecessary burden. I had read many fascinating critical analyses of these features of a frame, but they had generally pre-selected a particular word or phrase of interest, or analysed texts much shorter than the texts I was reading. Further, by simply having a category for 'miscellaneous interesting things', I would be able to capture interesting metaphors, visual images or lexical choices that I may find for further consideration.

By this process, I ultimately concluded that Lynch's five-element model was most suitable for my analytic purposes.

3.5.3b Creating a codebook

Having decided to use the five elements of Lynch's model of a policy frame for my analysis, I also decided I should apply it twice: to health, and to inequalities, both broadly conceived (therefore 'health' became 'health or wellbeing' (HWB)). During my piloting, I frequently coded mentions of inequalities, as they were obviously relevant to the interests of my thesis. If the term 'health' in 'health inequalities' is potentially problematic, it begs obvious questions about the term 'inequalities'. Might 'inequalities' be framed in different ways, including problematically? Which inequalities are of most interest to different types of documents? Having made this decision, I had an initial list of ten main categories: Lynch's five elements, twice. Based on the piloting experience, I added some further categories to this initial list of ten. My fifteen main categories are shown in Table 3f below:

Table 3f: Codebook Main Categories

1. Causal Stories of HWB
2. Problems of HWB
3. Solutions for HWB
4. Actors for HWB

5. Moral Language about HWB
6. Causal Stories of Inequalities
7. Problems of Inequalities
8. Solutions for Inequalities
9. Actors for Inequalities
10. Moral Language about Inequalities
11. Health inequalities (specifically)
12. Miscellaneous interesting things
13. References to IG/IE
14. This text…
15. Policy mechanisms

As most of the social and economic policy texts discussed matters other than health or inequalities, I first read through each text highlighting sections or areas that referred in any broad way to health or inequalities. This pre-selection approach is suggested by Hsieh and Shannon (2005) in their description of Directed Content Analysis. For coding, I read the whole document again, with particular attention to the highlighted areas. Upon noticing an idea relating to health and wellbeing, or to inequalities, I then captured that idea into the appropriate category or sub-category. After completing the full document, I used the Control + F 'find' feature to search each text for keywords relating to health and inequalities, as a final check.

This approach was informed by a process of comparing methods suggested in the methodological literature to my requirements. For example, Boräng et al. (2014) describes qualitative content analysis (QCA) using a codebook, drawing on previous framing research and initial inductive analysis of the corpus, as I had done. This led me to Schreier's (2012) textbook on QCA, and the Hsieh and Shannon-defined Directed Content Analysis (DCA). Further reading led me to Braun & Clarke's (2021) description of this 'codebook' sub-type of thematic analysis, which was described as comprising three further styles of analysis, all unified by a codebook ('matrix', 'framework' or 'template') to work from using a combination of *a priori* interests and preliminary data analysis.

Ultimately, I took the advice of Brooks et al. (2015, p206) that researchers should not become "*precious*" about the variations between each sub-style of thematic analysis. Braun

et al. (2018) and Braun & Clarke (2021) agree with this sentiment, while cautioning that researchers do need to be thoughtful about their processes and practices to produce coherent work. Although I gave up trying to name which specific brand of codebook analysis fit closest to my requirements, the process of mapping and comparing these styles in the literature did help me think through my analytical requirements in more depth.

3.5.3c Creating sub-categories

The iterative process of developing my codebook involved constant consideration of what details of the data I specifically wanted to capture, and how to organise it. For example, I could have quickly and easily categorised hundreds of data units into '3 Solutions for HWB', but this would have been such a broad category as to be difficult to analyse. I considered five different ways to sub-categorise this category, before piloting two texts using sub-categories derived from a King's Fund policy resource aimed at local authorities (Buck & Gregory, 2013), and the Marmot Principles[5] (Fair Society, Healthy Lives (2010); Health Equity in England, (2020)).

After this piloting exercise, I judged that I had captured more relevant data using the Marmot Principles. Further, despite the King's Fund typology being aimed at subnational authorities, I read that the Marmot Principles are "*used by the majority of public health councils as a framework for tackling health inequalities*" (LGA, 2020b, p10). I also considered it relevant that one of my chosen polities, GMCA, had commissioned a report into becoming a 'Marmot city-region' (Marmot et al., 2021)). Therefore, I decided to base my Solutions sub-categories on the Marmot Principles. I defined each sub-category according to the contents of each Marmot Principle chapter in the 2010 and 2020 reports (see Table 3h, below):

Table 3h: policy areas categorised by Marmot Principle, based on *Fair Society, Healthy Lives* (2010) and *Health Equity in England: The Marmot Review 10 Years On* (2020).

Marmot Principles	**Policy areas**

[T]The Marmot Principles expanded to eight in 2022 with the addition of '7. Tackle discrimination, racism and their outcomes', and '8. Pursue environmental sustainability and health equity together'. I had already coded many of my texts by then and did not have time to re-code with these additional new principles.

MP1: giving every child the best start in life	Early years services, child development, maternity services, childcare, parenting programmes, family support, ACEs.
MP2: enabling all children, young people and adults to maximize their capabilities and have control over their lives	Educational attainment, skills, training, youth crime/offending, re-skilling, employability, 'opportunity'
MP3: creating fair employment and good work for all	High employment, ALMP, fair work, workplace safety, healthy workplaces, zero-hour contracts, job security, public transport (for work opportunities).
MP4: ensuring a healthy standard of living for all	Minimum and living wages, poverty, tax and benefits, fuel poverty, food insecurity, household debt, social mobility, digital connectedness, affordable homes.
MP5: creating and developing sustainable places and communities	Built environment and planning, active travel, community empowerment, air pollution, climate change, green space, safe/warm/decent homes, local food environments, social connectedness, homelessness, crime victimhood, traffic accidents.
MP6: strengthening the role and impact of ill-health prevention.	"T*he purpose of this final Policy Objective is to address health behaviours*" (Fair Society, Healthy Lives); behaviour-change interventions, health-specific education, information campaigns.

I was also interested by the change in the Marmot Principles between 'Fair Society, Healthy Lives' (2010) and 'Health Equity in England: The Marmot Review 10 Years On' (2020). In the latter:

> *"The sixth area, 'Strengthen the role and impact of ill-health prevention', is not included. Much has been written on this topic and many interventions and policies have aimed to influence health behaviours… The approach we take is to address* the causes of the causes*."* (Marmot et al., 2020a, p35, original emphasis).

This policy focus on behaviours – considered to require no further encouragement – is redolent of the 'lifestyle drift' critique, as described in the literature review. By sub-categorising my 'solutions' data into one of these six categories, I intended to observe whether policy solutions for health were indeed focused on health behaviours, or whether they may be focused on upstream determinants of health. I therefore decided to shape my 'problems' sub-categories similarly: in this way I would be able to see whether health-related policy problems were described upstream (in which case they would be categorised within Marmot Principles 1-5) but solutions offered downstream (categorised in Marmot Principle 6). This provided a means to a 'Lifestyle Drift Analysis' (see section 3.5.4b, below).

3.5.4 Analysis of policy texts

3.5.4a Frame Analysis

I conducted two frame analyses of my codes for each policy document: I used data coded to categories 1-5 (see codebook, table 3f above) to construct a Health Frame, and data coded to categories 6-10 to construct an Inequalities Frame. For each document I completed a grid, as in the example below:

	Causal Stories	**Problems**	**Solutions**	**Actors**	**Moral Language**
HWB					
Inequalities					

I used the Coding Summary by File Report feature of NVivo to see all the data coded to each category and its sub-categories. Therefore, I was able to look at all the HWB Problems, or all the Inequalities Solutions, or so on, together. I used this view to construct a summary of the data of each category, which I entered into the grid. After constructing each of the five summaries, I constructed a sixth 'overall' summary that acts as the overall Health or Inequalities Frame for the document. These analyses informed findings in sections 5.2, 5.3,

7.3 and 7.4, as well as informing later interviews with policymakers. Examples of Health Frame and Inequality Frame analyses are included in Appendices C and D.

The above process was itself one of 'framing': I selected some meanings from category data I interpreted to be important and omitted others I interpreted to be less so. Each category summary was a description of around 50-100 words, when there were often several hundred words coded to a category. I judged meanings as more important if they were repeated, if they were selected for prominence in the document (e.g. headings or sub-headings, pull-quotes or infographics), or if they were given emphasis in the text. I then used those highly selected 250-500 words to construct an overall summary of 50-100 words, which was further reductive and selective. This kind of framing process is unavoidable with qualitative data that requires to be transformed and reduced through interpretation and summary.

3.5.4b Lifestyle Drift Analysis of texts

My decision to sub-categorise Problems and Solutions based on the Marmot Principles (as described in 3.5.3c, above) enabled me to analyse each text for 'lifestyle drift' (see Table 3j, below). For example, if a text had lots of Problems categorised within Marmot Principles 1-5, but Solutions categorised within Marmot Principle 6, this would indicate lifestyle drift. On the other hand, if a text had both Problems and Solutions mostly categorised as Marmot Principle 1-5 – or indeed mostly categorised as Marmot Principle 6 – then no drift would be evident.

Table 3j: Marmot Principle-based sub-categories

Category	**Sub-category**	**Downstream Drifts?**
2 HWB Problems	MP1 Children do not have the best start in life	Upstream problems
	MP2 Children, young people or adults are unable to maximise their capabilities…	
	MP3 Lack of fair employment and good work	
	MP4 Unhealthy standard of living	
	MP5 Unsustainable places and communities	
	MP6 Weak role or impact of ill-health prevention	

	Cat7 Inadequate healthcare services	Downstream problems
	Cat8 Poor health outcomes	n/a
2 HWB Solutions	MP1 Give children the best start in life	Upstream solutions
	MP2 Enable children, young people and adults to maximise their capabilities…	
	MP3 Create fair employment and good work	
	MP4 Ensure a healthy standard of living	
	MP5 Create and develop sustainable places and communities	
	MP6 Strengthen the role and impact of ill-health prevention	Lifestyle Drift?
	Cat7 Improve healthcare services	Downstream Drift?

I also added a seventh sub-category - healthcare services – as these are frequently described as problematic or offered as solutions relating to health and wellbeing or to inequalities. While not relevant to the specifically behaviour-based critique of lifestyle drift, it is relevant to the broader critique about downstream policy solutions based on the biomedical model of health dominating over upstream approaches based on a social model. Therefore, Problems categorised as Marmot Principles 1-5 but Solutions categorised in Marmot Principle 6 and category 7 might be thought of as indicating 'downstream drift'.

This form of analysis informed the findings described in sections 5.2.2 and 5.2.3. Examples of Lifestyle Drift analyses are attached in Appendix E.

3.5.4c Conceptualisations of Variations in Health in texts

My eleventh coding category was simply '11 Health Inequalities'. This is where I captured all specific descriptions of variations in health. In health policy documents, this was sometimes many; in social or economic policy documents, it could be very few or none. After initially sub-categorising each occurrence freely, I created Marmot Principle sub-categories 1-6, plus Category 7 (Healthcare Services) and Category 8 (Outcomes), to facilitate sorting. After completing GMCA text coding, only MP1 (Early Years), MP6 (Behaviours), Cat7 (Healthcare) and Cat8 (Outcomes) had been identified.

Within each of these sub-categories were categories of each measure – e.g. child development, physical inactivity, cancer diagnosis, healthy life expectancy – and within each of these, I created a final level of sub-categories to capture the axis of inequality described, as in the a-g example above. Capturing data this way informed my analyses of conceptualisations of health in section 5.3.2, and of conceptualisations of inequalities, in section 7.2.1.

3.6 Interviewing Policymakers

3.6.1 Rationale

To understand how policymakers consider socioeconomic variations in health in the construction of 'inclusive' economic agendas, I talked to some relevant policymakers directly. I considered semi-structured interviews to be preferable to focus groups as a methodologically natural way to generate detailed insights from individual actors which could be withheld in a group setting (Gill et al., 2008). Interviews were structured to the extent that the conversation was focused on the research topic, but I kept the schedule sufficiently flexible so that broader or related topics of interest could also be discussed (Brinkmann, 2013). Therefore, I aimed to ensure that I prioritised discussion of 'health', 'inequalities' and 'health inequalities', while allowing participants to explore related areas in a way that could potentially produce unanticipated insights.

3.6.2 Ethical considerations

Three main ethical issues concerning policymaker interviews were foreseeable: the potential for interviewees to become identifiable from their comments included in the thesis or subsequent research outputs; the potential for interviewees to feel discredited by research outputs; and the potential for unauthorised individuals to gain access to interview data. The following steps were taken to minimise the risks from each of these issues:

3.6.2a Confidentiality:

An encrypted digital recording device on my desk – which I showed each interviewee when checking consent - recorded the audio of each interview. Immediately after each interview, I transferred the recording onto my private and secure university server space, and deleted the recording from the digital recording device.

In batches of four, I sent all recordings to an independent transcription company for confidential transcription. I then checked each transcription against the recording for accuracy before permanently deleting the recording. Finally, I anonymised each transcription: I removed or altered specific information such as names or job titles that may imply the participation of specific individuals, to reduce as far as possible the likelihood of a participant being identifiable to others. I made these adjustments carefully so as to not change the meaning of the data.

Anonymised interview data is used in this thesis, but extra care has been taken in contextual descriptions to avoid giving clues as to participants' identities, beyond that which is necessary to understand the perspective of the participant.

3.6.2b Discredit:

Participants were each asked if they wished to view their anonymised transcripts, the thesis, and/or further research outputs such as publications in peer-reviewed journals. This would give them an opportunity to highlight anything they felt was potentially unfair or discrediting before it was published. No participant wanted to view the thesis or research outputs, but some did view their anonymised transcripts, and one participant used this opportunity to clarify a misspoken comment in the transcript of their data.

3.6.2c Data Management:

Anonymised transcripts were saved on to my secure private space on my university server, password-protected and saved with codenames. Nobody else has cause to know any passwords, understanding any codenames, or have any access to the data. I would make transcripts available for my supervisors to view were they to have specific reason to do so.

Following completion of this PhD, I will move the anonymised transcripts to a secure server at the university of SIPHER's primary investigator. Following the completion of SIPHER in 2025, I will store the anonymised transcripts on a secure server only if, and for as long as, I judge that they may remain useful for further research. In this scenario, I will store the anonymised transcripts on a secure server to which I retain exclusive access, such as the server of an affiliated university.

All participants were provided with a Participant Information Sheet and Consent Form prior to interview, by e-mail (see Appendix A). These were designed to outline the purpose of the research, what each participant was being asked to do, what potential risks were foreseen, what information would be collected, and how that information would be stored. Contact

details for myself, both my supervisors, and the University Ethics Committee were provided. All Participant Information Sheets and Consent Forms were returned to me, with confirmations and digital signatures, before each interview.

Ethical approval for interviews was granted by both the University Ethics Committee, and the Ethics Committee of the School of Social Work and Social Policy, of the University of Strathclyde, in May 2022. Interviews of participants in GM took place in the summer of 2022, while interviews of participants in SG occurred during the summer of 2023.

3.6.3 Recruiting interviewees

3.6.3a Inclusion Criteria

I wanted to interview policy actors involved in the construction of 'inclusive economy'-type social/economic policy agendas at my chosen polities. In particular, I was interested to speak to people who may have been involved in the development or writing of any of my chosen policy texts. I hoped these individuals would be able to provide some insight into the way these texts were developed, the way 'health', 'inequalities' and 'health inequalities' were considered, and the way these discussions and considerations fed into the written policy documents themselves. I also wanted to speak to policy actors in health policy settings who might have professional involvement with attempts to reduce unequal health outcomes, or attempts to take 'Health in All Policy'-type approaches.

Using Table 3b, from page 90 above, I primarily wanted to find participants involved in 'key' policy area development, with time for some generalists who may have lighter knowledge of more than one policy area, or who may specialise in other aspects of policy work, particularly involving cross-sectoral collaboration. Therefore, I sought to identify policy participants in domains I considered 'key' to an 'inclusive' or 'wellbeing' focused policy agenda.

3.6.3b Finding appropriate participants

In March 2022, I presented my initial text analysis findings at a SIPHER Consortium meeting in Manchester. Three attendees with good knowledge of and contacts within GMCA suggested thirteen potentially appropriate participants to talk to further about my research. I identified five of them as priority participants, based on the information

provided about their job roles and areas of expertise. I e-mailed these five priority participants inviting them to participate, with the intention to 'snowball' sample from them, and/or contact the remaining eight initially suggested participants. Four agreed to participate, and from each one I gathered further recommendations. I then contacted people who were repeatedly or persuasively suggested, with the aim of talking to at least one policymaker specialising in each key policy area, as above.

In Scotland, I similarly began by speaking to SIPHER colleagues about potential participants. At the end of my initial interviews, I asked each participant to suggest others who may be interested in the types of questions I had asked. Initially, most suggestions were for people working directly on health inequalities issues within DG Health and Social Care. Therefore, I began asking specifically for names within social and economic teams I was most lacking contacts.

Ultimately I recruited participants as indicated in the table below:

Table 3k: Interview participants by policy area

Key Policy Areas	GMCA	Scottish Government
Equalities	2	3
Economic Development	1	3
Skills	1	1
Employment	0	1
Housing	2	2
Transport	1	1
Spatial Planning	0	1
Public Services	1	1
Climate	0	1
Devolution	1	0
Research	1	1
Total Other	**10**	**14**
Total Health	**2**	**7**
Total	**12**	**21**

Potential participants specialising in employment, spatial planning and climate policy in GM, and devolution arrangements in Scotland, were invited, but were unable to participate.

3.6.4 Conducting interviews

At the request of interviewees, I conducted all interviews via Microsoft Teams software. Each interview took between 45 and 88 minutes. Each interviewee returned a completed consent form (see Appendix A) prior to the interview; nevertheless, I checked that each participant consented before commencing each interview. Interviewees were made aware of their right to withdraw from the interview at any moment, for any reason.

I conducted interviews by asking questions from the interview schedule I developed in advance (see Appendix B). I formulated a set of questions based on my research aims, themes described in the literature review, and based on preliminary findings from policy text analysis. I constructed two slightly different interview schedules so that I could ask more appropriate questions to health or to other policy participants. A SIPHER colleague with policy experience kindly agreed to a pilot interview, which helped me to finalise my questions. Finally, I structured both interview schedules as follows:

Preliminary: Introduction, essential information, confirmation of consent etc.

1. General introduction: the role of the participant and their relevance to the research
2. Questions relating to conceptualisations, framings and solutions
3. Questions relating to specific policy texts
4. Questions relating to policy processes
5. Wrap-up questions

Although I used the interview schedules to structure each interview, I also asked follow-up questions as and when appropriate, and I missed out some questions which I judged to be less relevant or important during each particular interview. Therefore, the interviews were semi-structured: based on a structured set of questions, but with scope for variation and interpretation.

After each interview, I quickly took notes of immediate reflections. These sometimes related to my own interviewing decisions: for example, sometimes I regretted not interrupting earlier to move participants on from less insightful responses, and later ran out of time to ask further questions. At other times, I noted specific answers or exchanges that were particularly interesting, and wanted to remember and reflect on them until it was time to formally code the transcript. I also noted when, for example, one participant appeared highly distracted; another seemed very nervous and gave limited answers; others were enthusiastic and offered to contribute further via e-mail or further interviews (I conducted no follow-up interviews, however I did e-mail two participants to clarify ambiguous comments in their transcripts).

In considering how my personhood influenced the data I generated, I must acknowledge that interview participants may respond differently to interviewers with different characteristics (Bourke, 2014). During interviews, which were conducted online, my gender, ethnicity, approximate age, and middle-class, Scottish accent and clothing were evident. Almost all of my participants were white, appeared highly educated and broadly middle-class, and were of a similar age to myself. The 'matching' of these social characteristics may have eased the establishment of rapport at the start of each interview; on the other hand, we may have shared assumptions about the topic of discussion that were not vocalised (Mellor et al., 2013).

With both GMCA and SG participants, I felt confident and relaxed before and during interviews, which may reflect that my relatively advantaged social position limits the potential social distance between myself and my interviewees. While I am not an 'insider' in policy circles, as a policy-interested academic I arguably inhabit 'the space between' insider and outsider status (Dwyer & Buckle, 2009).

Further, in late 2022 I began a three-month knowledge exchange internship within the Scottish Government, arranged via the Scottish Graduate School of Social Science. This included attending Scottish Government offices five or six times; I otherwise worked from home. In this time I gave an 'Intro to SIPHER' online presentation six times to different teams within SG, reaching around 140 policy and research staff. Although I did not draw on this experience directly for this thesis, it did inform my understanding of the structures and key actors within the Scottish Government ahead of my interviews, which commenced four

months following the end of the internship. It may also have informed SG participant perceptions of me before or during interviews, as they may have attended one of my presentations, or otherwise heard of my or SIPHER's work.

3.6.5 Coding interviews

I uploaded anonymised interview transcripts to NVivo and coded them one-by-one. I decided not to code my interviews using the same structure as for policy texts because, having conducted each interview and taken notes after each one, I was already aware of insightful data that begged analysis, but that would not easily fit within the reductive 'policy frame' model. The interview questions had been carefully calibrated to generate highly relevant data. Therefore, I sought to analyse the full richness of the data by coding the interview transcripts both deductively and inductively.

Easton (2010) suggests both deductive and inductive approaches for critical realist case research, for the former is useful for identifying the phenomenon of interest, suggesting mechanisms and linking to previous literature, and the latter provides specific data to be explained. For example, I made high-level categories to capture data relevant to major themes I had identified in the literature review, such as 'LR Framing of 'health inequalities', 'LR Joined-up Government', 'LR Performance Management'. I also made a 'Texts' category and then coded within it specific interview comments about policy texts I had analysed.

As well as these major 'top-down' categories, I created hundreds of further codes from an inductive, 'bottom-up' approach, as I read through each text. I attempted to allow participants' speech to define codes, where possible, to stay close to the data. New codes were constantly created to represent insightful data, while existing codes were always subject to merging with new data, or splitting to create distinctions, or to being moved within the coding structure. By the time I had coded all texts I was very familiar with all transcripts and could move between them quickly to find and code links between data.

After coding all texts, I noticed that six transcripts had particularly low numbers of references to codes, and that five of them were the first five interviews I had coded. The other had been a shorter interview with a nervous participant offering limited answers; I

judged this interview was unlikely to be significantly under-coded. But I returned to re-code the first five interviews, cognisant that I had likely added many new codes and altered others since I had first coded these interviews. This was a fruitful exercise, as I added around 25% more references to codes in the first transcript, around a third more to the second, and then under a fifth more to the third and fourth, and less to the fifth. As returns were diminishing, and subsequently conducted interviews each had hundreds of references to codes with no discernible deficit or pattern, I decided this re-coding was sufficient.

After I was satisfied that all coding was complete, I had 1,027 distinct codes in total, within five major categories: 'Texts', 'Policy Approaches to Health Inequalities', 'Policy Approaches to Health', 'Policy Approaches to inequalities', and 'Policy Issues more generally'. Within these five categories were further sub-categories for 'Ideas', 'Practices', 'Structures', answers to specific questions I had asked, and responses directly relevant to themes of the literature review. Sub-categories below this level became ever closer to the data, and often only represented single comments. Transcripts made reference to between 47 and 147 codes each. I referenced the most interesting interview 474 times to a code, and another contained 329 references; all others contained less than 300 references, with the least insightful interview generating 105 references to a code.

3.6.6 Analysis of interviews

The process of conducting the interviews, checking transcripts, anonymising transcripts, and then coding transcripts, included constant reflection on and consideration of the data, so must be considered part of the analytic process. Throughout the coding process, I noticed recurring patterns in the data, which could then be categorised together as themes which I could then write a few pages about, including with reference to similar (or dissimilar) accounts in previous literature. I also contextualised and analysed sections of data I considered to be clearly relevant to the subject of the thesis, even if not repeated or patterned in any clear way. This process of noticing patterns or key sections in the data, and then writing about them, continued until I had around fifteen written sections of analysis, each of between 400 and 2000 words, of data from interviews. This was a creative - or perhaps 'messy' - non-linear process of thinking, writing, re-thinking and re-writing.

As I gathered more sections of analysis, from both policy texts and interviews, I assessed them for similarities or patterns, to understand if any could be combined, or if they could be grouped together into fewer, more substantive chapters of related findings. This was

also an exploratory process, with much trial and error, before I settled on the structured Results chapter findings as presented below.

3.7 Limitations

Although I benefited from SIPHER's partnership agreement with the Scottish Government and GMCA in terms of accessing participants, I was not able to interview policymakers in several important policy domains, including employment, spatial planning and climate policy in GM, and devolution arrangements in Scotland. Further, interviews with policymakers may be limited by the 'official line' (Duke, 2002); particularly in Scotland, some participants were clearly cautious about their responses. Therefore, my interview data likely partly reflects participants' desire to say 'the right thing', at times.

Professional rules around policymaker disclosure mean this risk is not entirely mitigatable. However, while making clear to participants that I understood their limitations, I frequently used follow-up questions to probe for deeper answers. Further, by offering all participants the opportunity to view and edit their anonymised transcripts later, I hoped to put them at ease in the knowledge that they could later check their words. Only a few participants asked to review their transcripts, and only one made minor changes to the content.

My finding of section 7.2.1 – that the GM-disadvantage framing was so common due to its role in political negotiation with the UK Government – was supported by ample data. Unfortunately, responses from Scottish interview participants on similar questions were less forthcoming. Further, I had limited data from Scottish participants on the 'drug deaths emergency'. I believe this is partly because I too was misdirected by the framing effect of 'health inequalities': although a Scottish Government participant suggested I speak to someone in drugs policy, and an individual was shortlisted for contact, I did not prioritise contacting them as I intuitively considered drugs policy somewhat distinct from health inequalities. Therefore, the analysis of section 7.2.2 is more exploratory, combining implications of my GM data with Scottish-context data from different external sources. Further research could modify or strengthen this analysis.

Finally, as should be evident from the above description of my methods, I made many decisions or judgements which other researchers may reasonably have judged differently. For example, there is no academic consensus about the constituent parts of a policy frame: I

chose Lynch's five-part model, but others may fairly argue for other models. Further, analysing social and economic policy texts for 'health or wellbeing frames' necessitated important prior judgements about what may conceivably count as relating to 'health or wellbeing'. Each of these judgements – not to mention the thousands of judgements made during qualitative coding – are contestable, such that this research is the unique product of this researcher only. However, I believe I have constructed a credible account, by being rigorous with and transparent about my methods; and by regularly seeking and considering feedback from supervisors, and from policymakers and other academics after presentations.

Chapter 4 – The role of frames in policy approaches to health inequality

4.1 Introduction to the chapter

As described in the literature review, one of the key interests of this thesis is to explore the proposal of Lynch (2017, 2020) that the 'health inequalities' policy frame is ineffective because it does not align with the neoliberal policy paradigm, which dominates policy goals. Therefore, this short chapter has two purposes. Firstly, it is important to specify what is meant by terms such as 'frame', 'paradigm' and 'idea'. There is ample literature discussing these concepts already, but for the purposes of this thesis, a summarised analysis is sufficient.

Then, the chapter uses these concepts to analyse three issues found in my data: firstly, I discuss two 'frame disputes' (Benford, 1993, 2013) in Scotland; then I unpack how two related policy frames in Greater Manchester exclude a key idea related to health inequalities. By providing three specific analyses of idea, frame and paradigm interaction, this chapter aims to enhance the reader's understanding of these key concepts for the remainder of the thesis.

4.2 Frames, framing, ideas and paradigms

More than twenty years ago, Hertog & McLeod (2001, p141) described framing literature's conceptual openness as "*both a blessing and a curse*", and a decade later Vliegenthart and Van Zoonen (2011, p105) criticised the "*cacophony of new definitions*" since Entman's (1993) widely cited – but seemingly ineffective – article 'Framing: clarifying a fractured paradigm'. In this brief section, I shall attempt to avoid this trap with a description of how my reading of the literature informs my construction of these key concepts for the purposes of this thesis. To borrow a disclaimer from Entman (2003, p418): the below section "*is not the only way to, as it were, frame framing*".

Table 4a: Key conceptual terms and how they should be understood in this thesis

Term	Understanding	References
Idea	The basic unit of frames and paradigms; umbrella term for paradigms, frames and other 'mental constructs'.	Campbell, 1998, 2002; Beland, 2005; Beland & Cox, 2011; Swinkels, 2020
Frame	A specific arrangement of ideas, which importantly *includes* or *excludes* particular ideas, and is often subject to contestation.	Goffman, 1974; Gamson & Lasch, 1983; Schön & Rein, 1994; Rein & Schön, 1996
Framing	The agentic construction of an idea-arrangement; or the outcome of such a process.	Entman, 1993; Benford & Snow, 2000; van Hulst & Yanow, 2016
Paradigm	An embedded interpretive framework, a set of shared ideas or assumptions, rarely subject to contestation.	Hall, 1993; Baumgartner, 2013; Daigneault, 2015.

Conceptualisations of framing depend on ideas, which have a very long history in sociological thought, going back at least as far as Weber, who wrote that "*very frequently the 'world images' that have been created by 'ideas' have, like switchmen, determined the tracks along which action has been pushed by the dynamic of interest*" (1946, p280). But the role of ideas in social and political science has been much further developed in the last quarter-century due to an 'ideational turn' (Beland, 2005; Beland & Cox, 2011; Campbell, 2002; Swinkels, 2020).

Cairney (2019) identifies three main uses of 'ideas' in this literature:

1. As a specific proposed solution to a specific policy problem (as in 'I have an idea'),
2. Relating to persuasion and argument (including the strategic act of 'framing'),
3. As understandings "*so deeply accepted that they can be taken for granted, as part of everyday language, despite having a profound effect on the terms of policy debate*" (p191).

In this thesis, following Parsons (2007) and Cairney and Weible (2015), I shall consider ideas to be the basic unit of frames and paradigms, and I shall follow this tripartite conceptualisation of them.

Van Hulst and Yanow (2016) trace frame and framing literature to the anthropological work of Bateson (1955), who observed biting monkeys and supposed that there must be a 'meta-communication' between them as to whether they were fighting or playing. Erving Goffman (1974) developed this thinking and much frame and framing theory builds on his work: first, that each animal must unconsciously adopt a 'definition of the situation' as a guide to the interaction; and later, that conscious and strategic 'game playing' might define situations differently. While frame and framing literature expanded to disciplines such as social movements (Snow & Benford, 1988), psychology (Tversky & Kahneman, 1981), linguistics (Lakoff, 1987) and communication studies (Entman, 1993), Donald Schön and colleague Martin Rein developed influential approaches to frame analysis within public policy (Rein & Schön, 1977, 1996; Schön & Rein, 1994).

For Rein and Schön (1996), there are four ways of conceiving of frames:

1. as a scaffolding (or inner structure),
2. as a boundary that distinguishes relevant elements from less relevant contextual elements (like a picture frame),
3. as a cognitive schema of interpretation,
4. or as a diagnostic or prescriptive story.

These four conceptualisations of frames "*all rest on a common insight: there is a less visible foundation – an "assumptional basis" – that lies beneath the more visible surface of language or behaviour, determining its boundaries and giving it coherence*" (1996, p88).

I find this 'assumptional basis' phrase very useful when thinking about frames and paradigms, as it invites critical questioning. However, on reflection, for the purposes of this thesis I believe Rein and Schön's four conceptualisations may be adequately combined into two.

Firstly, the second and fourth types of frame, according to Rein and Schön, seem able to be combined into the 'foreground' frames strategically constructed and commonly contested, as described by Cairney's second level of idea-type. In this sense, 'picture composition' may be a superior metaphor to 'picture frame' as the word 'composition' more clearly implies agency and therefore the presence of an agent with positionality and intentionality. This is closer to Entman's (1993) widely cited definition, which defines the verb 'to frame' as a selection and promotion activity, and therefore closer to the common analytic perspective

of framing as a strategic political activity of different interest groups (Lakoff, 2004; Katikireddi et al., 2014; Hilton et al., 2020).

Equally, the first and third type of frame described by Rein and Schön seem to me rather similar: a scaffolding, inner structure, or schema of interpretation. Like the walls of a building, these structures are not invisible, but may constitute 'background' or taken-for-granted boundaries, subtly shaping our activities in the space, and rarely if ever being knocked-down or re-built differently (Campbell, 1998).

A better way to describe such a 'taken for granted' schematic frame may be as a paradigm. There are also a range of interpretations of policy paradigms, mostly based on the work of Hall (1993), which itself translated Kuhn's (1962) conceptualisation of scientific paradigms into policy contexts. Hall's own explanation warrants attention:

> "*More precisely, policymakers customarily work within a framework of ideas and standards that specifies not only the goals of policy and the kind of instruments that can be used to attain them, but also the very nature of the problems they are meant to be addressing. Like a Gestalt, this framework is embedded in the very terminology through which policymakers communicate about their work, and it is influential precisely because so much of it is taken for granted and unamenable to scrutiny as a whole. I am going to call this interpretive framework a policy paradigm*" (Hall, 1993, p279)

In this seminal definition, note that paradigms are described as "*interpretive framework*[s]" that are influential partly because they are "*taken for granted*". In this sense the meaning of paradigm seems to overlap with Rein and Schön's description of frames as an 'inner structure' or 'schema of interpretation', and with the third form of ideas Cairney (2019) described as similar to 'taken for granted' shared languages.

Therefore, for the purposes of this thesis, Rein and Schön's four frame-types can fruitfully be merged into two which align with Cairney's second and third idea-types, and can be considered simply as 'foreground' and 'background' frames, respectively. Here I shall follow Campbell (1998) and Rushton & Williams (2012) by using 'frame' to mean a 'foreground' arrangement of idea elements together. Unlike paradigms, these foreground frames are often contested, both within organisations (Benford, 1993, 2013), and in wider society (Hilgartner & Bosk, 1988; Snow & Benford, 1988; Ferree, 2003). While 'frames' are static

ideational constructs, 'framing' as a verb refers to the process of constructing a frame, which is often social and strategic; or as a gerund (as in 'this framing…') is the same as 'a frame', but with emphasis on the agentic process behind it.

Further, Cairney's third idea-type can be named 'paradigm', describing a set of ideas at the macro level that functions as an embedded interpretive framework. Paradigmatic ideas are often 'background' assumptions, and so rarely contested. In my view, using 'frame' or 'idea' here would be unnecessarily confusing.

Following Hall (1993), Campbell (1998), Rushton & Williams (2012) and others, I understand ideas to act and interact at different levels within policy, with policy frames being subservient to policy paradigms, and therefore able to fit, align, or resonate with them to a greater or lesser extent. These conceptualisations also align with Lynch's (2020) description of 'health inequalities' as a framing of five specific idea elements foregrounded by policy proponents, which is unable to align with the background policy paradigm of neoliberal economic interpretations and assumptions.

However, policymakers are not the only audience for policy communications, and other frame receivers may have different 'background' interpretive frameworks. As I shall describe in the next section, disputes about policy frames can emerge from different understandings of who will be tasked with interpreting the frame, and what their assumptions may be.

4.3 Framing disputes within Public Health Scotland

Public Health Scotland (PHS) was established in April 2020, just one week after the first UK-wide lockdown was announced in response to the novel coronavirus. Its establishment followed three main drivers for public health reform in Scotland between 2011-2016 - the Christie Commission, the Health & Social Care Delivery Plan, and the Public Health Review – which called for closer public service partnerships and stronger national-level public health leadership.

Both Scottish Government and PHS participants expressed the view that PHS's arms-length status gave it 'credibility' it would not possess as an internal government department:

> "*I think it's that what we're respected for and trusted with is that we're led by the evidence, so there's blue water between us and policy decisions, in that we will*

> *always be led by what the evidence says is, and we can give our view on that and then it's for policymakers to make the policy decisions."* [SCOP14H]

However, this rationalist division between evidence and politics is rather less clear than "*blue water*" suggests, as the same participant hinted at in an aside in their following sentence:

> "*That's so important, I think, in terms of our integrity and the trust that the public and other partners have in us, so* we can't be accused - although we are being accused in the MUP evaluation - *but there's fidelity there to the evidence and public health expertise view of what that evidence tells us.*" [SCOP14H, my emphasis]

This brief aside - "*we can't be accused, although we are being accused"* - concisely represents the political scientific critique of public health: that it is politically naïve, beholden to evidence-based policy ideals derived from evidence-based medicine but unsuited to social or political systems (Bernier & Clavier, 2011; Fafard et al., 2022; Lynch, 2023). This in turn is related to the well-described dilemma in which public health participants frequently express a tension between desires to present 'credible' research evidence, and desires to contribute more politically to inspire action to improve public health and reduce health inequalities (Carr-Gregg, 1993; Haynes et al., 2011; Rychetnik & Wise, 2004; Smith & Stewart, 2017). This dilemma is in evidence at PHS in two framing disputes concerning the appropriate presentation of public health ideas.

The first framing dispute has been prompted by work by the PHS leadership with a framing think-tank. Frameworks UK is a 'sister organisation' to the US-based Frameworks Institute, which was founded in 1999 by communications strategist Susan Nall Bales. Both US and UK-based Frameworks organisations have recently worked with UK think-tank the Health Foundation on reports about public and media understandings of health (Levay et al., 2018; L'Hote et al., 2018), framing the wider determinants of health (L'Hôte et al., 2022) and a 'toolkit' called 'How to talk about the building blocks of health' (The Health Foundation, 2022).

The toolkit promotes three key 'ingredients' to "*tell a more powerful story about health inequalities*" (p1): emphasising importance, increasing understanding, and promoting the possibility of change. For the latter two ingredients, it suggests using the metaphor of 'building a healthy society' with key 'building blocks' such as housing, transport, money, and

work. Frameworks UK report that this metaphor is highly effective with the public because it suggests both that health is shaped by interacting structural forces, and that those structures can be rearranged (L'Hôte et al., 2022, p14–15).

This approach appeared to be persuasive to leadership at PHS, and the 'building blocks' metaphor began appearing in organisational documents (PHS, 2022) and on its website (PHS, 2023). But PHS participants described how this work had received a "*hit or miss*" response from internal colleagues. Crucially, PHS's communications team "*haven't really bought into it*", despite Frameworks delivering an internal training session to try to embed it. Further, PHS staff in "*the academic bit*" of the organisation working on inequalities "*really didn't like these frames*", causing "*so much pushback*", one senior PHS participant said.

The objection was that Frameworks-suggested frames that focused on the 'building blocks of health' were inaccurate and "*too simplistic*":

> "*They felt that the frames weren't accurate because they didn't talk about the more upstream drivers in terms of inequalities in power and wealth. Because the building blocks tend to focus more on specific policy areas really when you think about good work, income, housing, so it was the lack of the wealth and power inequalities as being even further upstream than availability and access to these building blocks."* [SCOP14H]

This participant added that the Frameworks research was "*evidence-based*" - referring to the on-street interviews, survey experiments and focus groups conducted by L'Hôte et al. (2022) – and that it was "*more likely to engage [actors] across the political spectrum*". In support of this, another PHS participant cited several senior Scottish politicians, from different political parties, who had used Frameworks-type language publicly after PHS input.

For another participant, the objectors were "*purists*" preferring to critique rather than to support policy change. The participant quoted above also used this term, saying the objectors were being "*a bit purist in terms of [saying]: but the evidence is pointing to this"*, this time implying epidemiological evidence that inequalities in power and wealth drove inequalities in health. Therefore, both positions were said to be supported by evidence, but different types of evidence: for PHS-Frameworks, evidence supporting individual-level framing effects potentially leading to policy change; for the objectors, evidence supporting population-level health effects of stratified distributions of power and wealth.

The second framing dispute referred to in my data related to the recently coined term 'commercial determinants of health' (CDoH), which have been defined as: "*strategies and approaches used by the private sector to promote products and choices that are detrimental to health"* (Kickbusch et al., 2016, p895). For many years, private sector industries producing health-harming products such as tobacco, alcohol and unhealthy foods, have made use of their power and wealth to frame health issues in ways that exculpate their products (Oreskes & Conway, 2011; Hilton, 2023). The 'commercial determinants of health' term acts as a counter-framing to foreground the key role of these sectors and others in shaping population health outcomes.

One PHS participant told me that internal work on the 'commercial determinants of health' had been re-framed higher up the organisation as 'health behaviours'. This reframing swaps the focus on powerful commercial forces shaping population health outcomes for a focus on individual agents making de-contextualised choices.

> "*We need to make this term [commercial determinants of health] acceptable and understandable by civic community, not dumb it down to behaviours because it's fundamentally two different things*."

These framing disputes can be assessed in terms of how each policy frame relates to dominant ideas or paradigms in particular arenas. In the first framing dispute – between discussing health inequalities in terms of 'building blocks' or in terms of 'inequalities in power and health' – the different types of evidence used to support each frame implies different anticipated frame receivers, and therefore different sets of shared assumptions.

When PHS is aiming to communicate directly to Scottish Government policy audiences, the paradigmatic assumptions they seek to engage with include the perceived electoral benefits of media coverage, and the organisational structures of the Scottish Government. In the former case, the aforementioned 'building blocks' toolkit (The Health Foundation, 2022, p8) promotes the 'building blocks' metaphor as "*catchy and memorable*" for headlines and press quotes, therefore boosting its appeal to politicians. In the latter case, the participant quoted above highlighted how the 'building blocks' framing aligned with specific policy areas, reducing the need for notoriously problematic joined-up government work. In these two important ways, this framing aligns with Scottish Government policymaking norms.

On the other hand, frames about 'inequalities in power and wealth' are likely to misalign with policy paradigms in these two ways. While 'building blocks of health' is simplistic, 'inequalities in power and wealth' may be too complex for media readerships, or too challenging to private media interests, to gain or sustain broad media attention. Unlike 'building blocks of health' like good work, income or housing, power and wealth have no clear lines of accountability within policy settings, and therefore need to be addressed cross-governmentally with a range of unspecified policy instruments. A PHS-Frameworks participant explained this issue as: "W*e need to use the frames to lead them towards tangible action, and if we come in talking about power and wealth […] well, what is the tangible action you're trying to lead them towards there?*".

However, if the objectors of PHS expect other academics to be receiving their communications about inequalities in power and wealth, then the relevant background assumptions change. In this case, strategic intentional framing is anathema as communications should strictly convey research findings only. This would clarify the "*purist*" criticism: the objectors are perceived as attempting to stay 'pure' as impartial researchers rather than conceding any partiality to the cause of strategic framing. Their framing may align with academic public health paradigms, where inequalities in health are widely held to result from wider social and economic inequalities. But it may not align with existing policy paradigms, as described above. The senior PHS participant did not reject the diagnostic 'truth' of this framing, but did question its ability to resonate in policy settings and therefore to lead to policy change: "W*e're not saying that's not true, what we're saying is that's not engaging people and leading to the types of action that we want.*"

As aforementioned, this dispute also reflects the dilemma in public health between descriptive research activities and normative advocacy activities. As in the existing literature, all present participants believed themselves to be working to promote policy action to improve public health and reduce health inequalities. However, they used different strategies to do so: the objectors concerned with 'accuracy' and scientific 'purity', and the PHS-Frameworks approach of strategic framing to engage media, policy and political actors.

The second dispute is different: both groups appear to be fully aware of the political nature of public health policy. Here a different frame receiver is imagined by the participant who says: "w*e need to make this term [CDoH] acceptable and understandable by civic*

community". Therefore a strategic intention for the framing is acknowledged: diffusion into wider society. This acknowledgement of political intent may reflect the stark political critique inherent in the CDoH framing. But others in the organisation may have different intentions.

Without specific data on this point, we may surmise similar intentions as with the 'building blocks of health' example: to influence Scottish Government policy in the short-term. In this case, 'health behaviours' aligns with the individualistic medical model of health described as an 'institutionalised idea' in UK policy settings by Smith (2013). In that research, the medical model of health was described as visible in the organisational divisions of policy responsibility. A decade later, the present Scottish Government includes divisions and teams called 'Active Scotland', 'Diet and Healthy Weight' and 'Healthy Living', clearly indicating that behavioural ideas remain embedded within Scottish policymaking for health.

Further, the strong implication of CDoH that markets need tighter regulation is often held to run contrary to the second 'institutionalised idea' identified by Smith in UK policy contexts, that of the primacy of economic growth above all other concerns. Smith found this focus on maximising economic growth to be a common assumption in her interviewees; a decade later, a senior Scottish Government health policymaker offered me several critical comments of 'socialist' public health ideas, while also implying that their role made it impossible to support:

> "*I'm not putting forward advice to recommend to ministers… as I say, socialist revolution or whatever, political suicide or, these just don't feel like reasonable things that policymakers can recommend even if from an external perspective they seem like the things that are required*" [SCOP07H]

Therefore, if the intention is to engage with actors within policy settings, it is easy to see why 'health behaviours' may have been expected to resonate with existing policy paradigms better than CDoH.

This reframing within PHS recalls the concept of 'chameleonic ideas', also in Smith (2013, ch6), whereby research-based ideas with the potential to challenge institutionalised ideas can be reframed in ways that make them less challenging. In her data, policy mediators or entrepreneurs working between research and policy settings worked to reframe psychosocial theories of health inequality causation, allowing the economic elements of

psychosocial ideas to become discarded while elements more amenable to existing policy frameworks remained. Here, CDoH has apparently been reframed by a PHS actor so that the political economic critique has been completely excised, and only the health-harming consumer action has remained. Such a drastic conceptual reframing – to the extent that the participant described them as "*fundamentally two different things"* - indicates how challenging the CDoH framing was perceived to be to existing policy frameworks.

However, in contrast to the "*surprising lack of scepticism*" about behaviour change interventions found by Blackman et al. (2009, p769), my health policy interviewees were sceptical about downstream behaviour change as an approach:

> "*This isn't about making people stop smoking, get them doing smoking cessation, this is actually about trying to create upstream interventions as much as anything else. So it's the physical environments, it's the retail experience, it's the configuration of different types of outlets and communities, etc*" [SCOP17H]

Further, the senior Scottish Government policymaker quoted above was in fact aware of and enthusiastic about the CDoH frame, and comfortable with its implications for market regulation:

> "*I think that the commercial determinants of health are so profound in relation to health inequalities that you need to get into that space very substantially. But not just in the traditional health-harming behaviour sense of alcohol, tobacco, gambling, but in a much broader sense […] this is my gentle version of socialist revolution, which is, I don't think we can storm the barricades, but I do think economically from a health perspective and health inequalities perspective we're going to need a different economic settlement.*" [SCOP07H]

Therefore, these data suggest that the CDoH frame may appeal to Scottish Government health policymakers who feel unable to recommend "*socialist revolution*" but who are nevertheless aware of the various and unequal health harms of less regulated market economies. In this case, the reframing to 'health behaviours' may have been unnecessary or even contrary to policy expectations of evidential support for regulatory proposals. This participant's views are further discussed at length in Chapter 8.

4.4 Policy frames excluding key ideas in Greater Manchester

A key aspect of frames is that they necessarily exclude many ideas while including others. Rein and Schön (1977, quoted in van Hulst & Yanow, 2016) say "*Whatever is said of a thing, denies something else of it.*" But to be more specific, whatever is said of a thing denies *everything* else of it. The 'something' in Rein and Schön's formulation may be interesting or meaningful; the 'everything' in mine may not. The sense-making work of framing requires excluding the non-sensical, limiting the infinite range of possibilities to the conceivable and the related; and the precise positioning of that boundary may often be contested. An example of a contestable exclusion was found in my analysis of two Greater Manchester policy documents.

The major rail infrastructure projects HS2 (High Speed 2) and NPR (Northern Powerhouse Rail) are mentioned over seventy times in the GM Transport Strategy 2040 and over one hundred times in Places for Everyone. Both documents repeatedly discuss the major economic benefits of both projects, including many thousands of new jobs and reductions in north-south inequality, and the likely reduction in car use. These benefits could be repeatedly connected to health or wellbeing via increased employment opportunities, increased income and living standards, and/or improvements to places, mobility and air quality. These connections would also align with the most common axis of health inequality identified in GM texts – that of Greater Manchester's disadvantage compared to the rest of the UK (see Chapter 7) - and the very prominent 'Levelling Up' agenda of the time which promised additional resources for the north of England (Ralston et al., 2022).

But these substantial potential benefits to health or wellbeing and to a prioritised axis of health inequality are not mentioned at all in either document. When asked about this, a participant involved in transport policy in GM said: "*That's a good point, I'd not thought of it. I think that speaks to what you were saying earlier, about when we're thinking about transport do we also think about health? And, I guess, I think the answer is no.*" This participant's emphasis on 'thinking' indicates a psychological framing effect: frames which focus on these major rail infrastructure projects exclude ideas about health or wellbeing.

This also recalls Smith's (2013) work describing how ideas may 'journey' more easily within 'institutional filters' - namely the policy paradigms separating vertical lines of accountability

– than they can horizontally across paradigms. Applying this model to the above scenario, the separation of GM policymakers into 'transport', 'spatial planning' and 'health' domains allows specialised or complex ideas about each to flow within each silo, but limits which ideas may travel across. Indeed, the transport policy participant's first suggestion for why these documents did not mention health or health inequality in relation to HS2 or NP2 was that they were managed by experts more concerned with such specialised ideas: "*technicians… who are interested in procurement and costs and routes and trains, and those considerations*".

Further, ideas linking transport and health – such as via pollution, physical activity and accidents – were accommodated within the transport and spatial planning documents. Also accommodated were ideas from economics about capital infrastructure, productivity and employment. But ideas connecting employment and health were excluded. This made some sense for the transport policy participant, whose use of 'lens' is similar to my use of 'frame':

> *"Whilst there will be a health benefit to a massive civil engineering programme such as HS2, it's not immediately obvious that it would be viewed through that public health lens… there is a health dimension, I guess, to be made, but it's a bit looser, I think the argument is slightly looser."* [GMP05O]

This comment that the argument is "*looser*", and "*not immediately obvious*", implies that it is a more complex idea, and so less likely to journey horizontally across policy domains. On one hand, the impacts of pollution, physical activity and accidents on health are direct and intuitive; on the other hand, the impacts of employment on health are indirect and require consideration of complex pathways. This dichotomy between quick, intuitive cognition, and considered, slow reflection, is described by Kahneman (2011) as Type 1 and Type 2 thinking, and the latter is required to transcend the boundaries created by policy paradigms.

Therefore, the connection between the agentic process of 'thinking' and the structural forces of institutionalisation is made clear: previous arrangements of ideas into policy domains with vertical lines of accountability embed those ideas together, facilitate paradigmatic policy development, and exclude non-paradigmatic ideas, obstructing joined-up government to address complex policy challenges. This is a form of path dependency - of ideas laying the tracks along which action is pushed many years later – and it is also visible in many of the health and inequality frames which shall be discussed in the next chapter.

Chapter 5 – Conceptualisations of Health 1: as ill-health

5.1 Introduction to the chapter

As described in the introduction, previous research on policy approaches to health inequalities has tended to focus on health policy settings (Graham, 2009; Baum et al., 2013; Kriznik, 2015; Kriznik et al., 2018; Lynch, 2016, 2017, 2020; Maybin, 2015, 2016; Povlsen et al., 2014; Smith, 2007, 2013a; Smith et al., 2009; Vallgårda, 2007, 2008). This reflects the usual policy practice of placing responsibility for health inequalities within health departments. However, this body of research shows that locating policy responsibility for health inequalities within health departments encourages a narrow range of downstream policy solutions, rather than the wider range of upstream solutions implied as necessary by the social model of health and often acknowledged as such in policy texts.

Therefore, while health policy texts may describe population-level social and economic causes of health inequalities, their proposed solutions tend to be limited to individual-level healthcare or behavioural interventions. The movement from social causes to behavioural or healthcare solutions has been characterised as 'lifestyle drift' or 'downstream drift', both indicating a move from population-level problems to individual-level solutions.

The key implication of this downstream drift is that policy approaches to health inequalities may be more successful if they can be located outside of health departments. But this raises further questions. Which policy teams or departments should have policy responsibility for health inequalities, if not health teams? If it is to be a cross-governmental approach, which team or department should lead it, if any, and if not a health team? Might other policy teams or departments fall into similar traps as health policy teams, again leading to 'downstream drift' rather than the upstream approach sought by such a novel policy approach? The aim of this chapter and of chapter 6 is to understand how social, economic and health policy teams conceptualise 'health', to illuminate potential answers to these questions.

This chapter describes results which broadly support existing findings associating health policy with downstream policy solutions, highlighting a basic incoherence between present

health policy structures and practices and the policy requirements of the social model of health. This is evident in the first main section of this chapter (5.2) which contains detailed analyses of specific lifestyle and downstream drift present in the texts, particularly in the health policy texts.

The second major section of this chapter (5.3) also describes alternative framings of health present in social and economic policy which, while individually narrow, are consistent with the social model of health. However, individualised conceptualisations of health are also present in social and economic policy settings. This section contains five shorter sub-sections to describe these different sources of individualisation: conceptualisations of health as illness; comparisons with 'wellbeing'; in response to the Covid-19 pandemic; contributions from UK government actors; and contributions from health policy actors.

Overall, whether directly within health policy texts or through contributions to social and economic policy texts, health policy actors appear responsible for most of the individualistic framings of health or wellbeing present across each corpus. But individualised framings of health also persist among social and economic policy actors, suggesting a need for alternative routes to a consistently social framing of health in policy settings.

5.2 Conceptualisations of health in health policy

Firstly in this section, I will analyse how health policy texts frame health or wellbeing, starting with the three health policy texts from Greater Manchester, and then the five health policy texts from Scotland. Then, I will describe and assess clear examples of lifestyle drift in two of the analysed health policy texts. Finally in this section, I will describe two further cases of downstream drift in the chosen health policy texts.

5.2.1 How do health policy texts frame health or wellbeing?

Health is framed individualistically in both GM health texts aimed at adults - Taking Charge: the Next 5 Years (2019) and Transforming the Health of Our Population (2019) - as visible in the table below:

GM Health	Health or Wellbeing Frame
Taking Charge: The Next 5 Years (2019)	Healthcare systems in GM can be improved in dozens of ways, including localising and joining-up healthcare services, innovating interventions, and improving efficiencies. These are made possible by devolution.
Transforming the Health of Our Population (2019)	Health outcomes in GM are generally worse than in England overall. We run a series of programmes for healthier lifestyles in adults, and childhood and elderly health. We are developing a new radical approach to population health in GM, enabled by devolution.

The former presents health as disease, which is suffered by individuals and resolved medically, while minimising wider determinants of health or wellbeing. Its interest in 'innovation' and 'efficiency' portrays a technocratic approach to healthcare improvement. It includes a textbook example of Lifestyle Drift, described in the next section. The latter text focuses on small-scale behaviour change programmes which ignore determinants of health behaviour. It quotes the Marmot Review (2010) in large text saying - "*This link between social conditions and health is not a footnote to the 'real' concerns with health – health care and unhealthy behaviours – it should become the main focus*" – in what appears to be a footnote across the text's final two pages (p46-47).

The Children and Young People's Health and Wellbeing Framework is less able to responsibilise children or young people, or to emphasise disease. It takes a lifecourse approach, recognising that "*disadvantage starts before birth and accumulates throughout life".* It makes clear that children are shaped by their "*earliest experiences*", and that they need to grow up in "*an environment that nurtures their development*", including "*places to play*" and with better air quality (p4-5). However, despite its well contextualised constructions of children's health or wellbeing, its solutions are almost entirely service-based or aimed at parenting behaviours.

GM Health	Health or Wellbeing Frame
CYP HWB Framework (2018)	A lifecourse approach, starting in early childhood, should be taken to health and wellbeing. Educational and employment outcomes are key. High quality support services are needed for children in care and families at risk.

Similarly, the Scottish Government's Mental Health Strategy (2017) focuses on a deficit framing of mental ill-health, and proposes various contextual causes of mental ill-health, but is entirely reliant on downstream, reactive solutions based on access to 'help' or 'support'. It also emphasises that mental health should have 'parity of esteem' with physical health, a proposal underpinned by medical model assumptions (see 5.2.3, below).

Sco Health	Health or Wellbeing Frame
Mental Health Strategy (2017)	There are many causes of poor mental health, including adversity or trauma, poverty, unemployment, isolation, disability, and discrimination. Support services should be embedded across public settings to improve accessibility and enable early intervention.

Public Health Scotland's Strategic Plan emphasises a multistakeholder rationale of collaboration (Godziewski, 2020) that obscures the need for trade-offs, while focusing on a different set of priorities from the Public Health Priorities for Scotland (2018) text, risking confusion (see Chapter 6). It also repeatedly conceptualises health individualistically. The Programme for Government 21-22's Health Chapter is highly individualistic, focusing almost entirely on medical services, with prevention immediately connected to health behaviours. These texts are further discussed in the next section.

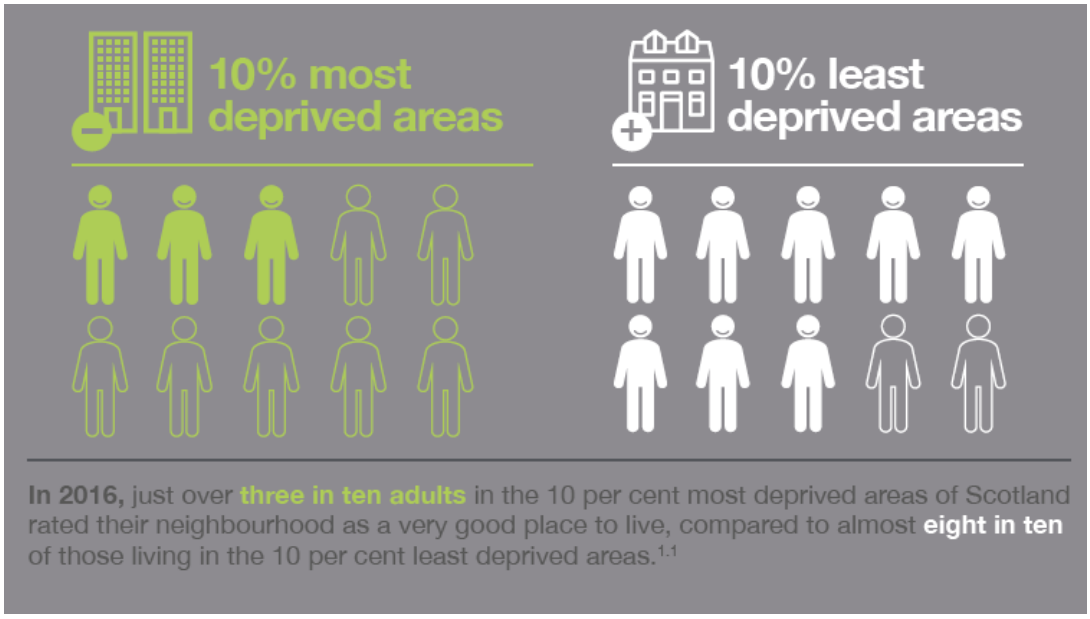
Sco Health	Health or Wellbeing Frame
PHS Strategic Plan (2020)	By working together, communities can thrive. This means controlling Covid-19, tackling mental illness, supporting communities and places, understanding the needs of children, and reducing poverty. We can achieve this by collaborating.
PfG 21-22 Health Chapter (2021)	To recover from the pandemic, we will provide new investment in frontline services, NHS infrastructure, staff wellbeing support, mental health services, a new National Care Service, and services to tackle the drugs death emergency. Longer-term we must move to prevention by promoting active, healthy lifestyles.

On the other hand, both the Public Health Priorities text, and the PHS Delivery Plan, consistently frame health or wellbeing as contextualised within social and economic systems.

Sco Health	Health or Wellbeing Frame
Public Health Priorities (2018)	Wellbeing and health are created in the lives we lead. Living in deprived areas and suffering adversities, particularly in childhood, contribute to poor physical and mental health, and to unhealthy behaviours. By improving our environments, reducing poverty, and limiting harmful behaviours, we can work in partnership to create wellbeing.
PHS Delivery Plan (2021)	Health is threatened by many things in the community, including Covid-19, which caused serious long-term harms. Mental health and wellbeing needs more focus. Long-term efforts are needed to address poverty and help children

In the former document, each of the six public health priorities is described in a chapter, each of which features statistics shown as infographics. Four of the priorities – relating to place and community, early years, mental wellbeing, and an inclusive economy – feature infographics showing social patterning, as in the example below.

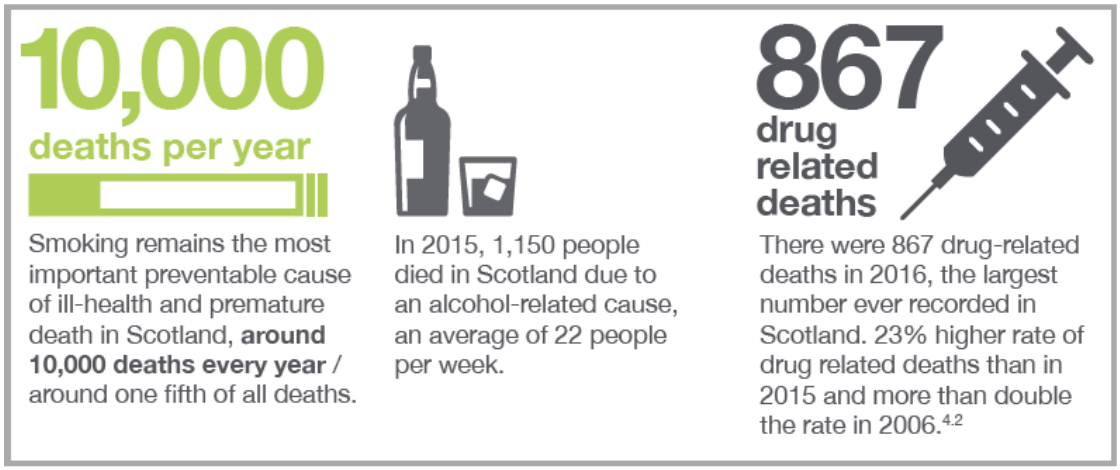
Fig. 5a: Infographic from p12 of Public Health Priorities for Scotland (2018), chapter '*Priority 1: A Scotland where we live in vibrant, healthy and safe spaces and communities*'



Almost half of the 57 statistics in these chapters refer to an inequality, usually of area deprivation as in the above example. However, in the two chapters which concern priorities commonly associated with health behaviours – alcohol, tobacco and other drugs, and

eating well and physical activity – none of the 27 statistics used refer to inequalities (as shown in the example below).

Fig. 5b: Infographic from p31 of Public Health Priorities for Scotland (2018), chapter 'Priority 4: A Scotland where we reduce the use of and harm from alcohol, tobacco and other drugs'



Similarly, while Chapter 4 vaguely says that "*substance use varies across communities*", it adds that the harm "*disproportionately affects those living in deprived communities*" (p26). This passive construction acknowledges unequal health harms without responsibilising individuals for substance use; instead the deprivation of the community remains in focus. A participant closely involved in the Public Health Priorities document told me this was deliberate: "*We didn't want to stigmatise, we definitely have a policy, so to speak, not to stigmatise communities, so the language was chosen carefully in that respect, that's definitely something I recall discussing … I think the framing was intentional".*

In this analysis, the Public Health Priorities and the PHS Delivery Plan are able to avoid downstream drift because they do not have to commit to policy action: there is nowhere, as it were, for their upstream conceptualisations to drift. The participant closely involved in developing the Public Health Priorities said: "*We decided that we don't need another strategy, but what we do need is a call to action and the priorities are supposed to serve as a call to action for stakeholders to coalesce their efforts around this agenda.*" The PHS Delivery Plan emphasises the supportive and collaborative role of Public Health Scotland in providing data, evidence and analysis for others to make decisions. In the next section, several individualistic assumptions in the PHS Strategic Plan are discussed; why it includes these without a need to commit to policy action is less clear. In contrast to the very plain Delivery Plan, the highly colourful, photo-filled Strategic Plan appears intended for a wider

audience, which may influence how ideas are framed within it (see Chapter 4). Unfortunately no interviewee was able to offer a view on these two PHS texts.

5.2.2 Lifestyle Drift in health policy texts

Lifestyle drift – the move in policy texts from upstream causal descriptions of health and health problems to downstream policy solutions (Graham, 2009; Popay et al., 2010) - was clearly observed in two health policy texts: GMHSCP's Taking Charge: The Next 5 Years (2019), and the Health Chapter of the Scottish Government's Programme for Government 2021-22 (2021). Both texts are focused on hospitals and the various ways to improve hospital care: the former introduces itself as being about health and social care following devolution in 2016; the latter is titled 'A Caring Society' and opens with a full-page image of a mask-wearing nurse. Both promise person-centred approaches - meaning services that cater to human individuals rather than depersonalised service users – with the latter going so far as to promise "*Redesigning the system around the individual*" (p23). Therefore, each text's focus on healthcare services brings with it an inevitable focus on individuals.

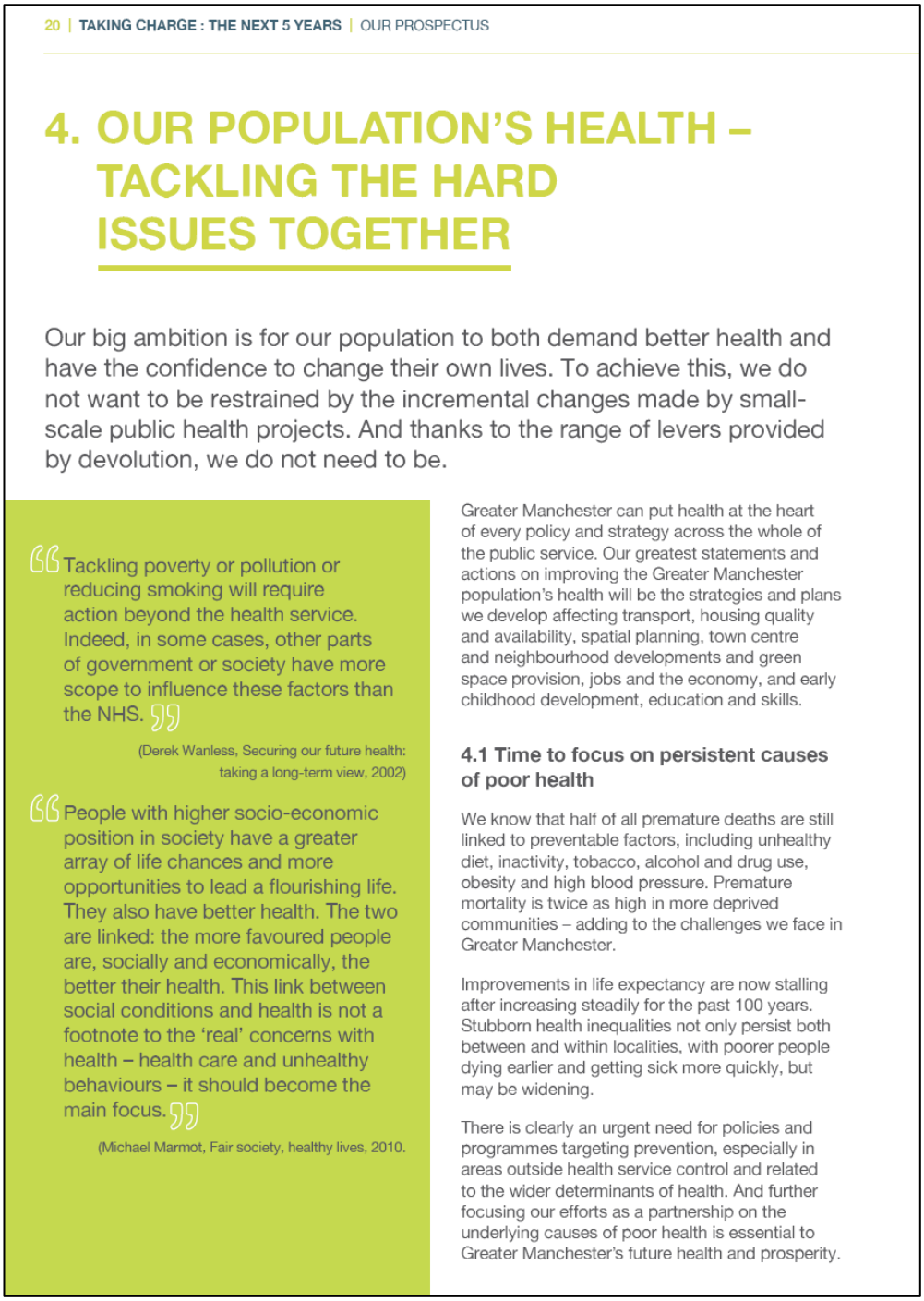
The Health Chapter of the Scottish Government's Programme for Government 2021-22 (2021) leads on the theme of 'recovery' from Covid-19. In a section titled 'Tackling the drugs death emergency' (p28), upstream determinants of drug use are inferred in broad terms: children must have "*the best start in life*", the "*social safety net*" must be strong, and a "*fairer, more equal country*" will tackle the issue "*at source*". A later section, titled 'Tackling inequality' (p32), introduces the problem of "*health inequalities*", and then "*inequalities across society*". This is the extent of the text's acknowledgement of a social model of health, despite child poverty, the poverty-related attainment gap, fuel poverty and affordable housing being key themes in other chapters.

Otherwise, the text 'drifts' to focus on lifestyle solutions. One section is titled 'Prevention and promoting active, healthy lifestyles' (p30), demonstrating the narrow focus on individual-level behavioural prevention. It immediately promises to "*prioritise services*" to improve health and wellbeing, including action to "*inspire healthy behaviours and lifestyles*". Further, smoking is described as "*the primary preventable cause of ill-health and premature death in Scotland*". This use of "*preventable*" (also seen in Taking Charge: the

Next 5 Years (2019) and the PHS Strategic Plan (2020)) places responsibility on individuals to prevent their own ill-health, rather than on policy actors, for example, who may prevent population ill-health using a range of policy levers. Therefore, while the 'drugs death emergency' has upstream root causes, general population health prevention is presented as a matter of 'promoting' or 'inspiring' individuals to change their 'lifestyle', rather than having structural or systemic sources.

Taking Charge: the Next 5 Years (2019) is a text by the Greater Manchester Health and Social Care Partnership about health and social care devolution, which was agreed in 2016. The text generally focuses on healthcare. However, the text's fourth chapter presents a textbook case of lifestyle drift as upstream causation is identified alongside downstream solutions.

Fig 5c: Page 20 of Taking Charge: the Next 5 Years (2019)



20 | TAKING CHARGE : THE NEXT 5 YEARS | OUR PROSPECTUS

4. OUR POPULATION'S HEALTH – TACKLING THE HARD ISSUES TOGETHER

Our big ambition is for our population to both demand better health and have the confidence to change their own lives. To achieve this, we do not want to be restrained by the incremental changes made by small-scale public health projects. And thanks to the range of levers provided by devolution, we do not need to be.

"Tackling poverty or pollution or reducing smoking will require action beyond the health service. Indeed, in some cases, other parts of government or society have more scope to influence these factors than the NHS."

(Derek Wanless, Securing our future health: taking a long-term view, 2002)

"People with higher socio-economic position in society have a greater array of life chances and more opportunities to lead a flourishing life. They also have better health. The two are linked: the more favoured people are, socially and economically, the better their health. This link between social conditions and health is not a footnote to the 'real' concerns with health – health care and unhealthy behaviours – it should become the main focus."

(Michael Marmot, Fair society, healthy lives, 2010.

Greater Manchester can put health at the heart of every policy and strategy across the whole of the public service. Our greatest statements and actions on improving the Greater Manchester population's health will be the strategies and plans we develop affecting transport, housing quality and availability, spatial planning, town centre and neighbourhood developments and green space provision, jobs and the economy, and early childhood development, education and skills.

4.1 Time to focus on persistent causes of poor health

We know that half of all premature deaths are still linked to preventable factors, including unhealthy diet, inactivity, tobacco, alcohol and drug use, obesity and high blood pressure. Premature mortality is twice as high in more deprived communities – adding to the challenges we face in Greater Manchester.

Improvements in life expectancy are now stalling after increasing steadily for the past 100 years. Stubborn health inequalities not only persist both between and within localities, with poorer people dying earlier and getting sick more quickly, but may be widening.

There is clearly an urgent need for policies and programmes targeting prevention, especially in areas outside health service control and related to the wider determinants of health. And further focusing our efforts as a partnership on the underlying causes of poor health is essential to Greater Manchester's future health and prosperity.

The upstream causation is prominently highlighted by two large pull-quotes on the left side of page 20: that "*action beyond the health service*" is required, from the Wanless Review (2002); and that the impact of social conditions on health "*should become the main focus*", rather than health care or unhealthy behaviours, from the Marmot Review (2010). The text then states:

> "*Our greatest statements and actions on improving the Greater Manchester population's health will be the strategies and plans we develop affecting transport, housing quality and availability, spatial planning, town centre and neighbourhood developments and green space provision, jobs and the economy, and early childhood development, education and skills.*"

However, the very next sentence is the sub-heading "*Time to focus on persistent causes of poor health*", which is followed by the "*preventable factors*" of "*unhealthy diet, inactivity, tobacco, alcohol and drug use, obesity and high blood pressure*." Therefore, Marmot's prominent request on the same page to focus on social conditions is immediately rejected. As in the Health Chapter of the Scottish Government's Programme for Government 2021-22 (2021) (above), this framing of "*preventable*" as including health behaviours and associated biomedical risk factors subtly implies that it is individuals who have responsibility for preventing their own poor health, excluding the idea that policy actors might act on social determinants. A hypothetical alternative framing of preventable factors "including poverty and inequality, unemployment, inadequate housing and social stigmas" would shift the onus to act to those with power; and thus makes the assumption of the original text clear.

One interviewee was closely involved with the drafting of Taking Charge: The Next 5 Years. On the purpose of the text, they said:

> *"We were asked by NHS England and the Treasury to do an update. So I don't think it was something we decided in Greater Manchester that we needed to do […] There's a lot of almost copying and pasting and a little bit of editing from the original Taking Charge […] I'm fairly sure there was some box we had to tick for the Treasury as well in terms of getting the next year's money paid.*"

When asked about the lifestyle drift on page 20, they said:

> "*At the time this was written, and it probably is still true now, if you were a policymaker or doing anything in strategy development, you didn't write anything about population health without bunging something that you'd copied and pasted from Michael Marmot in there, because it was the on-trend, you know, person to quote. So I think there is definitely a bit of, like, well let's just stick that in there because it sounds good."*

These quotes present a prosaic explanation for the presence of lifestyle drift in health policy texts. Firstly, the text is described as a box-ticking exercise to secure funding: already establishing that the conceptual consistency of the contents represented a low priority. Further, the interviewee names Michael Marmot as an "*on-trend person to quote*", whose work can be copied-and-pasted "*because it sounds good*". Asked about another section of the text, they said: "*I wouldn't say there's necessarily any substance behind that […] I will readily say this, it's very much empty rhetoric around policy that sounds nice.*" These comments emphasise the presentational priority of the text: that it "*sounds good*" or "*sounds nice*" is important for a document that is apparently required only for procedural reasons.

Continuing about the lifestyle drift on page 20, they said:

> "*I think then you end up with this detachment between this copy and pasting of very high-level ambitions about how we're going to completely transform people's health, and then I suppose what you're looking at which is then the actual practical programmes we're putting in place don't really speak to that […] I suppose a lot of that is probably how the health and social care system is set up and funded which is realistically we get funding to commission very small-scale programmes that you have to be able to evidence work, which is why you then commission like smoking cessation because that is a service that you can quantify and you can put in place metrics to measure that. And that is historically how we've organised health and social care. Whereas, I don't know, how do you put together a programme of work that tackles endemic poverty? You go for those low-hanging fruits, the easy things, smoking cessation and things like that."*

This quote explains the lifestyle drift critique described in the literature review (section 2.3.1) as a "*detachment*" between ambitious upstream rhetoric that "*sounds good*" and the policy options available to the team or department responsible for the document. The participant gives a specific example of this: healthcare commissioning procedures which privilege small projects with quantifiable outcomes, "*low-hanging fruit*", rather than something more complex like "*a programme of work that tackles endemic poverty*". So in this account, the lifestyle drift is connected to the evidence-based policymaking ideal and performance management regimes (both discussed in the literature review section 2.3) which prioritise funding for programmes with short-term quantifiable outcomes, rather

than the long-term, difficult to measure outcomes of upstream social or economic policy change.

This description demonstrates the basic incoherence between health policy as it has "*historically*" been structured, and the social model of health. By rhetorically asking "*how do you put together a programme of work that tackles endemic poverty?*", this health policy interviewee highlights that health policy teams could never lead such a programme. The limitations of health policy mean that even a health policy strategy with no concern for inequality would encounter the same "*detachment*" between acknowledging the social determinants of health, and downstream policy levers. This is evident in the downstream drift found in further health policy texts.

5.2.3 Downstream Drift in health policy texts

In the Scottish Government's Mental Health Strategy (2017), health-related problems were identified across all six Marmot Principle categories, indicating a wide range of ideas associated with causing mental health difficulties. For example, it states that low-paid work and unemployment are causes of poverty, which is described as "*the single biggest driver of poor mental health*" (p8), and that "*the inequalities that drive differences in physical health outcomes are the same inequalities that detrimentally impact on mental health*" (p11).

However, despite these strong statements on poverty and social inequality, policy solutions to these problems were almost all service-related at the individual-level: parenting programmes for parents of children with a conduct disorder diagnosis; ACE-awareness and mental health training for frontline service workforces; improved employability support; targeted smoking cessation and physical activity programmes. A further seventy-nine solutions relating to improved healthcare or social services are offered.

This clear downstream drift appears to be supported by a framing of 'inequality' between mental health and physical health, represented by a lack of 'parity of esteem' which is evidenced by inadequate treatment provision for people with mental health issues. Overall mental health spending in Scotland has risen significantly in recent years to 8.8% of NHS spending (Scottish Government, 2023a), but this low proportion superficially supports the

idea of non-parity. Framing inequality this way conceptualises people with poor mental health as a population group suffering a healthcare inequality compared to people with poor physical health. Therefore, instead of committing to action on the social inequalities identified as upstream causes of poor mental (and physical) health, this construction of an inequality of 'esteem' evidenced by poorer healthcare provision justifies a focus on improving mental healthcare services

Further, the 'parity of esteem' argument makes strong biomedical assumptions, since it neglects the key epistemological difference between physical and mental health: the lack of biomarkers for any mental illness. All mental illnesses are 'diagnosed' based on individual responses in interviews about feelings, beliefs and behaviours. But there are many different interviews that may be conducted, and huge variation and overlap both within and across 'diagnoses': for example, over 1000 unique symptom profiles are available for major depressive disorder (Fried & Nesse, 2015). This heterogeneity represents a profound conceptual confusion that is unparalleled for major 'physical' health conditions due to the constraints on theory provided by biomarkers (Eronen & Bringmann, 2021).

By equivalising physical and mental health, 'parity of esteem' takes the medical naturalist perspective (Pilgrim, 2007) which accepts medical terminologies as entirely valid representations of unidentifiable biological pathologies. For critical realists, the labelling of clustered feelings, beliefs or behaviours as medical 'diagnoses' despite them being undetectable by any 'objective' medical test must be open to question (Pilgrim & Bentall, 1999; Kinderman et al., 2013). Instead, mental health and illness must be understood as conceptually fluid and profoundly shaped across time and place by social, economic, cultural and political contexts (Conrad, 2007; Watters, 2010; Wilkinson & Pickett, 2020; Davies, 2021; Brossard & Chandler, 2022). This Mental Health Strategy acknowledges the parallel social origins of physical and mental ill-health problems but does not acknowledge the deep uncertainties that underlie mental health.

While this topic is too vast to explore satisfactorily in this thesis, there are clear parallels between these arguments and that of Lynch about 'health inequalities'. For example, Moncrieff (2010, p381) argues that psychiatric diagnoses are part of "*the medicalization of social problem*s", and that the framing of 'mental illness' locates social problems within individuals without objective identification, while delegating solutions to external non-political (health service) actors. This is very similar to Lynch's claim that 'health inequalities'

"*medicalizes the [*social*] problem of inequality*" (2017, p656), is associated with 'lifestyle drift' which attributes responsibility for socially patterned behaviours to individuals, and invariably leads to interventions being delegated to health service actors. In both cases, individualised 'health' framings are associated with depoliticization and ineffective policy responses.

The PHS Strategic Plan was released six months after the establishment of Public Health Scotland in April 2020, just one week after the first UK-wide lockdown was announced in response to the novel coronavirus. Its establishment followed three main drivers for public health reform in Scotland between 2011-2016 - the Christie Commission, the Health & Social Care Delivery Plan, and the Public Health Review – which called for closer public service partnerships and stronger national-level public health leadership..

The PHS Strategic Plan identifies important upstream determinants of health, such as poverty, income inequality, good work, quality housing, and education. However, an information box covering most of page 12 makes several biomedical assumptions. It lists "*three ways to prevent ill health and improve health and wellbeing*" as:

1. *Improve the foundations of community health and wellbeing to prevent people becoming unwell in the first place (e.g. immunisation, preventing the spread of diseases or promoting healthy behaviours)*
2. *Identify illness early, so it can be treated faster and more effectively (e.g. screening)*
3. *Improve treatment and recovery in health and social care services*

In this description, the "*foundations of community health and wellbeing*" are built on medical intervention, hygiene, and the promotion of "*healthy behaviours*". Secondary prevention also requires medical intervention, and tertiary prevention is entirely health and care-service based. The upstream determinants of health identified previously appear forgotten.

This tri-partite model of prevention can be contrasted with a later Public Health Scotland discussion paper (McAdams, 2023) which describes prevention differently (p6):

1. *Primary prevention: these actions try to stop problems happening in the first place, either through actions at a population level that reduce risks or those that address upstream drivers*
2. *Secondary prevention: these actions focus on early detection of a problem to support early intervention and treatment or to reduce the level of harm*
3. *Tertiary prevention: these actions attempt to minimise the negative consequences (harm) of a problem through careful management*

This time, primary prevention is either "*at a population level*" or addresses "*upstream drivers*"; while secondary and tertiary prevention are similar but allow for non-medical ways to "*reduce the level of harm*" or to "*minimise the…harm… through careful management*". Therefore, this latter framing of primary, secondary and tertiary prevention is much more inclusive of social or economic intervention than the framing of prevention in the PHS Strategic Plan.

After the section describing three forms of prevention, the PHS Strategic Plan states that "*only around 40% of cancer cases in Scotland have preventable causes*" (p12). This statistic is not referenced but is easily found in a PHS document released the previous month which explains: "*About 40% of cancers in Scotland are* preventable through lifestyle changes – *principally smoking, alcohol consumption, being overweight, physical activity and diet*" (Public Health Scotland, 2020b, p5), emphasis added). Therefore, the non-specific "*preventable"* is used in place of "*preventable through lifestyle changes*", and the individual responsibility assumed in the use of 'lifestyle' is hidden. This repeats the subtle lifestyle drift of the meaning of 'preventable' also found in Taking Charge: The Next 5 Years (2019) and the Health Chapter of the Scottish Government's Programme for Government 2021-22 (2021), described above. Again, no mention is made of the social and economic patterning of health behaviours, nor the potential impact of social or economic policy on the remaining 60% of cancers, which are implied to be unpreventable because they are not linked to individual 'lifestyle' choices.

5.3 Conceptualisations of health in social and economic policy

5.3.1 How do social and economic policy texts frame health or wellbeing?

Health or Wellbeing Frames within the social and economic corpus demonstrate two key findings: firstly, that a broader language is required to meaningfully describe health or wellbeing according to these texts; secondly, how policy domains serve as embedded interpretive frameworks to facilitate certain health or wellbeing frames, which include some ideas and crucially exclude others. These two findings combined mean that, while individual texts may seem to frame health or wellbeing rather narrowly, such a corpus of social, economic and health policy texts taken together can encompass a range of conceptualisations of health or wellbeing, with various causal stories, problems, solutions and actors identified. This suggests that social and economic policy settings can often have conceptualisations of health or wellbeing that are more consistent with the social model of health than health policy settings.

For brevity, a sample of social and economic text Health or Wellbeing Frames is presented below. Further Health or Wellbeing Frames can be found in Appendix C.

GM Other	Health or Wellbeing Frame
The Greater Manchester Model (2019)	Joined-up public services can holistically address the health, wellbeing and other life issues of GM residents. This should be co-ordinated at neighbourhood level, to better understand individuals' experiences and needs.

The GM Model for Public Services (2019) text outlines plans to integrate a range of public services into neighbourhood-based, person-centred services covering various 'needs', so that service users are not required to navigate a variety of services each with limited scope. The text regularly describes situations and services using the language of 'needs' or 'support' instead of 'health, 'wellbeing' or related language. The one time 'health' is foregrounded in the agenda is to highlight the need to assimilate it: "*Implementing the GM Model means we can exploit the opportunity to integrate health with everything and everything with health*" (p21).

SG Other	Health or Wellbeing Frame
Economic Recovery Implementation Plan (2020)	A wellbeing economy is built on economic, natural, social & human capitals, the latter including physical and mental health. Fair work and reducing inequalities are vital to public wellbeing, which is threatened by the climate crisis.
Climate Change Strategy (2020)	Our wellbeing will be enhanced by a just transition agenda that reduces climate emissions while tackling inequalities by creating green jobs.
Scotland's Vision for Trade (2021)	Wellbeing should be a core principle underlying trade policy decisions. Trade can improve our wellbeing by providing jobs and lowering prices. However, it can also threaten our wellbeing by threatening jobs, and can harm our health by undermining the NHS.
NSET (2022)	The wellbeing for people and planet is created by nature-positive economies that provide fair and well-paid work.

The move towards preferring 'wellbeing' in the Scottish Government (see chapter 6) is evident in several of the Health or Wellbeing Frames; meaningful 'Health Frames' would have been impossible for several of the social and economic texts which barely discuss 'health' specifically at all. The Economic Recovery Implementation Plan and Climate Change Strategy both emphasise the connection between climate and wellbeing; while the latter and Vision for Trade emphasise the connection between fair work and wellbeing. For the Vision for Trade, that connection between wellbeing and work can be contrasted by the strong connection between health and the NHS. Scotland's National Strategy for Economic Transformation (NSET) strongly associates wellbeing with both climate and fair work, with very little mention of health at all. These texts each prefer to connect 'wellbeing' with wider determinants of health, while either neglecting 'health' entirely, or associating it with healthcare.

Housing texts	Health or Wellbeing Frame
GM Housing Strategy (2019)	Health is shaped by housing. Good housing and neighbourhoods shape health positively; bad housing and neighbourhoods contribute to illness and injury, particularly for older people, and vulnerable households.
Housing to 2040 (2021)	Safe and warm homes in green and well-connected neighbourhoods promote health and wellbeing. Many homes need upgraded to meet their inhabitants' needs.

The extent to which social and economic policy domains provide frameworks for understandings of health within is especially apparent in the texts concerning the built environment: housing, spatial planning, and transport texts. For the GM Housing Strategy and SG's Housing to 2040, health and wellbeing are created in 'good', safe and warm homes, located in 'good', green and well-connected neighbourhoods. Across both documents, no causal stories or problems were identified connecting health or wellbeing to early years experiences, education or skills, or employment, with just one association made with poverty, and one reference in each text to healthcare. So health and wellbeing are conceptualised very specifically in relation to the policy domain, which is nevertheless a key social determinant of health.

Similarly, GM's Places for Everyone (2019) and Scotland's National Planning Framework 4 (2021) overwhelmingly conceptualise health or wellbeing as a matter of place or community, to the almost total exclusion of other ideas. Both texts identify areas for children to play, and areas for people to be physically active, as important for health or wellbeing; these could be coded as 'early years' and 'health behaviour' ideas, but equally they are concerned with the physical infrastructure of place. A planning policy participant told me planning "*can't change people's physiology or individual risk factors that come from their own biology, but we can help to change risk factors that come in association with place*" [SCOP20O]. Again, this indicates a very narrow conceptualisation of health, but one that is inevitably part of a social model of health.

Planning texts	Health or Wellbeing Frame
Places for Everyone (2021)	Health in GM can be improved by increasing walking or cycling, to both boost physical activity and reduce pollution. Attractive natural spaces, both green and blue, are also vital to wellbeing, and facilitate physical and social activity.
National Planning Framework 4 (Draft) (2021)	Health and wellbeing is shaped by natural environments that facilitate active lifestyles. Local neighbourhoods that meet community needs foster social wellbeing.

Both Scotland's National Transport Strategy 2 (2020) and the GM Transport Strategy 2040 (2021) emphasise the mobility benefits of transport, and highlight the negative health impacts of motorised transport, including less physical activity, accidents, and pollution. Again, while these texts both connect health or wellbeing with place dozens of times, connections of health or wellbeing with ideas around the early years, education, employment, or material resources are rare. Both documents' desired modal shift towards active travel is associated with health benefits, but is contextualised rather than individualised. A transport policy participant told me: "*if the behaviour change system isn't in place to make the desirable behaviour easier than the undesirable behaviour, then that's actually not a fault of the individual"* [SCOP08O].

Transport texts	Health or Wellbeing Frame
National Transport Strategy 2 (2020)	Scotland's health and the wellbeing of future generations can be improved by gradually moving away from motorised transport towards more active forms of travel.
Transport Strategy 2040 (2021)	Transport is vital for people to participate in society, but motor traffic harms health through air pollution and accidents. Active travel improves health by minimising those harms and increasing physical activity. Therefore, motor traffic should be discouraged and active travel encouraged.

In the examples above, the health or wellbeing frames of social and economic policy domains consistently portray health or wellbeing within a social model of health. Taken

together, the narrow frames of social and economic policy texts can combine to represent a much wider range of ideas about the social determination of health, and about health inequality.

However, the limited scope of each health or wellbeing frame results in some potentially useful ideas being excluded. As previously described in section 4.4, this limitation is visible in the failure of either Places for Everyone (2019) or the GM Transport Strategy 2040 (2021) to connect the projected economic benefits of HS2 (High-Speed Rail 2) or NPR (Northern Powerhouse Rail) to health benefits; nor to connect those localised health benefits with GM ambitions to reduce health inequalities compared to the rest of England (see section 7.2).

Further, individualised conceptualisations of health are present in some of the texts, and in many of the interviews with social and economic policy participants. In the remainder of this chapter, I will identify and contextualise individualistic conceptualisations of health found in social and economic policy interviews and texts.

5.3.2 Health as (physical) illness

Social and economic policy participants frequently used 'health' to mean 'illness, 'ill-health' or 'disease'. No health policy participant used 'health' in this way. This 'health as illness' conceptualisation was particularly apparent in responses from economic policy participants, including in the use of terms such as "*health-related inactivity*", "*health-related benefits*" and "*health-related benefit dependence*" [GMP10O]. Social policy and health policy participants more often used the adjective 'healthy' to describe an absence of illness, and one who worked between social and health policy teams specifically defined health as "*an absence of infirmity or a health condition*" [GMP09O].

On the other hand, both 'Ill-health' and 'disease' were only specifically used eleven times each across all 34 interviews, the latter normally within a narrow range of specific collocations: 'respiratory disease', 'cardiovascular disease', and 'infectious disease' in relation to Covid-19. 'Illness' was used only four times across all interviews; on one occasion, it was used by a health policy participant to contend that what I had described as 'non-health' policy texts were in fact "*very much health policy plans, they're just not illness policies, they're not NHS policies*" [GMP12H]. By implying that the strategies produced by

health policy teams were in fact concerned with illness, this comment acknowledges that this conceptualisation of health as illness was common.

Further, while 'health' includes mental health, limited data suggest a tendency for 'health' to be predominantly understood as physical[6]. Transport policy participants in both settings responded to questions about 'health and wellbeing' by describing 'health' as predominantly having a physical meaning:

> "*I think sometimes when we think about health, we do put an emphasis on physical health, I think that's almost a default thing… so, wellbeing, I suppose, is a slightly broader, I understand it as a slightly broader category than just physical."* [GMP05NH]

A Scottish transport policy participant identified the use of 'health and wellbeing' to mean 'physical health and mental health':

> *"When we talked about 'health and wellbeing' in the National Transport Strategy… it was about physical health and mental health, I think. So 'health and wellbeing' I think enables that, physical health and mental health broader definition than 'health' only."* [SCOP08NH]

However, while the term 'mental health' was used repeatedly by almost all participants, the term 'physical health' was rarely used, and only specifically in contrast with mental health.

Analysis of conceptualisations of health inequality across the GMCA and SG texts also suggests a tendency for health to predominantly refer to physical ill-health. As seen in Figure 5d below, across the GMCA corpus, inequalities in mental health outcomes were specified only six times[7], from a total of 86 mentions of inequalities in health, or 70 if unspecified 'health inequalities' are excluded.

In Figure 5e, below Figure 5d, inequalities in mental health outcomes were specified in the SG corpus 28 times from a total of 139 health inequalities, or 120 if non-specific 'health

[6] This also reflects my conceptualisation of health for the purposes of this research. I chose to include the Mental Health Strategy (2017), and a participant from a mental health policy team, as 'health' texts and actors. I further analysed seven health policy texts, and interviewed nine more health policy actors, without specific ties to mental health.

[7] I used a broad definition of mental health for these counts, including adjacent outcomes such as suicide, and indicators of drug or alcohol misuse.

inequalities' are excluded. Of these 28, ten were found in the Mental Health Strategy (2017), and a further 8 in the Covid Recovery Strategy (2021).

Fig. 5d: Specified health inequality outcomes: GM

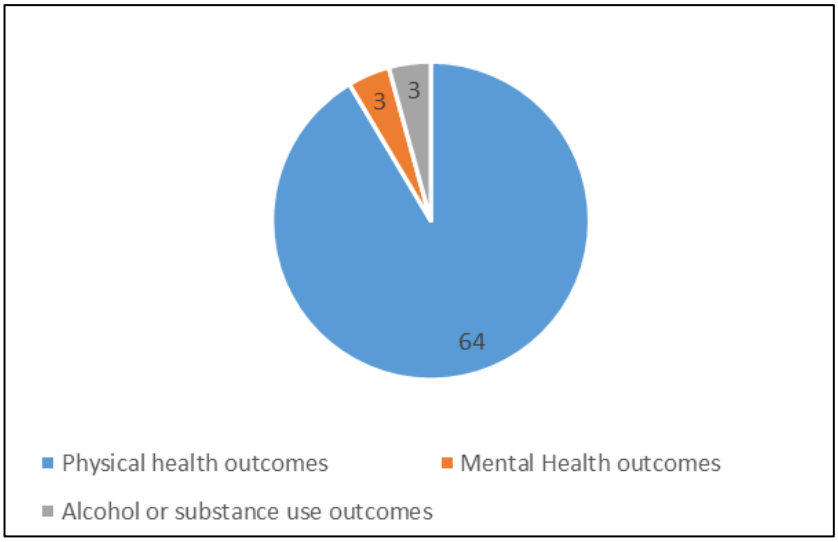
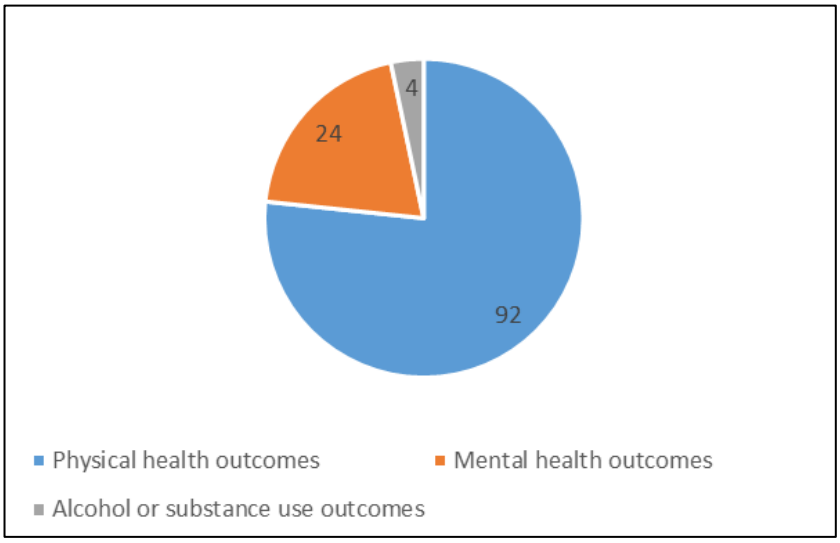


Fig. 5e: Specified health inequality outcomes: SG



Therefore, policy texts appeared to primarily describe inequalities in physical ill-health, rather than in mental ill-health.

The inclusion of mental health within 'health' reflects institutional structures in the NHS, which has responsibility for mental healthcare, and in both Greater Manchester and the Scottish Government, where GM's Health and Social Care Partnership, and Scotland's DG Health and Social Care, had policy responsibility for mental health at the time of analysis. It

also reflects the Scottish Government's definition of mental health, as read to me by a mental health policy participant:

> "*Mental health is part of our overall health, alongside our physical health. It is what we experience every day, and like physical health it ebbs and flows daily. Having good mental health means that we can realise our full potential and feel safe and secure, it also means we thrive in everyday life."* [SCOP07H]

One Scottish employability policy participant echoed this definition, specifying that mental health was included within their conceptualisation of health:

> "*When I say health I mean mental health including drug issues in there, as well, because we consider that a health condition*" [SCOP021NH]

However, as described in section 5.2, mental health spending in Scotland reached its highest ever proportion of NHS spending in 2023 at just 8.8% (Scottish Government, 2023a). This supports the contention of the Mental Health Strategy (2017) that mental health lacks 'parity of esteem' with physical health, and that 'health' is conceptualised predominantly as physical.

This 'health as (physical) illness' conceptualisation is a core feature of the medical mode, and contrasts with the oft-cited (and criticised (Huber, 2011)) WHO definition "*Health is a state of complete, physical, mental and social well-being and not merely the absence of disease or infirmity*". Therefore, this finding illustrates that while social or economic policy texts may often frame health or wellbeing as contextualised according to a social model of health, social and economic policy participants still consider health largely in relation to the medical model. The role of 'wellbeing' in this differentiation is discussed in 5.3.4 below, and further in Chapter 6.

Although social and economic texts frequently aligned with the social model of health, some took an individualistic approach to key social determinants. For SG's No-One Left Behind and GM's Local Skills Report and Labour Market Plan), the primary risk to beware is falling out of work, not personal suffering. These texts allow no health status beyond that adequate for employment, for employment is the exclusive focus. There is no indication of where ill health or disability originates other than unemployment (and in the latter document, Covid-19). This binary conceptualisation of healthy or unhealthy implies a vicious cycle with only one way out: medical treatment for existing illness or disability for

the purpose of attaining or sustaining employment. Alternative non-medical, preventive or population-level solutions are not considered.

Participants in both GMCA and SG confirmed this employability approach to health. One participant in GM recounted a story of a toothless man who was helped to get dental treatment and then quickly found a job. An SG participant agreed that the main way their department contributed to reducing health inequality was by helping unwell people to access medical treatment, not by helping disadvantaged people access employment and income with consequent health benefits. The consequence of this medicalised perspective is a policy focus on negotiating access to healthcare for particular individuals.

This approach was criticised by a Scottish health policy participant, who said economic policy colleagues were unreceptive to their argument for a continuous conceptualisation of health with upstream policy solutions, rather than a binary conceptualisation with downstream solutions:

> "*The other thing I was going to say in terms of economic policy or non-health policy people is around what health means. OK so we've got, I don't know, it was like 230,000 people who are economically inactive because of health outcomes so we want to sort that. So we need to address the health problems. And I say actually it's got nothing to do with health problems; it's all to do with the determinants. And I can see them glazing over going 'it clearly has to do with the health problems'. And I'm like it doesn't, it's to do with poverty. You've got people with quite chronic rheumatoid arthritis in really high paid jobs because the job's flexible and this that and the other. So I said if you've got a health condition you can maintain a job if it's high enough wages and all that kind of stuff. And I must say that's a struggle for me to try and get non-health folk to see health more than just the thing that you might go to the doctor with. And if you then take away that thing clearly they'll be able to walk into a job. So that's the tricky thing.*" [SCOP12H]

In this account, a key economic determinant of health – sufficient income – is rejected in favour of medical intervention. As with the 'mental health' and 'health inequality' framings, therefore, this individualised conceptualisation of health depoliticises the policy response and delegates solutions to external actors with less effective solutions.

5.3.3 Health inequality as population-wide illness

In health policy teams, health inequality was generally considered a problem due to the moral injustice of preventable illness, as discussed further in section 8.4. In contrast, particularly in economic policy teams, following from the common conceptualisation of health as illness, 'health inequality' was often used to mean widespread illness. This was therefore seen as an important impediment to economic performance, a cause of unemployment, and therefore a cause of child poverty. For example, participants in Greater Manchester cited a recent economic report which had connected Greater Manchester's relatively poor health in comparison with national averages (see section 7.2) with its relatively low economic productivity in comparison with national averages:

> "*The Independent Prosperity Review […] I think for the first time a group of heavyweight economists pulled out health inequalities as one of the key issues holding back productivity, and made a link between the core productivity debate and the health inequality debate*" [GMP08O]

In Scotland, a senior policymaker interested in child poverty repeatedly referred to health inequality as a general impediment to employment:

> "*She'll say to me, 'yes I'm really interested to know about how the work you're taking forward in the child poverty sphere will help me with health inequalities', and I'm like 'well actually no, it's what you're doing in terms of tackling health inequalities will help the child poverty work'. Because obviously if we've got a healthier population they're more likely to be able to take up work*" [SCOP03O]

Similarly, an employability policymaker used 'health inequalities' to describe widespread but undifferentiated ill-health:

> *"Within my area* [employability] *I have three different strands of work. One of them is 'tackling inequalities' but that really is health inequalities […] If we are actually engaging directly with those providing health services… that's really key and a really good method in terms of making sure that we are targeting those who are really facing health inequalities at this time."* [SCOP21O]

This conceptualisation of health inequality is one of three suggested by Wainwright (1996) in his analysis of why health inequality might be of political interest to a New Labour party that had previously minimised its interest in inequalities more generally: the maintenance of a healthy and compliant workforce would be essential to the new market economy. However, recurrent policy short-termism again means this conceptualisation is likely to translate into a focus on illness as the cause of present problems remediable by medical care, rather than health as a variable continuum of feelings shaped by long-term social and economic policy. The political implications of this finding are discussed further in Chapter 7.

5.3.4 Health as narrow compared to broader 'wellbeing'

As mentioned in 5.3.1 above, Scotland's Vision for Trade repeatedly associated 'health' with healthcare, while associating 'wellbeing' with the positive life impacts of jobs and cheaper prices enabled by trade policy. In its section describing Wellbeing as one of five key trade policy principles, it uses Scotland's eleven National Performance Framework (NPF) outcomes to define 'wellbeing', one of which is 'health'. In its three sentences connecting trade policy to health, it describes trade as benefiting "*a healthy and active workforce*", providing opportunities for "*our life sciences and biotechnology industries*", and not damaging our public services: a reference to its key "ask" of UK Government to "*Shield the NHS in Scotland from any risk of enforced privatisation, competition or fragmentation in trade agreements*" (p10).

The conceptualisation of 'health' as a narrower constituent part of broader 'wellbeing' was visible in several other texts. For example, the GM Strategy conceptualises 'health' as part of the "*wellbeing of our people*" theme, alongside jobs, homes, culture and leisure, and transport; while SG's Economic Recovery Implementation Plan only briefly mentions physical and mental health as components of human capital, one of four capitals said to "*generate wellbeing for current and future generations*".

This conceptualisation of narrow health within broader wellbeing was also repeated by many social and economic policy interviewees, for example:

> "*So for me, wellbeing, it's that broader 'what makes a good life?'. Whereas when I think of health, I think more about the physical and mental health*" [GMP06O]
>
> "*A personal view but wellbeing for me has a much wider meaning than health*" [GMP08O]
>
> "*Health is a big, very big part of that [wellbeing] if not the biggest part of it*" [SCOP04O]

Data on these comparisons are further explored in section 6.5.

5.3.5 Health narrowed following the Covid-19 pandemic

Along similar lines, the Covid Recovery Strategy refers to 'health' frequently to indicate the impacts of the coronavirus, as opposed to 'wellbeing' which indicates the broader impacts of the pandemic and social restrictions. However, a chapter focused on 'the Wellbeing of Children and Young People' repeatedly relates impacts of social restrictions on diet and physical activity to 'health' and 'health inequalities', for example:

> "*The pandemic has* also *had an impact on health, both on physical activity levels and on increased purchases of food higher in fat, salt and sugar, and these are likely to have exacerbated health inequalities, including among children and young people"* [emphasis added]

In this chapter, 'health' specifically does *not* mean coronavirus infection, but instead something close to physical fitness, perhaps because of the focus on youth and assumptions about health at different life stages. The following page describes the action being taken: an increase in budget for weight management programmes, including pilots in three NHS board areas, and "*training for frontline staff… to have conversations about healthy weight and diet in a non-stigmatising way*". Therefore, individualistic, biomedical and rational actor-based assumptions are visible in the NHS-led, conversation-based solutions on offer.

A participant with close knowledge of the Covid Recovery Strategy told me it had been compiled based on contributions from other policy teams, but was not able to say which teams had written which parts. However, they did feel that the Covid-19 pandemic had had

an impact on understandings of 'health' and 'wellbeing', as observed in the document, including the distinct biomedicalization of 'health':

> "*Especially immediately post-pandemic, health was the NHS and it involved scrubs, wellbeing is wider because you think about the impact of lockdown on children and young people. For some it was that they weren't getting enough exercise and that their mental health suffered. For others, you couldn't measurably say that their mental health had suffered, but you knew that they'd lost out on something.*"

A health policy participant in SG also reflected that Covid-19 had narrowed conceptualisations of health and the role of public health:

> "*I think the drawback is people felt that health became such a dominant focus in everyone's life as a result of Covid and influenced things in many negative ways in people's view. Potentially it's also kind of tainted the image of health, in particular public health, or it's oversimplified what public health is … I think, unfortunately, it's kind of narrowed that focus, rather than broadened it."* [SCOP05H]

5.3.6 Health medicalised by UK Government contributions

In 2018, the UK government announced they would work with local partners on local industrial strategies to align with their national Industrial Strategy of 2017. GMCA's Local Industrial Strategy (2019) was one of the first wave of eight, with other combined authorities and local enterprise partnerships also developing local strategies.

No lifestyle drift was identified in the GM Local Industrial Strategy because health is not conceptualised as having upstream origins at all: poor health seems to pre-exist in the population with only the ageing process and air pollution identified as causal. Further, health behaviours are neither problematised nor offered as policy solutions.

However, health-related solutions were overwhelmingly based on 'innovation' and 'technology' in medical services and products. The document repeatedly asserts, without explanation, that the presence of medical research institutions and facilities in GM would both improve the health of GM residents and reduce health inequalities. But these assertions fail to consider basic issues of market distribution, and therefore mirror the

'trickle-down' assumptions of neoliberal economic theory which inclusive growth and related agendas seek to redress.

Firstly, rather than naturally distributing benefits appropriately to all, markets tend to create inequalities in part because they serve those already advantaged by economic resources first, or exclusively (E. M. Rogers, 1962; Cozzens, 2010). Therefore, consumers with more flexible resources are more likely early adopters of innovative medical technologies, which means they are more likely to benefit from them first, contributing to economic health inequalities, rather than mitigating them (Rydland, 2020; Weiss et al., 2020).

GMCA participants distanced themselves from the Local Industrial Strategy, and told me they were working on a new strategy to replace it. One participant said "*I wasn't directly involved, but absolutely it is a government text*". Another participant who was more closely involved described the drafting process as needing "*a huge amount of toing and froing, everything had to be signed off by both parties and there was a lot of nervousness from government about wording and a lot of frustration from the people writing the words … It's all been written very, very carefully, every single word has been fought over and decided. So yeah, anything you spot has been placed there for a reason."* This means the highly medicalised, market-driven and techno-optimistic conceptualisation of health within the text is attributable, at least in part, to UK government co-drafting.

5.3.7 Health individualised by health policy contributions

Three social or economic policy texts contained individualised conceptualisations of health that appear to have been inserted by health policy colleagues. Firstly, the Tackling Child Poverty Delivery Plan (2019) regularly discusses poverty's impact on 'quality of life' and 'wellbeing', while its discussions of 'health' (without wellbeing) are strongly associated with mental health services and NHS services. The sole mention of 'health inequalities' in its 156 pages is on page 100 under a headline of '*Working in Partnership with the NHS*'. Its response to health inequality is "*We continue to target health policy and services at areas of deprivation*", highlighting increased investment in the primary care workforce. Therefore, poverty impacts 'quality of life', while 'health' is a matter of healthcare.

A participant closely involved in the Tackling Child Poverty Delivery Plan was surprised to be told about this sole reference to health inequality in the text. They attributed its exclusion to having had a "*laser focus*" on child poverty, "*this totemic thing*" and a "*defining mission*" for the then-First Minister, Nicola Sturgeon. This description of a psychological "*laser focus*" to the exclusion of other ideas implies that the 'child poverty' frame included ideas such as 'quality of life' and 'wellbeing' but excluded the idea of 'health inequality'. I asked if health policy colleagues may have contributed to this section about partnership with the NHS: "*Absolutely, we would ask them to contribute and to do drafting on the section*". Therefore, it seems plausible that this very long strategy text describing an other policy agenda on a key determinant of health inequality may have entirely lacked reference to health inequality had it not been inserted by someone working in health policy.

In the second case, almost all the health-related problems and solutions identified within GMCA's Housing Strategy referred to social and economic conditions, rather than individual behaviours or health or social care services. However, there was one short comment about health behaviours in the 'health and social care' section of the document: that GMCA will "*use the housing sector's workforce as key agents of behaviour change*".

Interviewees presented conflicting views of this section, surfacing tensions about policy team roles and joined-up service provision. One policymaker with close knowledge of the Housing Strategy linked this reference to GMCA's wider efforts to integrate public services, as detailed in The Greater Manchester Model, rather than "*throw[ing] a lot of professionals at people in households and expect[ing] them to magically stitch together the advice*". But they expressed reservations about the appropriateness of a housing strategy promoting behaviour change for health:

> "T*hat term 'behaviour' is an interesting one. That's not something I'd have written, personally, because that feels to me like that's beyond the scope of a housing strategy, changing people's behaviours.*"

Elsewhere, they described tensions between housing and health policy aims:

> *"We get a semi-regular push from the health system about smoking cessation in social housing, and why do we allow tenants in social housing to smoke in their homes? And you think, well is it because it's their homes?… there's a disconnect in people's understanding of what the housing system is there to do."*

However, another participant closely involved with the text expressed excitement about this section, and went on to explain the benefits of a 'making every contact count' approach that the housing workforce could contribute to:

> *"We started doing some work with one housing provider in particular around smoking cessation, Stop to Swap campaign, which was really successful in switching people to vaping, providing the materials for them, to enable them to do that. So really we'd always be keen to do more on that."*

If the first interviewee's view that behaviour change is "*beyond the scope of a housing strategy*" had been agreed, then the text would not have included this single reference to behaviour change, and it would have instead presented health entirely as a product of contextual conditions. I asked the first interviewee if colleagues in GM's Health and Social Care Partnership may have had some input into the section where behaviour change was mentioned, to which they responded, "*The bottom line is they pretty much wrote it*". Therefore, the section of this social policy document written by health policy colleagues brings subtle 'lifestyle drift' into a text that otherwise conceptualises health and wellbeing in an entirely contextualised way

The third example of individualised conceptualisations of health being inserted into other policy texts by health policy involves GMCA's overall strategy text Our People, Our Place (2017), which contained three notable health-related targets (p59):

> • *By 2020, improving premature mortality due to cardiovascular disease will result in 160 fewer deaths per annum*
> • *By 2020, improving premature mortality from cancer will result in 350 fewer deaths per annum*
> • *By 2020, improving premature mortality from respiratory disease will result in 150 fewer deaths per annum*

These targets appear unnecessarily challenging because they specify precise numbers of deaths to be reduced by specific diseases. For example, were deaths due to cardiovascular disease to fall by 1000, but deaths from cancer and respiratory disease by only 300 and 100 respectively, then this hugely successful reduction in premature mortality by 1400 deaths in a year would nevertheless seem a political failure due to two out of three targets being missed. A single target such as (for example) "By 2020, improving premature mortality will

result in 660 fewer deaths per annum" would be far more achievable because of the reduced specificity. Such a target might therefore be more politically appealing, without changing the ultimate outcome of interest: reducing premature mortality.

I asked a participant closely involved with Our People, Our Place about these targets:

> Q: Why did you have this specific focus on different forms of disease that required you then to kind of put very specific numbers on how many people would die of different illnesses?
>
> *A: "That's a very good question. They're not my numbers, those bits actually. They are detailed in Taking Charge [...] so we inherited those. I think we felt that we needed to align with their targets."*

Taking Charge of our Health and Social Care in Greater Manchester (2015) was the first 5-year plan of the new Greater Manchester Health and Social Care Partnership (GMHSCP) (it was the predecessor to Taking Charge: the Next 5 Years (2019), which is included in this research). Page 10 of that document includes disease-specific mortality targets for cardiovascular disease, cancer and respiratory disease, which the participant says Our People, Our Place (2017) borrowed updated numbers from. The participant went on to note the downstream nature of this target inherited from GMHSCP: by choosing disease-specific targets, last-minute medical interventions are required.

> *"The other thing on that of course is that it's a fairly downstream indicator, and it's generational… what we do in terms of improving our population health? I mean I suppose there are things we can do to reduce the number of people dying from cancer, but it's very much at the tail end of that journey, isn't it? It's about identifying cancer quickly and then getting people into the system, get the treatment they want quicker."*

This reflects findings in previous literature on policy approaches to health inequalities. For example, in Qureshi's (2013, p7) policy ethnography of New Labour's approach to tackling health inequalities, one senior civil servant is quoted as saying in 2006-7: "*Lots of people think 'this isn't for the NHS, it's to do with child poverty'. But as the PSA target is 2010, it makes you focus on people who already have disease – it makes you focus on how inequitable the NHS is'".* Another civil servant in that research said: *"We need something that will categorically have an effect within the five-year targets".* Despite the first

participant's observation that health inequalities may not be "*for the NHS*", it was an NHS Plan where the targets were first announced in 2000, before being formalised the following year by the Department of Health (Nutbeam, 2003b)).

The specific disease focus is also noteworthy. A short-term target such as the one suggested above - "By 2020, improving premature mortality will result in at least 660 fewer deaths per annum" – may not severely restrict policy solutions as much as the actual targets do, such as they are focused on cardiovascular disease, cancer, and respiratory disease. This hypothetical target would allow for improvements due to all upstream or downstream health, social or economic interventions impacting on any illness at all contributing to premature mortality. The actual targets necessitate responses from clinical experts in these three specific medical areas only. This likely means extra funding and widening criteria for cancer screenings, smoking cessation programmes and nicotine replacement therapy, and further prescriptions for statins and antihypertensives.

This downstream approach was also found by Qureshi (2013), where New Labour's Department of Health drew a 'coloured scarves' diagram that divided male and female life expectancy gaps into specific diseases, then matched those diseases to specific interventions, such as those above. This specifically medicalised approach was criticised by Blackman (2007) as representing the pharmacological redistribution of health in preference to an economic redistribution of wealth.

One Scotland-based health policy participant in the present research contrasted the different approaches of their colleagues in health and in other policy teams. While social and economic policy teams "*will think of health as health conditions*" or "*the thing that you might go to the doctor with*", health policy participants were portrayed as fixated on *numbers* representing health conditions:

> "*What I do find sometimes with health policy folk though is the focus on health. So how does lack of autonomy in the workplace impact on health, for example, and I'm like, it doesn't really matter, it's actually going to be shit if you've got lack of autonomy […] I would take it from a health from a WHO thriving aspect and it doesn't matter if it decreases your serotonin but increases your mental health issues. I would say sometimes with health folk they go to a health outcome and I'm like that's not health, that's just a number that you have. So I do get sometimes a*

bit frustrated with health folk who are too focused on a health outcome I would say and I'm kind of focusing on health as thriving, thriving individuals." [SCOP12H]

It may seem odd to criticise people who work in health policy for a "*focus on health*". In my understanding, this comment seems to represent a critique of 'healthism', described by Crawford (1980, p365-368) as a "*form of medicalization*" that involves a "*preoccupation with health as a primary – often* the *primary – focus for the definition and the achievement of well-being*" [emphasis as original]. Therefore, the criticism is of an over-emphasis on narrow 'health' measurements as ends-in-themselves, rather than on health as a means to "*thriving*" more broadly. For this participant, lacking autonomy at work is "*shit*" whether it measurably impacts on health or not. Here, focusing on health is a distraction.

Further, this perception of healthism appears to include a preoccupation with quantified research evidence as preferred by the hierarchy of evidence, a core principle of evidence-based medicine. In this hypothetical example, the participant describes frustration with a health policy colleague asking a research question, hoping to show specific causal links between working conditions and a quantifiable metric, rather than being satisfied with other forms of knowledge that make the negative impact clear. What "*doesn't really matter*" is the biochemical measurement as the experience itself is so obviously "*shit*". In this reading, the criticism is that health policy colleagues display excessive faith in the value of quantified research evidence to inform evidence-based policymaking, rather than understanding the more social and political construction of knowledge for policy (Parkhurst, 2016; Cairney & Oliver, 2017).

This is reflected in previous research literature on policy approaches to health inequalities. For example, health inequalities policymakers in Petticrew et al.'s (2004, p813-4) workshop were critical of researchers' "*apparent obsession*" with rigorous evidential critique rather than understanding the "*mixed economy*" of knowledge and evidence. This comment also resembles the political scientific critique of public health more generally, as described in Chapter 4: that its fixation on evidence-based policy ideals is politically naïve (Bernier & Clavier, 2011; Fafard et al., 2022; Lynch, 2023).

On the other hand, Maybin (2016, p98) finds that "*in the context of the Department of Health, being in possession of numeric data on a policy issue was also an effective way to demonstrate having some command of a topic*". She reports policy analysts describing the "*almost insatiable appetite for numbers*" of policymakers in health and other policy

departments, who considered their use essential to the effective framing of a potential policy to their political leaders. This was due to their apparent simplicity and certainty; but the analysts were aware that these impressions of simplicity and certainty were illusory, as choices and assumptions lay behind the construction of these numbers. Maybin quotes Deborah Stone, writing:

> "*In our profoundly numerical contemporary culture, numbers are symbols of precision, accuracy and objectivity […] And certain kinds of numbers – big ones, ones with decimal points, ones that are not multiples of 10 [...] seemingly advertise the prowess of the measurer, as if to say that he or she could discriminate down to the gnat's knees*." (Stone, 2002, p177 quoted in Maybin, 2016, p100)

So while the above participant of my study resents the apparent obsession of health policy colleagues with numerical research outputs representing narrow health outcomes, Maybin's and Stone's work suggests at least two benefits to this kind of focus: firstly, that numerical health data appears simple, certain, and apolitical, and is therefore highly useful in framing policy ideas to political leaders; and that it embellishes the authority of health claims-makers, to the anticipated political benefit of their claims. This may be why the original Taking Charge (2015) text and then Our People, Our Place (2017) made such precise numerical claims about its disease targets – that improvements related to cardiovascular disease would result in ten fewer premature deaths than improvements related to respiratory disease, in a population of two-and-a-half million people – because this precision conveys a reassuring expertise and authority.

Accounts describing a particular approach to evidence within health policy are further discussed in section 6.3.3, in relation to its potentially unhelpful impacts on attempts to implement 'Health in All Policies'.

5.4 Conclusion to chapter 5

Existing literature reviewed in chapter 2 implies that individualised conceptualisations of health are dominant in health and public health policy settings. This research set out to explore other policy conceptualisations of health and health inequalities, to clarify whether there might be policy settings with broader conceptualisations of health.

The findings explored in this chapter agree that individualised conceptualisations of health are prevalent in health policy, and add that in comparison, other policy texts are less likely to conceptualise health individualistically. Table 5a below provides an overview of each policy text analysed in this literature: those on the left repeatedly individualise health or wellbeing; those on the right consistently frame health or wellbeing within social contexts; those in the middle provide contextualisation, but not consistently.

Table 5a: Individualisation or contextualisation in health and other texts

	HWB is repeatedly individualised	**HWB is individualised and contextualised**	**HWB is consistently contextualised**
GM Health	• Taking Charge: the Next 5 Years • Transforming the Health of Our Population	• Children and Young People's Health and Wellbeing Framework	[none]
SG Health	• Mental Health Strategy • PfG 21-22 (Health Chapter)	• PHS Strategic Plan	• Public Health Priorities • PHS Delivery Plan
Health total	**4/8**	**2/8**	**2/8**
GMCA Other	• Our People, Our Place • Local Industrial Strategy • Local Skills Report…	• Children and Young People's Plan • Transport Strategy 2040	• Housing Strategy • The Greater Manchester Model • Places for Everyone

			• Good Lives For All
SG Other	• No-One Left Behind	• Tackling Child Poverty Delivery Plan • National Transport Strategy 2 • Scotland's Vision for Trade • Covid Recovery Strategy: For a Fairer Future	• Economic Recovery Implementation Plan • Climate Change Strategy • Fair Work Action Plan • Social Enterprise Action Plan • Housing to 2040 • PfG 21-22 (Other chapters) • National Planning Framework 4 • Delivering Economic Prosperity (NSET)
Non-H total	**4/22**	**6/22**	**12/22**

In total, half of the analysed health policy texts made strong or repeated biomedical or behavioural assumptions about health. Only a quarter consistently contextualised health outcomes as determined by social and economic conditions. On the other hand, more than half of the social and economic texts consistently framed health as an outcome of social or economic conditions. Only four predominantly presented health biomedically or as behavioural.

This suggests that social and economic policy settings can often have conceptualisations of health or wellbeing that are more consistent with the social model of health than health policy settings. This was most clearly visible in texts concerning the built environment - housing, transport, and spatial planning – where conceptualisations of health or wellbeing were narrow, but inherently contextual. But there are a number of caveats to this conclusion, which are explained in sections 5.3.2 to 5.3.7 above.

Firstly, the biomedical conceptualisation of health as illness remains prevalent in social and economic policy settings. Following from this, health inequalities is used by economic policy participants to mean population-scale illness, usually problematized as an impediment to

work. This is likely to translate into a policy focus on healthcare for the unemployed, rather than social or economic intervention (discussed further in section 8.2).

Secondly, narrow, biomedical conceptualisations of health are often present alongside broader, social conceptualisations of wellbeing. This duality seems to allow both medical and social models of health to be represented. The findings of this chapter suggest that while social or economic policy texts may contextualise health or wellbeing according to a social model of health, social and economic policy participants still discuss health largely in relation to the medical model. Therefore, it appears to be the social or economic focus of the written policy text that creates the contextualisation, rather than the beliefs or understandings of the actors in different policy settings.

Thirdly, contributions from external colleagues seem to have contributed to individualistic conceptualisations of health appearing in at least four social and economic texts; in three cases, contributions from health policy colleagues are associated with individualistic conceptualisations of health. Therefore, attempts to integrate 'Health in All Policies' can lead to individualistic conceptualisations of health appearing in other policy texts.

Chapter 6 – Conceptualisations of Health 2: as health policy

6.1 Introduction

In chapter 4, I discussed ideas, frames and paradigms, with a view to clarifying for this thesis three key concepts with vast theoretical literatures; and I then used these concepts to discuss how key ideas were excluded from relevant policy frames in Greater Manchester, and how two framing disputes (Benford 1993; 2013) within Public Health Scotland may relate to an analysis of paradigmatic assumptions.

Chapter 5 began with an analysis of individualism in policy texts, particularly in health policy texts where downstream drift, including lifestyle drift, was prevalent, reflecting medicalised understandings of health or wellbeing. On the other hand, social and economic policy texts often framed health or wellbeing in social and economic contexts, in line with the social model of health. As part of that analysis, chapter 5 also presented individualistic framings of health or wellbeing within social and economic policy texts, showing that that individualism had a range of sources: conceptualisations of health as disease; comparisons of narrow health with broader 'wellbeing'; as originating in perceptions of the Covid-19 pandemic; and via contributions from UK government actors and from health policy actors.

As with chapter 5, the aim of this chapter is to explore conceptualisations of 'health' in social, economic and health policy settings. To this end, this chapter describes a key meaning of 'health' found within social and economic policy settings: as shorthand for health policy. Therefore, I found two main meanings of health in policy settings: often 'health' was used to refer to a human condition, or more accurately a negative human condition when used in close relation to 'illness'; and 'health' was often used to mean 'health policy', and therefore was accompanied by relational baggage reflecting tensions between health and other policy teams.

As I shall be describing in this chapter, the regular use of 'health' to mean 'health policy' gives a new perspective to 'Health in All Policies' and to 'health inequalities': when 'health' is understood to represent a group of actors competing for resources, those framings may

evoke friction and rivalry, rather than the co-operation required by the social model of health.

However, this chapter also describes how 'wellbeing' is understood in contrast to the two key conceptualisations of 'health' identified in this and the previous chapter: firstly, as relating to the wider or social determinants of 'health', rather than to individual illness; secondly, as not representing any particular policy team, and therefore being a plausible common cause without the attendant relational or competitive baggage of the term 'health'. For these reasons, 'wellbeing' may act as a 'coalition magnet' (Beland & Cox, 2016) – an idea that attracts wide support through its ambiguity – and a potential new policy avenue for an upstream approach to preventing systematic variations in population health.

6.2 Health as health policy

All but two of the 22 social and economic policy participants interviewed used 'health' as shorthand for health policy colleagues or teams. Only one of the 11 health participants did likewise, in the context of discussing policy team responsibility for health inequalities. Some examples of the social and economic team use of 'health' to mean 'health policy' colleagues or teams are given in the box below:

Box 6a: 'Health' as 'health policy' according to GM and SCO social and economic policy participants

"It's a deliberate decision not to talk about health, as it's a deliberate decision not to talk about any particular policy line"	GMP01O
"The timing of the writing of the new GMS coincides with a lot of change in the health world, the integrated care system"	GMP03O
"I think that they have done more on health because they've been funded by health [budgets]"	GMP04O
"I think even within health, although it's notionally delegated […] you've got a lot of individual acute trusts that are almost freestanding legal organisations in their own right"	GMP07O

Q: What role does health play in your work*? A: "So I have a lot of interactions in different ways with [senior health policymaker]."*	SCOP03O
"We know that there's some significant analytical heft in health"	SCOP09O
"Sometimes you're helping health itself make a stronger case for its economic contribution"	SCOP13O
"In the Scottish Government health is a very set thing, there's an area that works on health and I've never worked there so I don't feel like I know huge quantities about it"	SCOP18O

In the above quotes, 'health' is used variously to mean a policy area with responsibility for health inequalities; a 'world' involved in Greater Manchester's new unified public service provision; a source of funding; a group of legal organisations; a type of colleague to interact with; a source of analytical support; a contributor to the economy; and a specific area of work unknown to outsiders.

In one interaction, I asked a participant from GMCA about the role of health in their work:

> Q: Is there any part of your work where you focus on health?
>
> "*Not a huge amount that's overtly focused on health if I'm honest, because generally health policy is the responsibility of the health and social care partnership, to an extent […] "*
>
> Q: And does your answer change if I ask, is wellbeing part of your work?
>
> "*Yeah, that changes because I think that most aspects of public policy influence wellbeing. They also influence health, but you asked about health policy rather than health, if you see what I mean.*" [GMP07O]

This response revealed the underlying assumption, as the transcript shows the question had been about 'health', but it was understood to mean 'health policy'.

As shall be described in this chapter, the conflation within policy settings of ‘health’ with ‘health policy’ leads to the complications of social relations being attached to ‘health’ within that setting. Discussions of health are not limited to the embodied experiences of populations or individuals, but also of favourable or unfavourable judgements of colleagues, or of organisational competition between teams. This has particular relevance in settings where groups of people are in competition – for the attention of political leaders, for example, or additional resources for the better pursuance of their interests – where the actions of some individuals or groups may be judged in ways entirely disconnected from the social problems they professionally pursue.

These relational issues are evident in the data discussed in the following sections. First, I shall describe how the equivalisation of health with ‘health policy’ creates competitive perceptions of policy priorities and the ‘Health in All Policies’ approach. Then, I shall discuss how health’s meaning as health policy causes the assumption that health inequality is a core responsibility of health policy teams. Finally, I shall describe how the term ‘wellbeing’ differs from the term ‘health’ in two key ways relating to the findings of this and the previous chapter.

6.3 'Health (policy) in All Policies': what can *you* do for *us*?

6.3.1 Social or economic policy accounts of Health in All Policies: the health imperative

When 'health' is understood to mean 'health policy', as described above, 'Health in All Policies' (HiAP) also takes on a different meaning: that health has imperative status among all policy issues. But social and economic policy participants in the present research rejected this health imperative as implied by 'Health in All Policies'. This rejection was not based on any moral or political argument against the importance of health or health inequality; instead all critical reflections from social and economic policy participants about HiAP concerned its implication that health had status higher than the interests of their own policy domain.

Scottish Government participants were particularly clear that health did not have such priority in a crowded field of policy considerations. For some, the lack of a health imperative was evident in its absence from mandated assessment procedures: a lack of regulatory legitimacy (Synnevåg et al., 2019). For others, health was just one of many sets of outcomes to consider in a setting of limited capacity.

Box 6b: Scottish social & economic policy participant rejection of health imperative implied by HiAP

"We did SEA [Strategic Environmental Assessment]*, equality impact assessment, child rights and wellbeing, Fairer Scotland, island communities assessment, and various other bits. So there wasn't a health in all policies requirement"* [SCOP08O]

"I think the challenge with us is, we've got the National Performance Framework, we've got a whole load of outcomes, we're meant to look across the piece, properly understand the impact that we're having, positive or negative, against those various outcomes when we're putting together advice. Doing that in practice is really difficult" [SCOP13O]

"In terms of what gets done and what doesn't, the equality impact assessment is a legal duty we have to do, and I think so is the Fair Scotland Duty for example, and there are some others as well" [SCOP15O]

"Yeah I understand why you're coming to say 'think about health', but there's messages coming across government 'think about race equality', 'think about gender', think about, there's quite a lot of messages coming across. And now I work in trade and I tell people 'think about trade', so that's another aspect that you're trying to mainstream" [SCOP16O]

These quotes portray a competitive marketplace for limited policymaker attention: while some cross-governmental issues are given the status of legal duty and therefore prioritised, others must be promoted by the policy teams primarily responsible. This internal marketing, determined by an actor's changeable professional interests, is exemplified by SCOP16O's comment: "*And now I work in trade and I tell people 'think about trade'*". Further, both transport policy participants briefly advocated for 'Transport in All Policies'. These participants did not attempt to legitimise a trade imperative, or a transport imperative, on normative grounds, but were acting according to their professional roles.

During a discussion about health expansionism – explored in the next section - an economic policymaker in Greater Manchester expressed a preference for 'inequalities in all policies', or 'all policies in all policies', as follows:

> "Q: So if 'health in all policies' doesn't quite sit well with you, do you think 'inequalities in all policies' or 'climate in all policies', do these have a better chance of success?
>
> *A: I think yes, because inequalities captures all of them. It's not putting one type of inequality over and above another. It's saying actually these are all important, they all interact with each other and you can't place one above the other. And therefore it doesn't exclude in the same way that making health inequality* [sic] *dominant then obviously excludes* [GMP08O]

Here, the different 'types' of inequality are those owned by policy actors in each domain: housing inequalities, economic inequalities, transport inequalities, health inequalities, and so on. Therefore, this refusal to grant imperative status to any, because to do so would "*obviously exclude*", makes clear that the participant's priority is the *inclusion* of various policy teams and interests.

6.3.2 Social or economic policy accounts of Health in All Policies: health (policy) expansionism

The above economic policymaker in GMCA also insisted that population health teams took a unique approach within policy circles to pushing a health imperative:

> "*It's not true of health and care generally, [but] it is very true of people in population health who see everything exactly through that lens of: the ultimate aim of everything has to be health. And they view everything through that lens and go round telling other bits of the system what they think they ought to be doing in order to improve population health and, a fair amount of time, piss other people off, in the same way as if I went round telling the system you've got to be doing this for the economy, it would piss them off as well. And I put that down as a particular attitude and approach of people who work in public health that I don't see in other parts of the system, or other policy areas."* [GMP08O]

This clear account of health expansionism (also known as 'health imperialism' (Nutbeam, 1994)[8]) was perceived by the participant as potentially undermining collaboration:

> *"It's interesting that you described it as a common phenomenon because that would exactly chime with me. It doesn't undermine my relationships with them, I understand that, but it does lead to a fair amount of eye-rolling in the rest of the system I think. But I guess it means it might undermine some of the impact that the population team could have, because when they're going to other parts of the system to some extent it's taken with a fair pinch of salt, because it's like 'OK, here they go again'. So in some ways it might backfire."* [GMP08O]

This discussion came up during the following interview with another GM participant whose work involved regular collaboration with NHS staff on policy for a key social determinant of health:

[8] Following a presentation about findings from this thesis towards the end of completion, an attendee strongly objected to the use of the term 'health imperialism', saying it was an insensitive use of a term more often associated with colonialism, oppression and murder. I am satisfied to use the term 'expansionism' in its place, which conveys a similar meaning without such associations. However, I have not changed 'health imperialism' where participants used it, or where it is specifically used in previous research.

> *"I've noted down that phrase health imperialism because I feel like it's something that I live with on a daily basis <laughter> yeah absolutely ... I think it also applies to, not even necessarily just health policy people but clinicians as well... And sometimes it's a battle to get this wider determinant stuff on the table."* [GMP09O]

This participant also considered this attitude to hinder collaboration:

> "*It's annoying that sometimes things take far longer than they should... in terms of wanting to progress key pieces of work or speak to specific organisations and sometimes having to go through that - it absolutely is - health imperialism sort of conversation multiple times before you can make some headway.*" [GMP09O]

At the end of this interview, I asked broadly if there was anything else the participant wished to add. They chose to return to this subject, and to the language of war, to say: "*It's still a battle, all the time.*" I asked who they were battling against:

> "*I suppose organisationally with the NHS, but it's not, it's individuals within those infrastructures isn't it? To take your blinkers off and look at the broader system and the impact of that broader system on your patients.*" [GMP09O]

The former participant's suspicion of population health teams included alleging an expensive and time-consuming duplication of work had occurred in Greater Manchester because of competitiveness from population health teams. In March 2021, an Independent Inequalities Commission published a report about inequalities in Greater Manchester (Pickett et al., 2021), which was followed in June by a report about inequalities in health in Greater Manchester led by renowned health inequality researcher Professor Sir Michael Marmot (Marmot et al., 2021):

> *"That was an interesting one because the Inequalities Commission came in and did its work, and that was driven out of the Combined Authority* [GMCA}*, and did I think a fairly thorough job and did it quickly. But then within the population health world there was a real rush to try and get the Marmot thing out because it was then seen as competitive with the Inequalities Commission and came up with a set of overlapping recommendations. It didn't feel very joined-up, we're all part of the same thing. It felt like 'we've got to have a health version of this and it's not right that the CA have gone and done an inequalities version beforehand', which was an interesting way of viewing it."* [GMP08O]

In this account, the population health policy-led Marmot report is not criticised on its own terms, but the process of its creation is criticised for creating a sense of division between policy teams: "*it didn't feel very joined-up, we're all part of the same thing*". A health policy participant in GM acknowledged that the release of two similar reports just three months apart may have appeared unhelpful, but explained that the Marmot-led work had begun before the Covid-19 pandemic, and then delays had made its release shortly after the other report coincidental. Their view was that the reports were not 'overlapping', but 'aligning', and therefore complementary. Whatever the fairest assessment may be, the suspicion of competitiveness outside of health policy was also held by another participant: "*there's lots of politics with a small P around this*" [GMP04O].

While GMP08O described the "*evangelical*" approach of population or public health teams of going "*round telling other bits of the system what they ought to be doing*", and of competitively rejecting "*joined-up*" work with social or economic policy origins, GMP09O described the "*blinkered*" perspectives of individuals within the NHS, particularly clinicians, who would "*battle*" against their attempts to collaborate on policy for a key social determinant of health. .

These criticisms may seem to present a no-win situation for health actors. On one hand, they are criticised for crossing boundaries; on the other hand, they are criticised for maintaining boundaries. Those who try to engage with others are "*evangelical*" and "*piss people off*", while those who do not are "*blinkered*". Perhaps this reflects unclear expectations of population health actors and of healthcare actors: while both are nominally 'health' actors, the former must prioritise boundary-crossing collaboration to achieve their long-term goals in accordance with the social model of health. While no clinicians were interviewed in this research, their daily experience with patients might understandably encourage shorter term, more acute priorities, even among those who understand well the social model of health (Mackenzie et al., 2020). But these very different approaches are mixed together – including in this research – by sharing the 'health' label in policy settings.

An alternative reading is that the above critiques are of expressions of 'healthism', as described by Crawford (1980) as a "*preoccupation with health as a primary – often* the *primary – focus for the definition and the achievement of well-being*" [emphasis as original]. In contexts such as HIV/AIDS (Crawford, 1994), physical education in schools (Kirk & Colquhoun, 1989) and obesity (Mackert & Schorb, 2022), healthism is said to encourage

harmful othering and stigmatisation. The allegation of healthism is apparent in the perspective that "*people in population health […] see everything exactly through that lens of: the ultimate aim of everything has to be health".* In the policy context of this research, this boundary-crossing emphasis on health appears to "*piss other people off*" by devaluing the interests and work of other policy areas, exactly as suspected may be the case by Synnevag et al., (2019) in their analysis of perceptions of HiAP legitimacy in Norwegian policy settings.

This presents two fundamental challenges to population health actors: how can they promote the importance of health to non-health policy actors while avoiding the charge of healthism? And how can they work across policy domains while avoiding the charge of health expansionism? These challenges each relate to the two ways 'health' is understood in policy settings. In the first case, because 'health' is associated with narrow understandings of illness (as described in Chapter 5), such a focus is rejected by proponents of broader conceptualisations of "*well-being*". In the second case, because 'health' is associated with health policy (as described in this chapter), such boundary-crossing is resisted by those with inter-relational suspicions or resentments.

6.3.3 Social or economic policy accounts of Health in All Policies: health (policy) evidential barriers

As well as regularly using 'health' to mean colleagues or teams working on 'health policy', several other policy participants associated 'health' with a particular approach to evidence that compelled them to confess a lack of health expertise. In Scotland, a social policy participant struggled to answer the question, "*is health part of the work you do?*", pausing several times to reflect on it, and preferring other descriptions of their work, such as "*helping people to thrive*":

> "*Why am I shying away from 'health'? Partly because in the Scottish Government health is a very set thing; there's an area that works on health and I've never worked there so I don't feel like I know huge quantities about it […] I'm really interested by that question, I'm also really interested by me using all sorts of euphemisms for health which is not something I've spotted myself doing before. But I think it's partly because I'm not a health policy expert*" [SCOP18O].

This quote recalls a comment, already discussed in Chapter 5, by a Scottish health policy participant who also contrasted their preference for 'thriving' with their health policy colleagues' focus on quantified biomedical evidence:

> *"I would take it from a health from a WHO thriving aspect and it doesn't matter if it decreases your serotonin but increases your mental health issues. I would say sometimes with health folk they go to a health outcome and I'm like that's not health, that's just a number that you have."* [SCOP12H]

In Greater Manchester, when asked about the role of health in their work, one GM social policy participant responded "*I am absolutely not a health professional*" [GMP01O]; while another answered the question with an explanation of their "*superficial*" understanding of health:

> "*The importance of the quality of a home to people's health, and the negatives of poor quality, cold, damp or whatever homes on people's health. I will often say that, and I'm absolutely confident that that's true. But if you say to me, 'talk to me about that in more detail', I'll be trying to google Marmot or somebody as I'm talking. So to some extent it's superficial I suppose. But I almost feel like we're so far away from delivering on it that I don't need to worry too much about the precise nature of exactly how better homes deliver health benefits.*" [GMP02O]

For the participants quoted above, there is either no need to know "*the precise nature of exactly how*" an intervention impacts on health; or scepticism about the type of evidence preferred by "*health folk*" that aims for such precision. As described in other literature (Klein, 2000; Cairney & Oliver, 2017), assumptions of evidence-based medicine are often transposed into the evidence-based policy-making imperative identified in previous policy approaches to health inequalities (see section 2.3.4 of the literature review, above). For these participants, demands for precise causal evidence are misplaced, either since "*we're so far away from delivering on it*", or because numbers fail to represent broader conceptualisations of health.

The significance of this for Health in All Policies-type approaches was made clear in an interview with a Scottish social policy participant who recounted a specific example of when this expectation of rigorous 'health' evidence caused problems for their policy development:

> "*When you're talking about health […] we basically had an internal conversation about diet and health and would reducing meat intake be beneficial for health? Because people were saying it would, people were saying it wouldn't and we were just like, this is too much, we need a baseline of information. So some [external] research was commissioned […] and that's just an example, with health it's like, you can't really just say, 'oh it's good for health to cut down meat', we can't even just say that. Because without, people would be 'actually no, wait a minute, we need to have X, Y, Z research to actually prove that that's the case'. And you could read different academic papers which say different things […] With wellbeing, I don't think anybody would be quite as concerned about us just saying, 'oh more trees are good for wellbeing', or 'less cars is good for wellbeing' or whatever, I don't think there'd be as many checks or balances.*" [SCOP19O]

This participant anticipated such rigorous critique of a health claim that new research was paid for and had to be waited for before such a claim was made. This expectation of the strict evaluation of the evidence created a sense of intimidation for this and other participants outside of health policy, leading to both financial and time barriers to the integration of policy work for health into this social policy agenda. However, such rigorous challenge was not anticipated for the broader concept of 'wellbeing', which is portrayed as having a more flexible meaning. In this way, the term 'health' (but not the term 'wellbeing') appeared to create evidential barriers to cross-governmental work. The term 'wellbeing' is further discussed in section 6.5, below.

6.3.4 Social or economic policy accounts of Health in All Policies: health (policy) authority

Sociological work on 'medical dominance' has examined the particular power of medical doctors within healthcare and associated settings (Coburn, 2006). Lewis's work on the medical influence on health policy in Australia found that "*Medical expertise is a potent embedded resource throughout this network … making it difficult for others to be seen as influential*" (2006, p2134). Limited data in the present research described a similar

perception of authority, attributed to medical colleagues or people who "*work in health*", that diminished the contributions of other policy actors.

In GM, an economic policy participant described how colleagues associated with the NHS, or with health policy, were more able to influence decision-making than they were:

> "*I think what was more important than anything else, was [pause] to get buy-in at a local level it needed somebody there with an NHS badge on to be talking about it or else it would just get no traction. So I'd have conversations, present information, it wouldn't really land the same way as if it was a colleague working for the NHS. So that was something we found, that was quite interesting, I suppose.*"
>
> Q: So the NHS badge, the NHS brand has a power to it?
>
> "*Yes. Whether it's the NHS brand or whether it's 'this is somebody who works in health', it's 'they know what they're talking about so therefore we will do it'. Rather than, I don't know, if I worked in economic development, you know, there's this 'you're not interested in people, you're just interested in GVA and money' and so on.*" [GMP10O]

For this participant, a health policy or NHS-affiliated speaker is assumed to have both expertise ("*they know what they're talking about*") and moral authority in contrast to – in the example, an economic development speaker – who does not ("*you're not interested in people, you're just interested in GVA and money*"). This moral authority attributed to those "*with an NHS badge on*" is not presented as a marginal concern: it is "*more important than anything else*", for without someone with such a badge, the participant says, an idea "*would just get no traction*". Although no other participant described such a dynamic, this account suggests a significant imbalance of power that presents clear barriers to non-health policy actor aims.

The accounts described in section 6.3 so far, from a variety of social and economic policy actors, make it clear that health policy-specific attributes could make social and economic policy actors "*feel devaluated*" (Synnevåg et al., 2019). Specifically, social and economic policy perceptions of population health policy teams "*going round telling other bits of the system what they think they ought to be doing"*, and clinical actors being seen as having "*blinkers*" against non-medical policy interests, expectations of health policy evidential scrutiny that can hinder collaboration; and assumptions around NHS or health policy

expertise and moral authority, all may contribute to interpersonal tensions between social and economic policy actors and health policy teams seeking collaboration.

6.3.5 Health policy accounts of 'Health in All Policies'

Meanwhile, health policy participants acknowledged that health may not justify the cross-governmental imperative status implied by 'Health in All Policies'; two opined that climate or the environment had a strong case to be a primary concern for all policy teams. The risk of health expansionism was also acknowledged, with one participant detecting "*mistrust*" from other policy colleagues, and two others referenced the 'fortress health' idea:

> "*I don't like coming in and saying this is about getting health in all policies, because I think that doesn't land well with policy teams outwith DG Health. Because there's this, people talk about fortress health, and the health budget has been protected at all costs really for the last 10-15 years […] I guess it's that, just from an interpersonal effectiveness kind of respect, I don't think that us going out and saying, 'what can you do for health?' is the way to engage people.*" [SCOP14H]

As noted in previous data, this quote also avoids any moral or political question of prioritisation in favour of considering 'interpersonal effectiveness' in policy contexts; this involves understanding 'health' in this context not as a social issue but as representing health policy teams. This conceptualisation is visible in the suggestion that 'Health in All Policies' is understood by other policy teams as a 'what can you do for us?' message, rather than a message such as 'how can your policies consider population health impacts?'.

Another Scottish health policy participant observed similar issues with 'Health in All Policies'. In the quote below, the participant describes 'Health in All Policies' as seeming to prioritise health, and the perception that 'fortress health' otherwise selfishly maintained boundaries to keep other policy teams out:

> *"It's been met with some opposition, just because people feel health in all policies automatically makes it a health-driven outcome … I think there is a mentality in government that I've noticed, that there's kind of this 'fortress health', that health*

doesn't want to engage with other parts of government until it feels there's value in engaging." [SCOP05H]

These self-aware comments do indeed reflect perspectives from other policy teams (in Greater Manchester at least), as described in 6.3.2 above: for example, the participant who spoke of clinicians with "*blinkers*" refusing to look at the broader system may have recognised this 'fortress health' idea.

For the Scottish participants above, the remedy to this relational issue between health and other policy teams was to position 'Health in All Policies' as a helpful offer of resources or support to help other teams:

"But what we're trying to do is challenge that, saying actually health does have something to bring to the table and we could be working together and if we do have extra resources, and we do have resources, then let's collaborate on it" [SCOP05H]

"So when I've led any of those engagements, it has been much more explaining why we're interested but it's there with an offer. It's not us going in and saying, 'you should do this', it's like 'we can offer this' […] just saying, I've got particular skills, my colleagues have got particular skills, can we come in and help you?" [SCOP14H]

Data from social and economic policy participants suggested these offers of additional resources would often be welcome. Without any prompting, ten of the 22 social and economic policy participants across both polities told me about a lack of resources or capacity in their teams. For example, participants outside of health policy told me "*Capacity is limited massively*" [GMP01O] and "*People don't have the capacity or the staff to maybe take something forward even if they think it might be a good idea, it can be really difficult*" [SCOP01O]. On the other hand, just two of the 11 health policy participants told me they lacked resources or capacity for some intended work, while three others – including the two quoted above - discussed having additional resources they were able to share with other teams. Therefore, this may seem to highlight another aspect of SCOP14H's perception of antipathy from other policy teams towards health policy: that "*the health budget has been protected at all costs"* to the extent that health policy teams now seem to be able to offer additional resources to other policy teams, while those teams perceive a lack of resources for their own core work.

Further, this conciliatory approach to avoid the impression of health expansionism may end up minimising the effectiveness of a HiAP approach:

> "*So there's often like, who or where did this work come from, why are you interested in this enquiry? So I think there's a mistrust around that […] if I'm aware that their issue is economic outcomes, I wouldn't try and flip it around and say 'the economy is there to deliver a good healthy population' […] So I do try and automatically focus on the outcomes that they're interested in.*" [SCOP12H]

In this quote, the health participant describes "*mistrust*" around the involvement of health policymakers in other policy discussions, and interpersonal appeasement of that mistrust by their decision to "*focus on the outcomes that they're interested in*". This refusal to make the moral argument for the importance of health may indeed allow for more interpersonal trust-building, as the data from 6.3.2 above suggests that makers of moral arguments can be resented. But it also concedes ground to whatever economic outcome the other policy team has been instructed to prioritise.

In the Scottish Government, a policymaker involved with a HiAP approach discussed alternative framing options that had been considered: 'Health for All Policies' and 'Healthy Public Policy'. Notably, all three options include the word 'health'; so to the extent that 'health' is associated by other policy teams with health policy teams and health expansionism in a competitive policy environment, 'Health for All Policies' seems unlikely to improve interpersonal relations. Arguably 'Healthy Public Policy' takes a lighter touch, as the adjective form 'Healthy' seeks only to modify the object 'Public Policy', rather than being an object in itself: therefore 'health' is an adjunct, not an ultimate aim. Nevertheless, 'Health in All Policies' and 'Healthy Public Policy' are not synonymous: the former is a policymaking approach while the latter is an analytical concept, or an intended goal of policy (Holt & Frohlich, 2022).

These data reflect the meaning of HiAP in practice described in the conclusion of Cairney et al.'s (2021) qualitative systematic review of HiAP literature: avoiding health expansionism encourages compromise, which dilutes the desired impact. In this example, it seems avoidable only by the other policy team being instructed to prioritise health by their political superiors; not by a health department-led initiative which undermines its own impact either by minimising the importance of health in social or economic policy development, or by maximising the importance of health and thereby "*pissing people off*".

6.4 Health (policy) inequalities: "health's business to fix"

Participants in both polities, from both health and other policy teams, commented that the 'health inequalities' framing implied that health policy teams had sole responsibility for the problem, or that it was an issue to be addressed by healthcare, rather than a policy problem solvable by cross-governmental working on inequalities in the social determinants of health. These data support Lynch's (2017, 2020) contention that 'health' has unhelpful framing effects on 'inequalities' in policy settings, counteracting the 'international consensus' that policy solutions to health inequalities require cross-governmental policy action (2020, ch3).

For example, this participant considered 'health inequalities' to have a particular tendency to imply sole policy responsibility to health teams, in contrast to another policy problem requiring cross-governmental action.

> *"Health inequalities is an interesting one because I think, almost by calling it health inequalities, it's health's business to fix […] you know, the response to the climate emergency isn't just the environment portfolio's responsibility, we've all got a job to do here, and I think one of the things about health inequalities particularly is I think it does end up going 'oh that's a health thing, health need to deal with that'.*" [GMP01O]

Here, 'the climate emergency' is well understood to require collaborative working, but health inequalities is not. This was echoed by a health policy participant in Scotland who had contributed to the development of the Scottish Government's Public Health Priorities (2018):

> "*I think health also has various specific connotations if you use the word health and we were quite keen to avoid that."*
>
> Q: What connotations?
>
> *"So, the rationale being that it's not just the health system's job to eradicate inequalities. This is an inequalities agenda, these priorities, that's what it's ultimately about. We wanted to encourage an appreciation that everyone's got a role to play to improve the public's health. Not public health, the public's health.*"

In this quote, and that of GMP01O further above, the word 'health' problematically contributes to a siloed perspective that attributes full responsibility to "*health* [policy]" or

"*the health system*". In the second quote, the participant explains that using 'health' less would foster a greater understanding of the need for collaboration, as the former participant said was already understood about 'the climate emergency'. The Scottish participant also clarifies the difference between the "*public health*" policy area or profession, and "*the public's health*", intentionally avoiding the conflation of 'health' with 'health policy' visible three times in the GM quote.

Importantly, the Scottish participant also says that minimising the word 'health' in the text would emphasise it as "*an inequalities agenda*", specifically echoing Lynch's (2017, 2020) argument: that in the 'health inequality' framing, 'health' distracts from 'inequality'.

Another participant who had contributed to the minimal use of the word 'health' in how each of the Public Health Priorities (2018) was framed, considered it preferable to move focus to 'wellbeing' instead:

> *"That was always a constant that we tried to do throughout … Most of it was trying to push away from thinking about these issues as health issues, and more so thinking about it as wellbeing more broadly"*.

This participant also discussed the process of developing Public Health Scotland's vision of "*A Scotland where everybody thrives*", of which they also had knowledge. For them:

> *"This was the first time from a public health perspective to say look, this is about reducing health inequalities, it's improving healthy life expectancy, but it's not the health service's role […] This is all about social determinants, about providing a language and a context which people could actually connect into what their role is. If you say, 'this is about improving health', people just default into saying 'well that's the health service then'."*

This latter comment about a 'default' response was similar to two other comments in Scotland. Firstly, when asked specifically about policy responsibility for health inequalities being located within health teams, a senior Scottish Government health policymaker said:

> *"That's also its downside which is, that when people hear 'health', they hear 'healthcare', when people think 'health', they think 'healthcare' or they think 'the NHS', more specifically"* [SCOP07H]

Secondly, when a social policy participant sought to distinguish between 'health' and 'public health', they explained that distinction:

> "*Well, I think, when I think about health, I think about the health boards. So that's predominantly a kind of health service, I suppose, and I know there's conversations around how much reducing inequalities plays through to your health service. But when I think about public health, I think about reducing poverty.*" [SCOP08O]

These descriptions of quick, intuitive cognition appear to represent what Kahneman (2011) describes as Type 1 thinking, a key psychological explanation for framing effects. Kahneman differentiates between fast, unconscious and automatic thinking (Type 1) and slow, conscious and effortful thinking (Type 2). Framing effects can be insidious because they activate automatic Type 1 responses, which are often misleading. According to the above three comments, there is no room for thoughtful considerations of the broader meanings of health or of social determinants: that would be Type 2 thinking, in Kahneman's model. Either 'people', or the participant themselves, are described as automatically associating the word 'health' with healthcare or health services. The consequence of this is that 'health inequality' is intuitively understood to be "*health's business to fix*", while health actors with collaborative aims try to "*push away from thinking about these issues as health issues*" to ideationally disconnect health inequalities from the health service.

Notably, no participant made similar comments about 'people' automatically associating health with 'lifestyle' behaviours. This suggests that 'downstream drift', which includes healthcare and behaviour change responses to health problems caused upstream, may be a preferable way to describe this framing effect of the word 'health' in policy settings; in comparison to 'lifestyle drift', which focuses on behaviour-based responses only.

6.5 'Wellbeing': an ambiguous and attractive alternative to 'health'

In both Greater Manchester and Scotland, social and economic policy participants frequently expressed a preference for 'wellbeing' rather than 'health' as a policy goal. Several participants described 'wellbeing' in ways that aligned it closely to the social model of health, while 'health' remained associated with health policy, healthcare, and a medical model of health. 'Wellbeing' had both a broader meaning, and a more ambiguous meaning, than 'health', which gave it wide appeal within both policy settings. While some small policy teams within SG had 'wellbeing' in their title, its lack of association with any specific policy team – particularly one of the scale or power as DG Health - seemed to allow social and economic policy participants to connect their work to it in a way they felt unable to connect to 'health'.

At the time of these interviews, 'wellbeing' was in a process of institutionalisation within the Scottish Government as part of its 'Wellbeing Economy' agenda. While earlier SG policy texts analysed in this research barely mention 'wellbeing', there was a notable shift towards it visible in the Economic Recovery Implementation Plan (August 2020), which conceptualised a 'Wellbeing Economy Monitor', consisting of four categories of capital assets that "*generate wellbeing for current and future generations*" (p11), and the National Performance Framework, which was described by participants as "*Scotland's wellbeing framework*" [SCOP02H] and "*our definition of wellbeing*" [SCOP04O]. The last SG policy document analysed in this research – the National Strategy for Economic Transformation (2022) – said on page 6:

> "*Our vision is to create a wellbeing economy: a society that is thriving across economic, social and environmental dimensions, and that delivers prosperity for all Scotland's people and places. We aim to achieve this while respecting environmental limits, embodied by our climate and nature targets.*"

Meanwhile, the name of GMCA's latest overall strategy text – Good Lives for All (2022) – reflects the common understanding of 'wellbeing' as meaning 'a good life' (see e.g. Bishop, 2014; Fischer, 2014). It established two overall priorities for the next decade of GMCA policy: responding to the climate emergency, and "*addressing inequalities and improving wellbeing for all*" (part 3). Further, one of its three 'Shared Outcomes' was "*The Wellbeing*

of Our People". 'Wellbeing' was not specifically used by GM texts or participants as often as by Scottish Government texts or participants, but GM participants did acknowledge its importance to the strategy, and specifically connected the strategy's title and the organisation's goals with 'wellbeing':

> "*I think effectively it's conceptualised in that wellbeing equals 'good lives for all', and the shared outcomes side of it, when it talks about decent homes, decent jobs, [that] is how we view wellbeing* […] *equality and wellbeing are rolled together, as two sides of a coin.*" [GMP03O].

> *"Wellbeing was chosen for a reason in the Greater Manchester Strategy. It's designed to be something that doesn't make people think 'oh that's NHS, shove it over there'."* [GMP07O]

Therefore, both GMCA and the Scottish Government were both pursuing overall agendas that sought to prioritise either 'wellbeing' specifically, or 'a good life' synonymously.

This section first describes how the narrow, medical conceptualisation of 'health' was acknowledged, but resisted, by health policymakers. It then describes a key finding: how 'wellbeing' is understood in direct contrast to the two main understandings of 'health' identified in this and the previous chapter: as representing individual illness, and as representing health policy teams. Instead, 'wellbeing' is conceptualised as representing a broader outcome of what are otherwise known as the wider or social determinants of 'health'; and further, 'wellbeing' is not associated with any specific policy teams, and therefore lacks the relational baggage of health expansionism or health dominance described in section 7.2, above. In these ways, 'wellbeing' may ideationally facilitate cross-governmental policy co-ordination on the social determinants of health and health inequality.

6.5.1 Narrow conceptualisation of health resisted by health policymakers

As described in Chapter 5, both health and other policy participants frequently used 'health' to mean 'illness, 'ill-health' or 'disease'. This also led to a very strong association between health and healthcare, and as described in this chapter, health policy. For example, twice

when I asked Greater Manchester-based social or economic policy participants "*To what extent do you think the devolution arrangements shaped GMCA's approach to health inequalities?*", the respondents defaulted to answering about healthcare devolution, rather than about GMCA or about health inequalities.

Health participants in both polities acknowledged and expressed dissatisfaction with this narrow conceptualisation of health. As described in section 6.4 above, participants involved in contributing to the Public Health Priorities for Scotland (2018) highlighted that 'health' was not used as a noun for any of the priorities ('healthy' was used as an adjective twice to modify 'places' and 'weight'). One had said "t*hat was intentional*" because of the "*specific connotations if you use the word health*"; while another said: "*That was always a constant that we tried to do throughout… to push away from… health*" to direct thinking towards "*wellbeing more broadly*".

One health policy participant in GM recalled the narrow use of the word 'health' being rebuked without a supplementary 'care' or 'wellbeing' to broaden its meaning:

> *"I do remember being in meetings and seeing people being told off for saying just health. And that's why I always say 'health and social care', and then that's morphed a bit more into 'health and care', because then care is I suppose a bit of a fluffy all-encompassing word. So I think I do see health and wellbeing thrown around a lot but it feels like sometimes it's to serve this purpose to be like 'well we're not just talking about the NHS part'."* [GMP11H]

These supplementary terms – "care" and "wellbeing" – were combined within the Scottish Government in the name of a group of programmes aimed at improving population health, reducing inequalities, and improving health and care system sustainability: the Care and Wellbeing Portfolio. As shall be further described in Chapter 8, this Portfolio reframed one of its internal missions from 'reducing health inequalities' to 'reducing inequalities', again seeking to avoid the narrow connotations of the word 'health'.

6.5.2 Wellbeing aligned with the social model of health

As aforementioned in section 5.3.4, policy participants in this research regularly described 'wellbeing' as representing something wider or broader than 'health', but otherwise not clearly defined:

> "Q: Is that a deliberate inclusion of health within wellbeing [in the text]?
>
> A: *Yes. What it means to be able to live a good life, a healthy, happy, fulfilled, economically viable, functioning life. It's yeah, all of the above, it's a broad brush.*" [GMP01O]
>
> *"I think for people wellbeing really speaks to health, mental health and physical health, and just quality of life I suppose in general in any sense."* [SCOP04O]
>
> *"I suppose because health is very, very specific; whereas wellbeing is more, there's a whole range of different forms of wellbeing."* [SCOP11O]

The broader meaning of 'wellbeing' also foregrounded mental health, in contrast to 'health', which data described in section 5.3.2 suggest predominantly referred to physical ill-health. While only one economic participant specified that health included mental health, several social and economic policy participants specified that mental health, and adjacent ideas such as social connection, were part of wellbeing:

> *"I think my conceptualisation of wellbeing would be that softer end, that it's broader than just health stroke mental health per se, and it is about positive engagement, relationships and all those other things that makes for a good life."* [GMP03O]
>
> "*There was one other thing I thought it was important to mention was social relationships that I think is a hugely important part of wellbeing*" [SCOP04O]
>
> "*We know that mental health is critical, it's just a critical part self-evidently for wellbeing, it's one of the biggest things that affects wellbeing*." [SCOP13O]

The combination of wellbeing's broadness compared to health, but without specific meaning, allowed social and economic policy teams to directly engage with 'wellbeing' in a way they felt unable to do with 'health'. This was revealed by asking social and economic

policy participants about the role of 'health' in their work, and then following that up with a similar question about 'wellbeing'. Several times, this allowed participants to give specific examples of policy they were working on that related to 'wellbeing', that they had not initially related to 'health':

> *"In terms of digital, wellbeing again would feature there, because you'd be thinking about a factor of a good life is that you've got ability to access the internet so you can speak to your friends and that kind of thing*." [GMP06O]

> *"I would say there's things like the Real Living Wage campaign or the Good Employment Charter work is about wellbeing, but not necessarily health, at least directly."* [GMP08O]

> *"For the cost benefit assessment we've asked for health and wellbeing, so just as an example I know that in our forestry sector they've given us some information about how forestry can positively impact the wellbeing of individuals."* [SCOP19O]

In this sense, 'wellbeing' was related directly to social or economic determinants of health, while 'health' remained individual and biomedical:

> *"Maybe it's also my interpretation of wellbeing, I then would really start to factor in the wider determinants of health […] I think that then wholly encompasses all of the work we do."* [GMP06O]

> *"I think if you'd asked the question based on wellbeing, I'd probably have given you an answer which was actually as much about the work that the economy directorate does, which probably has quite limited interaction with health policy directly."* [GMP08O]

> *"Not just health in particular but also how trade impacts the everyday life of people, so looking at their jobs, equality in general, their environment, so that all falls under the wellbeing principle."* [SCOP16O]

> *"I guess narrowly you could say health is the thing that is experienced by an individual and is related to their biology and their physiology, and wellbeing is that broader community-based public health aspect that then starts to link into*

employment and all those things that become the determinants of health." [SCOP20O]

Many of the quotes above would still make sense with the word 'health' replacing 'wellbeing', at least to proponents of the social model of health. Digital inclusion (Sieck et al., 2021), a living wage (Bindman, 2015), good employment conditions and employment generally (Bambra, 2011), forests (Nguyen et al., 2021), equality in general (Pickett & Wilkinson, 2015), and people's environments (Frumkin, 2003) are all regularly described as social, economic or wider determinants of 'health'. But in this data, social and economic policy participants preferentially connected them with 'wellbeing' and not with 'health'.

One health participant who worked closely with local councils in Scotland also insisted that 'wellbeing' was preferable for them:

"*Local government is much more comfortable with 'wellbeing', and their role in terms of improving population health through a wellbeing lens, as opposed to saying 'health' […] I think wellbeing […] is a much more inclusive way of thinking about the public health challenge. People are much more amenable to engage with that.*" [SCOP17H]

Indeed, the Scottish local authority membership body, COSLA, includes 'Wellbeing – including Health and Social Care' as one of the six priorities in its recent Blueprint (COSLA, 2020) text. This reflects the understanding of social and economic policy participants in this data that the term 'wellbeing' was broader than, and included, 'health', which was itself associated with illness, and healthcare.

6.5.3 Wellbeing unaffiliated with specific policy teams

Part of the identified preference for 'wellbeing' over 'health' outside of health policy was due to social and economic policy participants' association of 'health' with health policy teams and healthcare. For example, when asked whether their strategy text might have chosen 'health' as a key principle rather than 'wellbeing', a Scottish economic policymaker replied:

> "*Wellbeing is a lot broader isn't it? So you're trying to capture a lot more aspects there. Whereas, I think in a way you open the floodgates if you put health, then someone could say well why didn't you put climate or, you know what I mean. So you're opening the floodgates for it, whereas if you have something more, net zero for example instead of environment or climate or energy, that encompasses all of that.*" [SCOP16O]

Similarly, when asked about the limited use of the word 'health' in the new GM Strategy, Good Lives for All (2022), an economic policymaker in Greater Manchester responded:

> "*If you report about health or any other policy area in that way, it would have been going against the whole ethos or the whole approach that we were trying to take with the strategy*". [GMP08O]

On the same topic, a GMCA social policy participant described a conscious avoidance of referring to specific policy domains:

> "*It's a deliberate decision not to talk about health, as it's a deliberate decision not to talk about any particular policy line. So we had the same comments from education and skills, we had the same comments from the culture team, we had the same comments from digital, "I don't see where we are in this", well this is the whole point, you need find your place in this, because this is the bigger picture stuff, it's like how does everything that we do hook to it?.*"

In these three quotes, social problems concerning health, education and skills, culture, digital issues, and climate change, are translated into the professional identities of the colleagues who are tasked with dealing with each problem. So the lack of discussion of health in Good Lives For All is attributed to avoiding "*any particular policy line*" or "*policy area*" and complaints from colleagues; and making health a key theme of a policy text would "*open the floodgates*" to counter-claims by other teams. In this way, avoiding internal competitive conflict among different policy teams is described as a key motivation for the framing of cross-cutting policy goals.

This desire to avoid internal competitive conflict may also inform our understanding of data previously discussed in section 6.3.3 above: Scottish social policy participant SCOP19O describing how expectations of rigorous evidence demands for 'health' claims did not apply for 'wellbeing' claims. In that case, the perceived evidence culture around 'health' created a

sense of intimidation, whereas there was no policy team or advocacy group associated strongly with 'wellbeing' who might critique wellbeing claims. Therefore, both the ambiguity of 'wellbeing' as an idea, and the lack of any policy team ownership of 'wellbeing', made it less vulnerable to critique, and therefore easier to adopt as a stated policy goal.

6.5.4 Wellbeing's ambiguity: loaded with risk

The finding that social and economic policy actors feel included by 'wellbeing' as opposed to excluded by 'health' could be described using a range of theoretical constructs describing the characteristics of terms and ideas. For example, 'boundary terms' are "*able to link disparate groups on the basis of a broad common agenda*" (Scoones, 2007, p589), while 'buzzwords' can "*secure the endorsement of diverse potential actors and audiences*" by "*float[ing] free of concrete referents, to be filled with meaning by their users*" (Cornwall, 2007, p474). With the strategic promotion of policy entrepreneurs, malleable or ambiguous ideas such as 'sustainability', 'solidarity' or 'social inclusion' can be described as 'coalition magnets' (Beland & Cox, 2016) or 'collaboration magnets' (Khayatzadeh-Mahani et al., 2019).

A Scottish health policymaker in my research neatly summed up the combination of ambiguity and inclusion provided by 'wellbeing':

> *"I think wellbeing - similar to what we were talking about in terms of thriving – is a much more inclusive way of thinking about the public health challenge. People are much more amenable to engage with that. It feels a bit more nebulous maybe for some people."* [SCOP17H]

A Scottish Government health policy participant in Hill O'Connor et al. (2023) described 'wellbeing economy' in a very similar way to my participant quoted above:

> "*it's a pleasure to see other colleagues across different non-health areas using the term, because it means that I can easily get access to an open door to try to influence their policies and interventions around this space*" [Interviewee 33, Hill O'Connor et al., 2023, p1240.

Ideas which centre on wellbeing may have similar qualities. For example, in Smith's ideational model of policy responses to health inequalities, ideas based on 'wellbeing' might be described as 'chameleonic', which through the key quality of malleability "*can be used to attract actors with quite divergent interests to support what, by virtue of a shared terminology, appears to be the same idea, even though the various supportive actors may have rather different interpretations of what the idea entails*" (2013a, p198).

Common across these constructs is the premise that ambiguous terms or ideas are able to gain popularity by attracting support from actors with varying interpretations. But these varying interpretations cannot all be operationalised: policy ideas based on these terms must either be framed by policymakers making decisions that include some idea elements and exclude others, risking the fragmentation of support; or ideas that remain ambiguous are left vulnerable to the strategic framing of political actors with alternative interests (Cornwall, 2007).

The former process occurs in Hill O'Connor et al. (2023), which presents 'inclusive growth' as a chameleonic idea, attracting wide-ranging supporters. In that case, the ambition imagined by some participants to be part of 'inclusive growth' was disappointingly absent when 'credible' existing data-sets and indicators were chosen to represent the idea metrically.

Data from the present research suggest that, around the time of my interviews with Scottish Government participants (summer 2023), 'wellbeing' in the form of 'wellbeing economy' remained appealingly ambiguous, able to unite social and economic policymakers around a common cause that is conceptually very similar to a social model of health. However, there appeared to be a framing dispute around 'wellbeing economy', which potentially left it vulnerable to a similar fate as described above for 'inclusive growth'. A senior health policymaker used the example of alcohol to demonstrate how the meaning of 'wellbeing' was disputed and often in tension with the meaning of 'economy':

> "*I think my view would be that we're quite divided within the Scottish Government, about those people who think 'oh I could never talk about health because we were selling alcohol […] but because the alcohol industry in Scotland employs thousands of people I can talk about wellbeing, thank God' […] I would agree that from a public health perspective, economic participation income is a fundamental public health measure. Now I thank goodness every day that Scotland isn't a tobacco*

producing country, but we are a significant alcohol producing country, so we are placed in a dilemma […] But if you don't know what that means and you're simply bringing your previous frame - GDP for instance is literally almost whatever, short of illicit drugs perhaps, but alcohol certainly - and well you'd probably put up with tobacco if we produced it and it was making us enough money […] on concepts like wellbeing economy, without us having gone through a transformation of thinking, all we end up doing is bringing our previous frames into it." [SCOP07H]

In this comment, the narrower meaning of 'health' precludes talking about selling alcohol as 'promoting health', even though income is a key determinant of health. On the other hand, the meaning of 'wellbeing' is broader than the narrow 'health' associated here with alcohol consumption, so the effect of income is included. Therefore, the social model of health, including economic participation, aligns with 'wellbeing' but not with 'health', which is associated with two individual 'lifestyle' behaviours.

But more broadly, the above quotation makes a key point about the potential tensions that are surfaced by a broadly understood 'wellbeing', particularly where any increase in GDP can be framed as creating wellbeing. This can be illustrated with reference to the perspective offered by a senior economic policymaker in Scotland, who emphasised the need to remember the 'economy' side of 'wellbeing economy':

"I think the challenge with wellbeing, just being honest is, it's a bit more nebulous […] I suppose being honest I play a little bit of a role in making sure that we don't miss the mainstream part of the economy in terms of supporting wellbeing, generally successful economies tend to be happier populations […] I guess an example might be foreign direct investment or something, which wouldn't necessarily feature heavily in a wellbeing economy narrative, but actually we shouldn't lose sight of the fact that those things are very positive for those people benefiting from it" [SCOP13O]

This argument about "*generally successful*" economies "*tend*[ing]" to create happier populations, and foreign direct investment being "*very positive for those people benefiting from it*", seems to miss the point of a 'wellbeing economy' agenda, which specifically opposes the generalised pursuit of growth for the benefit of select groups (Coscieme et al., 2019). Such an interpretation allows almost any economic policy approach to be described as contributing to a 'wellbeing economy', including those growth-focused liberal economic

approaches that ‘wellbeing’ and ‘inclusive’ economic approaches aim to counter-act due to their disregard for social or distributional impacts (RSA, 2017; Fioramonti et al., 2022).

Therefore, as political ideas rising up the agenda within the Scottish Government and GMCA, ‘good lives’, ‘wellbeing’ and ‘wellbeing economy’ face risks from two directions: frame specifically for operationalisation, risking buy-in when idea elements key to support are excluded; or allow others to specify, in potentially undesired ways.

6.6 Conclusion to chapter 6

This chapter has described the common use of ‘health’ to mean ‘health policy’ by social and economic policy participants in this research. This is a key finding informing my first research question: ‘how is ‘health’ conceptualised by social, economic and health policy teams in these devolved settings?’.

My participants described three key particularities about health policy which were associated with ‘health’: firstly, the sense of health expansionism from population health teams, and similar resistance to social policy approaches to health from clinicians; secondly, a sense that discussing health matters required a high standard of expertise and ran the risk of rigorous critique, linked to the principles of evidence-based medicine; and third, a sense that health or medical colleagues were assumed to have expertise and authority, compared to social or economic policy actors. These all contributed to a sense of devaluation among social and economic policy teams, as predicted by Synnevag et al. (2019), which was detrimental to cross-departmental relationships.

These views also provided an alternative understanding of the ‘Health in All Policies’ approach, which could imply ‘Health (Policy) in all Policies’, and therefore seemed to be asking ‘what can *you* do for *us*?’. Most of my social and economic policy participants expressed no resentment towards health policy; but for those who did, health policy colleagues were perceived as hindering their own impact, creating battles, and acting selfishly rather than collaboratively. Health policy participants were aware of such distrust and suspicion from other policy departments, and attempted to ease this by offering resources, and by compromising on collaborative goals.

Secondly, this chapter discussed how social and economic policy team's understanding of 'health' to mean 'health policy' entailed that 'health inequality' was the inequality of health policy: "*it's health (policy)'s business to fix*". This logically places the location of responsibility for health inequality within health departments. But as many participants were aware, health departments had insufficient levers to reduce socio-economic health inequalities. Chapter 8 will discuss this in more detail: this research identifies other forms of 'health inequalities' that health policy teams are able to reduce.

Finally, this chapter discussed 'wellbeing' as an ambiguous and attractive alternative to 'health', from the perspective of many social and economic policy participants. The narrow conceptualisation of health discussed in chapter 5 was resisted by health policymakers, who sought to promote a broader conceptualisation. For many participants, wellbeing represented such a broader conceptualisation, more fully describing non-medical aspects of life quality. For social and economic policy participants in particular, wellbeing aligned with the social model of health. Further, wellbeing was not owned by or affiliated with any particular policy team.

However, existing literature highlights that ambiguous policy framings also present risks: they may lose support by being specified and therefore excluding ideas that made them attractive to some (as for 'inclusive growth' in Hill O'Connor et al., 2023); or they may be specified by other policy actors, who have alternative visions. This second scenario has already unfolded in Ecuador following the embedding of 'buen vivir' (good living) as the guiding principle of its new constitution in 2008. Initially promoted as an anti-neoliberal paradigm shift of concern for inequality and the environment, 'buen vivir' was inadequately specified, so became the subject of a deeply political struggle over meanings (Davidov, 2012; Florentin, 2018). Ultimately its ambiguity allowed it to become "*a signifier with no meaning of its own*" (Caria & Domínguez, 2016, p28).

In the next chapter, I shall discuss the different conceptualisations of 'inequality' found in the policy texts analysed. Firstly, I will explore how different axes of inequality convey different political messages, including in negotiation, and in shaping media narratives, aimed at larger policy goals. Then, I shall discuss two ideas excluded by the uniform presence of 'disadvantage' framings: the absence of the social gradient in health, and the absence of causal agents for inequality.

Chapter 7: Conceptualisations of Inequality

7.1 Introduction to the Chapter

In previous results chapters, I explored the meaning and importance of ideas, frames and paradigms in policy approaches to health inequality, and two key conceptualisations of 'health' found within social and economic policy settings: (1) as a policy area concerned with the real social world phenomenon of illness; and (2) as shorthand for 'health policy' (i.e. policy work by health focused teams). These findings highlight the continuing individualisation of 'health' within policy settings, and the difficulty of cross-departmental collaboration for a social approach to health when competitive relational issues interfere.

The findings of chapters 5 and 6 enhance our overall understanding of the meaning of 'health' in policy settings, which is key for this chapter, which aims to explore the meaning of 'inequality'. This chapter is based on an analysis of the axes of health inequality visible in each corpus of texts. I describe data revealing strategic reasons for GMCA's primary focus on the health disadvantage of Greater Manchester residents overall, compared to English averages. But this axis of health inequality – the disadvantage of the in-group overall compared to an external other – was almost completely missing from the Scottish policy texts, despite Scotland's reputation for particularly high mortality rates (McCartney et al., 2012). Therefore, after briefly discussing the Scottish preference for 'place-based' local approaches, I discuss why the Scottish health disadvantage axis may be almost entirely missing from 'health inequality' framings. I then consider the 'drug deaths emergency', a Scottish mortality disadvantage which achieves very high political salience.

Next, two short sections explore the finding that all axes of health inequality found in the GMCA and Scottish Government texts involve narrow comparisons of categorical groups – disadvantages or gaps involving the most disadvantaged - rather than inequality *per se*. Firstly, that means the social gradient in health was entirely missing from both corpuses of texts, which several interviewees reflected on. Further, it means the policy focus remains fixed at one end of the social hierarchy, and not at the most advantaged parts of society whose role in inequality remains under-scrutinised.

7.2 The use of health inequality in political negotiation and narrative

For each policy text analysed, I captured how variations in health were described by health issue, population group affected, and any comparison group, to assess how variations in health were conceptualised by different texts. I was particularly interested in the axis of inequality chosen each time, conceptualising eight across the corpus as in Table 7a, below.

Table 7a: Axes of health inequality found in the analysed texts

Axis of inequality	**Example**
General social-economic disadvantage	"*Poverty and differences in income across our communities underpin the unfair differences in Scotland's health and wellbeing*" (PHS Delivery Plan, p39)
GM/Scottish disadvantage	"*Compared to the UK average we know that: Children growing up in Greater Manchester have a lower life expectancy than the national average*" (GM: Children & Young People Plan, p4)
Within GM/Scotland disadvantage	"*The most deprived areas of Scotland have twice the density of shops selling cigarettes and twice the density of off-licences per person as the least deprived.*" (PHS Strategic Plan, p31)
Social group disadvantage	"*Covid has affected people's health in different ways, with higher levels of morbidity and mortality in certain groups including older people, men, disabled people, minority ethnic groups…*" (SG: Covid Recovery Strategy, p6)
Medical disadvantage	"*The disproportionate harm caused to […] people with obesity, diabetes and respiratory disease has highlighted vulnerabilities and widened existing inequalities."* (SG: Programme for Government 21-22 (Health Chapter) p32)
Globalised disadvantage	"*We will… continue to support our African partner countries with their response to COVID-19 through additional supplies of medical equipment and products this year*" (SG: Programme for Government 21-22 (Other Chapters) p14)
GM/Sco advantage	"*Overall, our cancer survival rates of 69.9% compare well nationally.*" (GM: Transforming the Health of our Population, p28)

Unspecified differential	"*There are significant continuing inequalities in diet, weight and physical activity that need to be addressed.*" (SG: Public Health Priorities for Scotland, p40)

How these axes of inequality are conceptualised has implications for the suggested solutions that may follow, for they act to categorise groups and present them as advantaged or (more commonly) disadvantaged and in need of additional policy attention or resources. How these groups are defined, and which groups are excluded from these conceptualisations, may then serve to disadvantage others.

These axes of inequality also tell stories. For example, the subtle implication of "*our cancer survival rates of 69.9% compare well nationally*" in Transforming the Health of Our Population (2019) is that other regions have poorer cancer survival rates that they may portray as a preventable and unfair 'health inequality' deserving of additional support. But this portrayal of unfairness is not present in the GM policy text. Instead, this statistic is portrayed as a positive to demonstrate good performance. This is a reminder that variations can be portrayed as unfair inequalities, or as evidence of good performance, by different actors and for different reasons, as the next section shall discuss.

7.2.1 'Poor us' stories: GM and Scottish health disadvantage

As seen in Figure 7a below, across the GMCA corpus, the relative health disadvantage of Greater Manchester residents compared to an external other (the 'national', 'English' or 'UK' average) was conceptualised 48 times (in light blue), from a total of 86 conceptualisations across the corpus, or 76 if the 'unspecified' axis of inequality is excluded. Therefore, this GM-disadvantage axis was by far the most common axis of health inequality conceptualised by GMCA.

Fig. 7a: Axes of health inequality specified in GM corpus

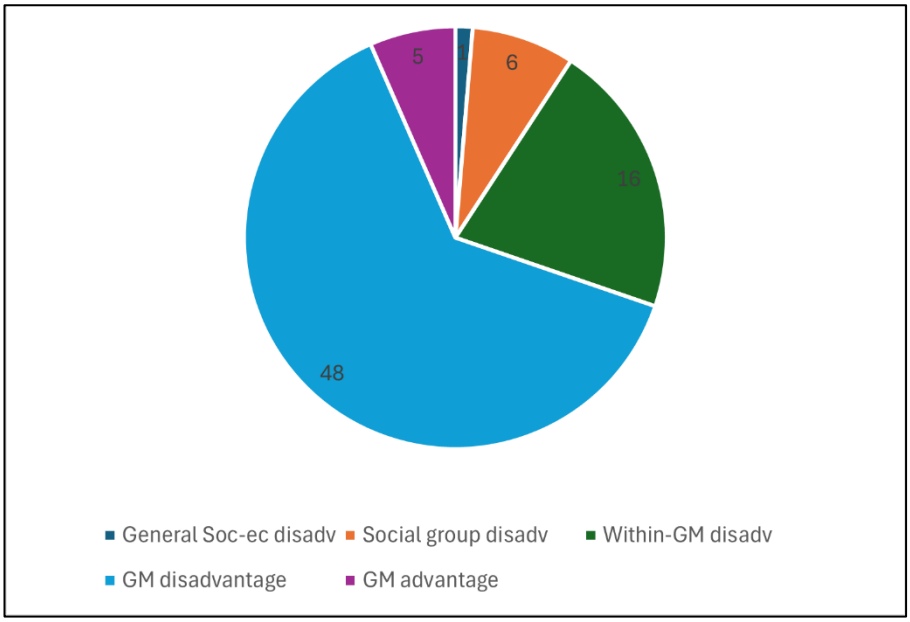
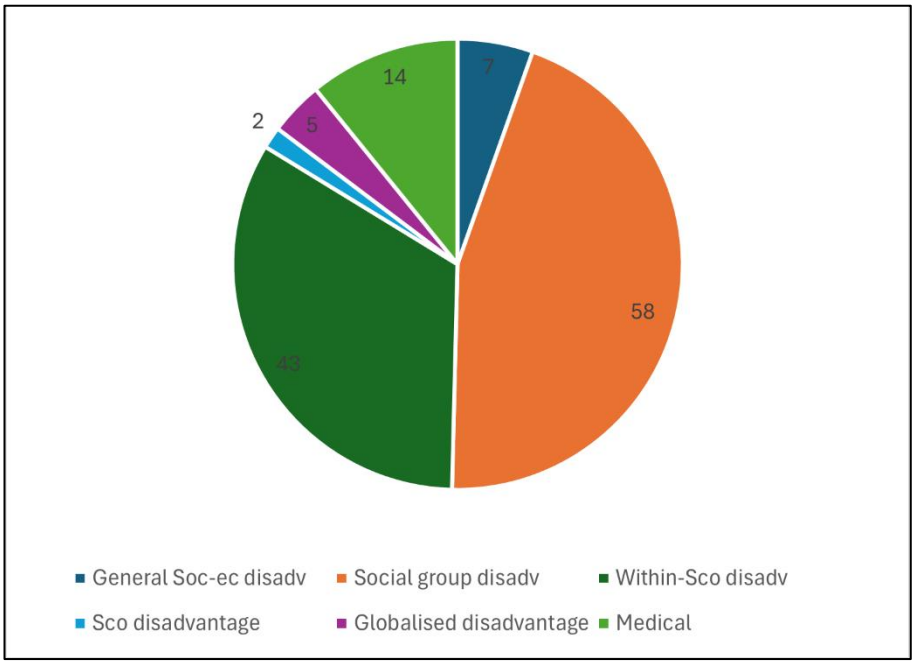


Fig. 7b: Axes of health inequality specified in Scottish corpus



On the other hand, as visible in Figure 7b above the relative health disadvantage of Scotland's residents compared to an external other (again in light blue) was conceptualised only twice, from a total of 139 conceptualisations across the corpus, or 129 where the axis of inequality is specified. These conceptualisations were both contained in a single sentence in Public Health Priorities for Scotland (2018) which compares Scotland's average life expectancy unfavourably with that of 'Western Europe' and 'other UK countries'. No other

sentence in the Scottish corpus made such a comparison. Instead, social groups within Scotland were identified as disadvantaged 58 times, and within-Scotland place-based inequalities were conceptualised 43 times.

This difference is potentially important because a focus on Greater Manchester health averages compared to national averages allows a policy focus on improving average health outcomes in Greater Manchester to reduce that inequality. This may appear to be a solution to the dual aims dilemma: the policy strategy habit of aiming for both overall health improvements, and reductions in health inequality, despite the extreme difficulty in achieving both within the same population (Mackenbach, 2015). But this 'solution' only works to the extent that inequalities within the group are neglected: improving overall health in Greater Manchester to reduce a disadvantage compared to England nationally risks simultaneously widening inequalities between places or groups within Greater Manchester, because population approaches often benefit more advantaged groups first (McLaren et al., 2010; Adams et al., 2016).

The almost complete absence of Scotland-disadvantage is also interesting because of the long-term reputation of Scotland as 'the sick man of Europe' (McCartney et al., 2012) and the persistence of multiple poor health outcomes in comparison to the rest of the UK (Finch et al., 2023). Prominent Scotland-disadvantage framings are visible in policy texts from much earlier in the post-devolution period: for example, the third sentence of New Labour's first green paper on health in Scotland (Scottish Office & Department of Health, 1998) says "*It is about respect, self-confidence and the firm belief that Scotland need not remain trapped at the foot of the health league*"; a large pull-quote on page 1 of the subsequent white paper (Scottish Office & Department of Health, 1999) says "*Our position at or near the top of the international 'league tables' of the major diseases of the developed world… is unacceptable and largely preventable*". In the early years of political devolution, this framing appeared to be a key part of the scene-setting of Scottish health policy strategy texts. Nevertheless, in contrast to Greater Manchester, this well-known inequality no longer appears to be serving as a motivator for the Scottish Government to focus on improving Scotland's health. I asked interviewees in Greater Manchester and in Scotland about why some health variation framings might be preferred to others.

In Greater Manchester, some interviewees suggested that the availability of data was an important factor in how axes of inequality were framed:

> *"When it gets down to district level, the confidence intervals are so wide that the data aren't available, and even if they were, we really wouldn't be able to use them because they wouldn't tell us anything much. So I guess that's in part why we have gone with the GM versus England thing"* [GMP03O]

> *"I also think that there are really tedious practical reasons that you end up doing stuff like that, which is that a lot of the relevant statistics don't exist at other spatial levels."* [GMP07O]

However, almost all social and economic policy participants agreed that there was a political reason for highlighting this axis of inequality. This suggests a widely known, cross-organisational approach that may also have applied to other framings of inequality, as well as health inequality:

> "*A lot of documents that we write, one of their primary purposes is persuasion of national government. So you're talking to people who don't understand, arguably don't care that much about the subtleties of the places within Greater Manchester*." [GMP02O]

> "O*ften when we are making proposals, requests to government, it's about saying 'Greater Manchester needs greater support because we lag behind the UK average on this metric and we need to catch up'. So the story that gets told is how as a place we differ from the UK and it's often a story of, how can we contribute more to UK plc, how can we catch up?"* [GMP06O]

> "*But I think at times and by some parties in GM it might be framed that way because it's a way of trying to extract more from central government*" [GMP08O]

These interviewees each offered an instrumental political reason for this framing of Greater Manchester's health disadvantage: to "*demonstrate*", "*persuade*" or "*make the case*" vertically to the national government in London that they "*can do more*", "*need greater support*", or to "*extract' more*" resources. These comparisons highlighting disadvantage can be seen as forming one strand of GMCA mayor Andy Burnham's "*political narrative of difference*" (Taylor, 2020, p3). To public audiences, Burnham repeatedly framed devolution as a means of 'doing things differently' from Westminster in terms of public engagement and integrated services. But GMCA policy texts speaking *to* Westminster sought to frame Greater Manchester as different from England in terms of health disadvantage, to

demonstrate a need for additional power and resources. Therefore, Burnham and GMCA framed their case for devolution in different ways for political and policy audiences, and for electoral audiences.

But interviewees also highlighted a risk about this GM-disadvantage approach:

> "*So it's a different narrative from the one that I think was more dominant in Greater Manchester 10 or 15 years ago, which was more of: talk up Greater Manchester because you want investors, you want more people to come. If you give out an external message of 'this place is terrible' then why is anyone going to invest? Why is anyone going to bring their business or open a new business, or want to move to Manchester? And so there's a risk that your inequality argument does become a 'this place is terrible' argument.*"" [GMP08O]

This comment reports a prior approach of boosterism (McCann, 2013) that implies social problems such as inequality be excluded from promotional framings so as not to deter investment. A health policy interviewee discussed positively framing healthcare outcomes, which similarly appeared to be motivated by a desire to prevent the withdrawal of investment:

> "*I suppose it's a really fine balance […] about […] we were four years post- signing the* [devolution] *deal. And there was definitely conversations about a fine line between evidencing that we'd done some stuff in that time and to justify remaining devolved because there was always the understanding it could be taken away from us at any point […] it was definitely a conscious decision around needing to showcase the wins but equally […] not wanting to say we'd fixed it all.*" [GMP11H]

In this comment, the participant describes the tension between portraying statistical variations as inequalities that need further attention, or as evidence of good performance, described above. They also articulate the power dynamic between the devolved administrations of Greater Manchester and central government in Westminster that necessitates Greater Manchester's Health and Social Care Partnership "*showcase the wins*" to reinforce support for the previous decision of central government to create it; and to "*justify remaining devolved*" while also asking for more resources. This may provide an explanation for the 'GM-advantage' variations observed in the texts, such as "*our cancer survival rates of 69.9% compare well nationally*":

> "*I think there was definitely a strategic decision made about how many wins we were going to showcase versus how much we were going to keep spinning a sob story almost about how bad it is in Greater Manchester.*" [GMP11H]

These comments show how variations in health outcomes can be framed in policy strategy texts with political instrumental ends in mind; namely, supporting the continued existence of a newly devolved administration while seeking additional resources. Further, several social and economic policy participants claimed that GMCA's focus had moved towards more within-GM inequalities more recently. For the economic policy participant who above described the 'boosterism' of the previous approach, the visible investment and regeneration of Manchester's city centre then provided a stark contrast to other parts of Greater Manchester. For this participant, the election of GMCA mayor Andy Burnham brought "*perhaps a more balanced view of: to what extent is this [investment] benefiting other parts of the city region?*", due to his relative lack of connection to Manchester compared to other local politicians.

Another economic policy participant attributed the high public profile of Burnham over several years as a facilitator of that new approach to inequalities, connecting this high profile to an increasing confidence within the organisation that its long-term future would be secure. This increasing confidence, they guessed, would manifest in an increasing focus on within-Greater Manchester inequalities later in the GMCA corpus:

> *"It's harder to churn an actual organisation with a political head who's got their own mandate […] you can't abolish the Scottish Government now because it's got its own independent civic identity […] My guess would be if you looked at the dates of when those [GMCA] documents were produced, you'd see a pivot over time to looking more at intra-Greater Manchester differences. I think that earlier in the last decade as you're still making the devolution case, there's quite a lot of 'look, Greater Manchester is different to England, we need a different set of arrangements'. And then over time the local political conversation has changed."* [GMP07O]

This change – although perhaps not a "*pivot*" - is indeed visible in the social and economic policy texts of the GMCA corpus. Across five such texts released between 2017-19, within-Greater Manchester health disadvantage is only described twice, while GM health disadvantage is described ten times; but in four texts released between 2021 and 2022, within-GM health disadvantage is found four times, compared to six occurrences of GM

health disadvantage. Therefore, the health disadvantage of Greater Manchester residents compared to external others remained the more common framing, but only slightly, as its use decreased while the use of within-GM health disadvantage increased.

A social policy participant also described the change in "*local political conversation*":

> *"Those variations within GM resonate much more strongly with the ten leaders of the districts, the people that live here, you know, 'I don't care how we're doing against London, how am I doing against my neighbour?', is much more relevant… I think there is that movement in terms of how we're using information to tell a story because we're talking to different people and we're trying to tell a slightly different story.*" [GMP01O]

Therefore, according to this data, the increasing visibility of local economic inequality, the appointment of an 'outsider' to high political office, and growing confidence in the long-term establishment of the organisation, led to changes in the people talked to, the conversations had, and the story to be told in Greater Manchester: from a focus on 'poor us', to an additional interest in the 'poor among us'.

7.2.2 'Poor among us' stories: Within-Scotland place-based disadvantage and the 'drug deaths emergency'

In contrast to Greater Manchester, participants in Scotland offered no suggested reasons for the absence of Scotland-disadvantage from the corpus of Scottish policy texts. However, several did speak about a new cross-departmental focus on place-based disadvantage within the country. This was the most common single axis of health inequality identified across the Scottish texts – with 43 health inequalities conceptualised in this way – while 58 disadvantages were identified for different types of social group.

A variety of reasons were given for this focus. As in GM, one participant highlighted data availability as a reason for the place-based focus: specifically the availability of neighbourhood-level data in the Scottish Index of Multiple Deprivation (SIMD). But they also noted issues with SIMD, such as the aggregation of household-level variance within each area. Another participant associated a new focus on places with Brexit and the subsequent

'Levelling Up' agenda at UK national level, which they linked to the particular issue of depopulation in Scottish rural areas:

> *"So I think that sort of population issue also has that geographical element in terms of rural areas and rural economies or islands are really significant parts of the Scottish economy."* [SCOP04O]

Participants involved in Scotland's 'Tackling Child Poverty' agenda were particularly interested in a place-based approach, and had created a 'Place-Based Social Justice' team to lead small-scale community-based pilot projects to improve access to services and mitigate some of the impacts of poverty. For three more participants, place was the new focus because it represented how people experienced inequality, through local services and their physical and social environments:

> "*Place making is actually where it is. At the end of the day, you and me interact with our public services through our neighbourhoods and communities and the places we live. So we experience transport, we experience health and social care services, we experience local government services, get the bins collected, we rely on the local police… our whole experience is through the places in which we live and that's where we need to think about.*" [SCOP17H]

To follow the logic of GM participant GMP07O quoted above, the lack of Scottish-disadvantage may reflect that the Scottish Government no longer has to make the devolution case, and very much has its own civic identity, so it should have more confidence to focus on internal inequalities, rather than those in comparison to England or European countries. For that participant, the increased confidence in GM coincided with a change in the local political conversation: "*it's a bit of a Rochdale, 'what has Greater Manchester ever done for us?' argument. Those intra-Greater Manchester issues have become more acute*" [GMP07O]. One economic participant in Scotland similarly suggested there was a new emphasis on geographical equality between areas: "*I would imagine some of that at least is probably political in the sense of thinking about different parts of the country, for your ministers, you're going to be thinking about different parts of the country wanting to make sure there's that sense of more equality between areas*" [SCOP04O].

Although the Scottish Government no longer has to advocate for devolution, its governing party since 2007 – the Scottish National Party – has been making a case for Scottish

independence, including holding a referendum on the matter in 2014. This may also impact the extent to which it wishes to highlight Scotland's poor health. This may be what a senior Scottish civil servant in Blackman et al. (2009) implied by explaining that comparing health gaps with the UK or England 'would not be acceptable to a Scottish government'.

Arguably, the high political profile accorded to the 'drug deaths emergency' illustrates the potential for unfavourable comparisons to England to motivate a Scottish policy response. In 2019, the Scottish Government committed £20m and created a 'Drug Deaths Task Force' in response to a surge in drug-related deaths, described by then Public Health Minister Joe FitzPatrick as "*an emergency*" (Scottish Government, 2019). Scotland's drug death rate had long been significantly worse than that of many other countries, including England's (EMCDDA, 2021). In other words, it is a stark example of a Scottish health disadvantage. In January 2021, the then-First Minister Nicola Sturgeon raised the stakes by announcing £250m for the new 'national mission' of reducing drug deaths (Scottish Government, 2022). Considering the long-term high levels of premature mortality in Scotland (Walsh et al., 2016), it is worth briefly unpacking why the 'drug deaths emergency' may have taken on such high political salience.

Firstly, drug deaths represent a narrow portion of Scotland's health inequalities, which may facilitate the appearance of taking strong action. McPhee and Sheridan (2023) describe this approach as a 'placebo policy' (McConnell, 2020), as it gives an impression of impact, without acting on the much wider and more difficult root causes that impact the whole population.

Secondly, this narrower approach is seen as actionable, due to the availability of emergency recovery and treatment services to achieve quickly visible results. This is despite the Programme for Government 21-22 identifying upstream determinants of drug deaths, as described in section 5.2.2. But the annual release of drug death statistics from the National Records of Scotland generates huge media coverage (e.g. BBC, 2022), providing a clear, short-term target. As seen in previous research on policy approaches to health inequality (Blackman et al., 2010, 2012; Qureshi, 2013), short-term targets incentivise the downstream drift. In the case of drug use, a range of medical treatments are available to prevent accidental deaths (RCPE, 2021).

Third, in 2020, unfavourable comparisons between drug death figures for Scotland and other countries including England led to political attacks, such as the conclusion of

prominent social activist Darren McGarvey that "*anything less than FitzPatrick's removal is an insult to the dead – as well as our intelligence*" (McGarvey, 2020); and his removal the following day (BBC, 2020). Stevens (2024, p90-92) reports from interviews with Scottish drug policy actors that media allegations of 'shame' (e.g. R. Davidson, 2021) were particularly powerful in creating this accountability. Although this level of accountability does exist for healthcare policy – Scottish Health Secretary Shona Robison resigned in 2018 on the day the BBC reported Scotland's 'worst ever' cancer waiting times (BBC, 2018) – this level of media pressure for accountability has never been seen for health inequalities more generally.

Fourth, the distinct framing may have facilitated policy action. The health chapter of the Programme for Government 21-22 frames the issue, as FitzPatrick did in 2019, as a "*drugs death emergency*" (p28), conveying a sense of urgency and priority. One of my Scottish Government health participants described "*Scotland's drug death crisis*" as "*where that inequality comes through at catastrophic levels, levels that are so bad amongst a very small cohort, that they impact on our life expectancy and healthy life expectancy statistics*" [SCOP07H]. But no other interviewee connected drug deaths and health inequality; and the Programme for Government 21-22 does not describe drug deaths in these terms; neither does its separate section on 'Tackling Inequality' mention drugs. Therefore, the 'drug deaths emergency' seems to represent a distinct agenda from 'health inequalities', rather than an alternative or partial conceptualisation of health inequality.

Why might this framing have facilitated such political prioritisation? Firstly, drug policy is not entirely devolved to the Scottish Government, while health policy is devolved. Therefore, highlighting an 'emergency' involving inadequate Westminster drug policy helps make a case for further devolved powers - or indeed for independence - allowing independence supporters to blame the UK government and cast English Conservative politicians as both unchosen by the Scottish electorate and uncaring for it (Garavelli, 2020; Harrison, 2023; Robertson, 2020). Considering the centrality of health policy to Scottish politics (Nottingham, 2000), highlighting a 'health' emergency instead may have encouraged an argument for Scottish Government incompetence or the failure of devolution instead (e.g. McLaren, 2023).

Therefore, it seems likely that this specific health inequality is politically prioritised because key political actors are held accountable in the media to widely covered annual statistic

releases; because medical solutions are available to work within the timeframe required to impact on those statistics; and because it can easily be framed to mobilise – rather than damage – the governing party's central argument in favour of Scottish independence. These explanations do not apply to Scotland's long-term health disadvantage more broadly.

A further, pragmatic explanation may also apply. One Scottish participant closely involved in policy approaches to health inequality said: "*I think that there's been a realisation that certain communities are disproportionately affected, so the efforts need to be focused or skewed towards that".* While not specifically identifying drug users, it is very arguable that this community may be the worst affected by social injustice. More than 200,000 Scots have experienced two of the three severe and multiple disadvantages - substance dependence (including drug use), homelessness, or offending - and who report very high levels of traumatic or disruptive childhood experiences (Bramley et al., 2019). More specifically, drug-related deaths are eighteen-times higher in the most deprived areas of Scotland than the least deprived (Finch et al., 2023). Their health does not represent Scotland's health overall; their health is among the poorest of the population. Therefore, a policy focus on drug deaths arguably focuses on the individuals who have suffered the most severe social, economic and health disadvantages of all. Seen this way, Scotland may also have followed the path observed in Greater Manchester: from a devolution-supporting 'poor us' story of health inequality, to an additional focus on the 'poor among us', after devolution has been long-established and attention turned to local representatives and electoral imperatives.

7.3 The missing axis of inequality: the social gradient in health

As can be seen in Table 7a above, seven specific axes of inequality in health were identified across the corpus. Variations in health were conceptualised a total of 202 times using one of these seven axes, and a further twenty times without any axis of inequality specified. There was no sign in any policy text of the social gradient in health: the epidemiological finding that health outcomes vary across a whole population, rather than only for specifically disadvantaged sub-groups (CSDH, 2008; Marmot et al., 1984, 2010).

As described in the introduction and the literature review, systematic variations in population health are commonly represented by the poor outcomes of those who are most socioeconomically disadvantaged, or framed in terms of 'gaps' between two groups (Graham, 2004b). In both cases, most of the population is excluded from consideration. For example, focusing on the health disadvantage of the poorest decile excludes attention to the health disadvantage of the second-poorest decile; attention to a health gap between two deciles excludes reference to the remaining 80% of the population. Approaches based on these conceptualisations tend to focus on the specified disadvantaged groups. For example, the Scottish Government's Covid Recovery Strategy (2021) cites health inequalities between those living in the most deprived 10% and the least deprived 10%.

However, epidemiological evidence shows that a gradient in health exists across all of society. The famous Whitehall studies (Marmot et al., 1984, 1991) found health outcomes to vary within the civil service according to professional hierarchy, despite the obvious lack of poverty or unemployment within the civil service. Similar gradients in health have been found extensively, across populations (Adler et al., 1994; Huisman et al., 2003, Semyonov et al., 2013; Chauvel & Leist, 2015), while work by Wilkinson and Pickett (2009, 2020) and others has mapped out various psychosocial pathways explaining poorer health outcomes for all in more unequal societies. McCartney et al. (2019) further point out that a focus on specific disadvantage risks 'othering' narratives if much of society believes the problem to be limited to the most disadvantaged groups only.

In this research, analysis of the Inequality Frames from all texts show that nine of the eighteen Scottish Government texts included focus specifically on poverty (including child and fuel poverty) rather than inequality as such, as in the below examples:

Scottish texts	Inequality Frame
PHS Strategic Plan (2020)	Living in poverty causes poor health and wellbeing. Deprived areas have poorer health outcomes on a range of measures. Some groups, such as children and ethnic minority communities, are also at risk of poverty.
Housing to 2040 (2021)	Child poverty, fuel poverty and homelessness could all be addressed by everyone having an affordable high-quality home that met their needs in a place they wanted to be.
Delivering Economic Prosperity (NSET) (2022)	Poverty, and in particular child poverty, must be tackled with a strong economy that delivers fair work and better wages for all.

As described above in relation to health inequality, in relation to inequalities generally GMCA texts commonly described the disadvantage of GM residents compared to national averages. While social group health disadvantage was extremely rare from the GMCA corpus, social groups were identified in relation to social and economic disadvantages, e.g.:

GM Other	Inequalities Problems
Local Skills Report and Labour Market Plan (2021)	GM suffers many disadvantages compared to national averages, for example in skill or qualification levels, employment rates, or economic disadvantages. This was clearly the most common axis of inequality. Some social groups within GM were identified as being disadvantaged - younger people, older people, and those with few skills. Place-based variation within GM in skills, employment, digital access and deprivation were also identified.

Therefore, in the texts analysed, categorical comparisons based on poverty or disadvantage are much preferred to the social gradient in health. This reflects a long-running trend: as Marmot and Wilkinson wrote in 2001: "*much of the debate on health inequalities has centred on the damage done by poverty. However, evidence suggests that health is also related to inequality*" (p1233). Similarly, this finding mirrors a finding by Smith (2013a, Ch3),

whose analysis of policy texts from England and Scotland between 1997-2003 found a focus on the impact of poverty and deprivation on health, rather than on inequality as such.

The social gradient in health implies that such approaches are too narrow, for they exclude policy attention to the much greater proportion of a society that is not in the compared categories. Policy approaches targeted at the most disadvantaged may benefit those at the lowest point of the gradient while entirely missing others who also suffer premature illness or death due to being low on the gradient. Instead, following the logic of the social gradient, policy should aim to improve the whole of society's health, but with effort amplified according to levels of disadvantage. This policy approach was described as 'targeting within universalism' by Skocpol (1991) and is now commonly known as 'proportionate universalism' (Marmot, 2010).

Scottish interviewees provided a range of responses to questions about the lack of a social gradient in policy texts. Two participants argued that it reflected a morally justifiable prioritisation of limited resources:

> *"And I think it's also a recognition […] I would imagine it's partly to do with acknowledging that the public purse has limited amount of funds, so we have to focus our energies and efforts where we can make the most impact*." [SCOP02H]

> "*In some ways it's kind of, intuitively are you as bothered that somebody who's doing all right with a couple of cars and some foreign holidays have got slightly worse health than they would if [they had even more]. Do you know what I mean? You've got inequalities. But where they're at and what they're losing is less than what's being lost at a lower level in the sort of resource continuum. So intuitively maybe it's harder to be so bothered."* [SCOP12H]

A recent analysis of health inequalities in Scotland finds particularly poor outcomes for people living in the most deprived areas, even compared to those in the second most deprived quintile (Miall et al., 2022). As described above, drug deaths have increased rapidly in recent years, and are concentrated in the most deprived communities. This may justify a policy focus on health disadvantage rather than a social gradient.

Reflecting further on the lack of any mention of a social gradient, two participants described it as a more cognitively challenging concept:

> "*I think it's probably been too technical for some policy texts, to be honest.. I think sometimes that's left out of the policy text or in our communications possibly because it's just seen as too complicated to communicate*." [SCOP05H]

> "*I personally find it, I have to get my head around it each time, it's a little bit of a harder concept. So maybe it's that I think"* [SCOP12H]

A GM-based participant agreed with this perspective, and discussed efforts to reframe the too "*technical*" 'proportionate universalism'

> "*I'm not even sure within the healthcare system how much people understand it… from the meeting everyone said, we agree with the principles but we need to think about the language, about how we're expressing this so that it's not technical, proportionate universalism doesn't mean things to people, so let's not use that word"* [GMP12H]

One interviewee with close policy connections to health inequalities was not familiar with the phrase 'social gradient' at all – "*could you elaborate a wee bit on that gradient, what do you mean? Sorry, because it's not language I am familiar with*" - although they were familiar with 'proportionate universalism'. Another interviewee – unaware of their colleague's unfamiliarity with the gradient - suggested that it may have been abandoned due to ineffectiveness:

> "I*f thinking about something one way doesn't seem to get us very far then we'll try another [...] [perhaps] it's not there because when we've spent 20 years thinking about it that way it didn't really get us very far."* [SCOP07H]

But this suggestion was rejected by another interviewee, who concluded that the complexity of the social gradient concept, and the weakness of the moral argument it added to simpler ideas, meant it had never really been adopted by policymakers in Scotland:

> "*Were we ever really on board with the social gradient though? […] I don't think we've lost it, I don't think it was that of a big understanding in the first place.*" [SCOP12H]

The Scottish Government's annual Long-term Monitoring of Health Inequalities reports do include relative index of inequalities (RII) measurements, representing the social gradient in

health. However, these measurements are not evident in any of the policy strategy texts analysed.

One problem with assessing policy responses to the social gradient is that interpretations of proportionate universalism differ (Carey et al., 2015; Francis-Oliviero et al., 2020). For example, should it describe the stated intentions of an intervention, or its effects? What granularity is required: if dichotomous 'gaps' are insufficient, to what extent should interventions vary? How should proportionate universalist approaches account for intersectional inequalities, so that the needs of multiply disadvantaged groups are met? Should it describe a single intervention, or clusters of interventions; and if the latter, of what breadth or scale? Given the expected long-term health impacts of so much social and economic policy, the latter analytic task is substantial.

An example of the analytical challenge can be found in the health policy focus of both Smith & Hellowell (2012) and Capper et al. (2023). Smith and Hellowell's (2012) analysis of policy approaches to health inequalities in England, Scotland, Wales and Northern Ireland found that all four polities conceptualised variations in health as 'gaps' resulting from deprivation, rather than existing across society. More recently, Capper et al.'s (2023) analysis of six national-level English policy documents from the acute phase of the Covid-19 pandemic also found a focus on the highest risk or most vulnerable populations, rather than addressing health across the gradient.

But just as the policy determinants of health gaps or health disadvantage lie mostly outside the control of health policy teams, the policy determinants of the social gradient in health are not within health policy control either. Therefore, the absence of the social gradient idea in health policy texts does not mean the absence of proportional universalist policy that may address the social gradient. To assess the extent to which a polity's approach may be proportionally universalist, it would be necessary to assess the social and economic policy approaches too.

Benach et al. (2013) make eight specific suggestions for gradient-based approaches to reducing health inequalities. Two of these – a progressive taxation system, and a public, universal healthcare system – already exist in Scotland, though the progressiveness of the tax system, and the universality of the healthcare system, could be increased. Another of Benach et al.'s suggestions – the widespread introduction of traffic calming measures – was

a declared intention of the power-sharing Bute House Agreement (Scottish Government & Scottish Green Party, 2021).

In Benach et al.'s analysis, any universal policy funded by progressive taxation can be considered as reducing the gradient. In a discussion on the lack of policies specifically targeting the social gradient in health, one of my interviewees highlighted a universal policy of the Scottish Government:

> "*I don't know whether you heard the First Minister earlier this week at his Poverty Summit, an illustration of this could be, for example, our policy on free school meals is universal, it's for everybody, every kid and even it's for kids whose parents are well-off.*" [SCOP02H]

The other five policies suggested by Benach at al. are evident in Scottish Government texts analysed in this research: social housing is promised in Housing to 2040; a cash transfer programme (the Scottish Child Payment) is found in the Covid Recovery Strategy; a means-tested subsidy for school clothing is offered in the Tackling Child Poverty Delivery Plan; population-based cancer screening is found in the Health Chapter of the Programme for Government 21-22; and psychosocial workplace interventions are present in the Fair Work Action Plan.

Therefore, even though the social gradient idea was not present in any of the thirty policy texts analysed across both polities; and was not recognised by a policymaker with close connections to policy for health inequalities; analysis of social, economic and health policy texts from the Scottish Government finds an approach that combines universalist policies with policies that target a range of social groups, funded by a progressive taxation system. This comfortably satisfies Benach et al.'s criteria for a policy approach to reduce health inequalities across the gradient.

That the Scottish Government feels no need to frame such policies as targeting the 'social gradient in health' implies that this frame, while representing an important set of ideas about the social patterning of health, may be incompatible with existing policy paradigms in a number of ways. Most obviously, policy aimed specifically at addressing a social gradient in health would require extensive cross-departmental collaboration, which has proven notoriously difficult over many decades (Exworthy & Hunter, 2011), to co-ordinate the particularly complex tasks of targeting cross-policy efforts along the full range of the

gradient. Even if such extensive and complex cross-cutting collaboration was possible, my participants highlighted the cognitive challenge of the idea, and the relatively weak moral force of its argument in comparison to health disadvantage conceptualisations. Both these attributes make it unlikely to attract sustained media attention or political commitment.

Equally, while research findings of systematic variations in population health are undoubtedly important, the social injustice/international consensus health inequalities policy frame appears to be incompatible with existing policy frameworks in various ways. But in neither case does that mean a lack of policy addressing the phenomenon. As described in section 5.3.7, the Tackling Child Poverty Delivery Plan uses the phrase 'health inequality' just once in over 150 pages, to describe initiatives to improve primary care in deprived areas. But the lack of a specific framing does not mean the lack of relevant policy action, as the child poverty agenda clearly has huge potential to reduce systematic and unfair variations in health. This is a reminder to distinguish policy frames from policy impacts: social, economic and health policy interventions are impacting the social gradient in health, and on health inequalities, all the time, whether they are framed to be doing so or not.

7.4 The missing agents of inequality: the passive construction of poverty

As described above, policy participants did not seem perturbed by the absence of the social gradient from health inequality conceptualisations, and made very plausible arguments to justify a focus on disadvantage instead. A focus on disadvantage may also be politically convenient. Arguably, focusing on one end of the social hierarchy diverts scrutiny from those at the other end, whose economic and social status confers power to intervene.

Analysis of ideas related to inequality in the thirty policy strategy texts allowed for 'causal stories' to be captured and categorised for each document. This analysis found very few causal stories of poverty or inequality located upstream (i.e. explanations for causes of

poverty or inequality), other than forces far beyond identifiable agentic control. For example, the global financial crisis of 2008 was identified by GMCA's Local Skills Report and Labour Market Plan (2021, p18) as leaving a "*deep legacy*" on economic inequalities. Brexit was identified as a cause of inequalities by two texts in each polity. In both polities, Covid-19 was highlighted in policy texts following its emergence as an important cause of inequalities, for example:

Scottish text	Inequality Causal Stories
Economic Recovery Implementation Plan (2020)	Harms from Covid-19 and lockdown restrictions were unevenly distributed in the population. People with underlying conditions, ethnic minority groups, and the elderly, were at higher risk of illness from Covid and social isolation due to restrictions. Restrictions hit economic sectors that many women, disabled people, people in minority ethnic groups, and younger disadvantaged people worked in. Working and socialising from home meant digital connectivity became particularly important. Economic, social, structural and cultural inequalities manifest in health inequalities. Increased caring responsibilities after school closures mostly fell on women.

While Covid-19 effects were often described as 'exacerbating' or 'amplifying' inequalities, the causes of such 'pre-existing' inequalities were very rarely identified. Disadvantage was frequently described in highly passive terms by using the passive voice adjectives 'disadvantaged' or 'deprived' to modify nouns such as 'areas', 'communities' or 'children'. In English grammar, passive voice is used to focus on objects or actions over actors, and to sound more formal (this can be called 'passivisation'). Policy texts, and academic texts such as this thesis, are expected to be highly passivised for formality, and this plays a role in communicating causation. Passive voice can be identified by combining the correct verb form of 'to be' (often 'is' or 'are') with the past participle of the main verb, as in the sentence above where I wrote "the passive voice *is used*" to write formally and generally.

In this construction of the passive voice, the verb invites an adjunctive 'by' to identify the actor: for example, "the passive voice *is used by* writers who wish to emphasise the action over the actor". Using this passive construction with the above terms would invite some readers to seek to identify causal actors: "Communities are disadvantaged *by*…"; "Areas are

deprived *by*…"; "Children are disadvantaged *by*…". Converting these past participles into passive adjectives ('adjectivisation') or into nouns ('nominalisation') obscures that invitation, transforming actions of disadvantaging or depriving into fixed states with no origin.

Analysis of passivisation, adjectivisation and nominalisation is commonplace in the critical discourse analysis of researchers such as Fowler (1991), Fairclough (1996) and Wodak (2014). Krista Ratcliffe, a Professor of Rhetoric and Composition in the US, explains my specific interest thus: "*passive voice mystifies accountability by erasing who or what performs an action; unattributed adjectives in such expressions as 'undesirable behaviour' suppress the agent's identity (i.e. who finds the behaviour undesirable); and generic nouns such as* people *and* they *allow particular perpetrators to hide behind the general*" (emphases original) (Ratcliffe, 2016, p94).

The terms 'disadvantaged by' and 'deprived by', which could be followed by an agent, and the active verb 'deprive', which could be preceded by an agent, are all entirely absent from the corpus of thirty policy texts (except for one phrase in PHS's Delivery Plan about ensuring its own recruitment processes ensure applicants are not "*disadvantaged by identifying with a protected characteristic*"). Two GM documents quote a consultation response that uses lightly passivised phrasing: "*we need equal life chances and better services for children and young people whose families are disadvantaged*", potentially inviting an identifying 'by'. Otherwise, these terms are used entirely in the adjectivised and nominalised forms, which exclude agency: across both corpuses, 'disadvantaged' is used as an adjective 75 times, and 'disadvantage' as a noun 62 times; 'deprived' is used as an adjective 128 times and 'deprivation' as a noun 116 times. In this way, disadvantage and deprivation are overwhelmingly portrayed as pre-existing states with no agentic origin.

Analysis of the causal stories of inequality in this corpus of texts finds very few clues as to any causes or responsibility for pre-existing inequality. The Scottish Government's Programme for Government 21-22 criticises the UK Government's withdrawal of a £20 weekly uplift to Universal Credit for hampering its efforts to reduce child poverty. Previously, SG's Tackling Child Poverty Delivery Plan (2017) had identified the UK Government's agenda of economic austerity as a contributing cause of child poverty; it was the only text to do so:

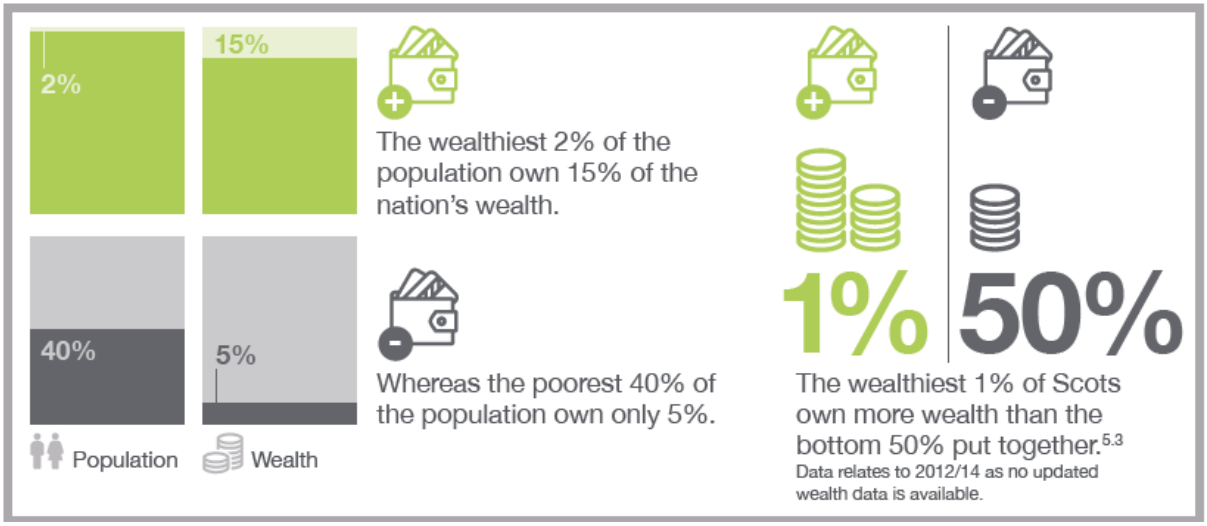
Scottish text	Inequality Causal Stories (excerpt)
Tackling Child Poverty Delivery Plan (2017)	Poverty has three main drivers: insufficient income from employment, insufficient income from benefits, and high costs of living. Poverty is not inevitable - while global trade and employment trends affect it, so do government austerity policies, and Brexit.

GMCA's Housing Strategy also identified clear agents at fault for contributing to housing inequalities:

GM text	Inequality Causal Stories (excerpt)
Housing Strategy (2019)	Housing inequalities are caused by high rents, discrimination, and poor practices by landlords in the private rented sector.

Otherwise, poverty and inequality are caused by individual-level problems such as health (or ill-health), low skills, low incomes, and high costs, with no further explanation about the causes of such ill-health, low skills, low incomes, or high costs. Therefore, the agents of inequality remain largely mysterious, and while the disadvantages of the disadvantaged are well explained, the advantages of the advantaged are surfaced just twice, in the same chapter of the same text, in infographics such as this one in Public Health Priorities for Scotland (2019):

Fig. 7c: Image from *Public Health Priorities for Scotland* (2019, p36)



Other than the image above and one other from the same text, the full focus across both corpuses of texts is on the disadvantages of the disadvantaged, without reference to the advantages of the advantaged. This reflects previous research with a small group of Scottish Government policymakers interested in health inequalities, which noted a similar focus on disadvantage limiting attention to more affluent groups (Mackenzie et al., 2017).

Such a focus on specific groups with health disadvantage, rather than whole society health inequality, ignores a wealth of evidence on the psychosocial health impacts of inequality on all (Wilkinson & Pickett, 2009, 2020) and may facilitate the 'othering' and stigmatisation of the disadvantaged (Tyler, 2024). It also spares the socially and economically advantaged from scrutiny of the impacts of their advantage on others (Reich, 2014). This may have the important effect of minimising political will to increase the progressivity of taxes, and could be related to further data and analysis, described in section 8.4.3 below, about the perceived 'political suicide' of redistributive economic policy.

7.5 Conclusion to chapter 7

This relatively short results chapter has focused on conceptualisations of inequality as identified in the two corpuses of policy texts and as described by interview participants. Therefore, the findings and analysis of this chapter are of particular importance to my second research question: 'How are inequalities conceptualised by social, economic and health policy teams in these devolved settings?'.

Section 7.2.1 described how the dominant axis of health inequality in GM analysed policy texts – the health disadvantage of GM residents compared to external others, characterised as 'poor us' - was part of an organisational strategy of negotiation with the UK national government to enhance arguments for devolution. However, several GM participants spoke of a new interest in within-GM inequalities, due to the increasing visibility of local economic inequality, the election of the 'outsider' Andy Burnham as Mayor, and growing confidence in the long-term establishment of the organisation.

As 7.2.2 describes, it was notable that the framing of Scottish-disadvantage compared to external others was almost completely absent from the Scottish Government corpus, despite Scotland's long-standing reputation for poor overall health compared to the rest of the UK and to Western European countries. Although data about this apparent anomaly was lacking, analysis of existing literature presented a hypothesis that Scotland's 'drug deaths emergency' framing supports a political argument for greater powers – Scottish independence – while a health-disadvantage framing may be avoided due to fear of it being weaponised by political opponents.

Equally, it was observed that those at highest risk of drug deaths in Scotland are also arguably the most severely disadvantaged residents within Scotland, and that therefore this focus does represent a 'poor among us' approach. Therefore, it is arguable that Scotland has followed a similar path to that on which Greater Manchester now treads: telling a 'poor us' story in the early days of devolution to justify the new arrangements and to optimise devolved powers and resources; before adding an additional 'poor among us' story when the devolution arrangements are established and focus turns to internal political imperatives. Both analyses convey a central point: the meanings and uses of 'health inequality' must be analysed with regard to political contexts and imperatives, rather than being naively considered an 'evidence-based' endeavour.

The following section focused on the notable omission from the policy strategy texts of the social gradient of health inequality, which was totally absent from both GMCA and SG corpuses. Data from participants suggested that this axis was difficult to conceptualise, and less important to focus on than health disadvantage, analogous to poverty. But this complete absence of social gradient framings must also be assessed with regard to political contexts. Analysis in section 7.4 of the language used to describe disadvantage and deprivation found a passive, formal style that functions to mystify agency.

This suggests an additional problem with the 'health inequality' framing – additional to the focus of the previous two chapters on the meanings and effects of 'health' – which is that the long-standing policy preference for disadvantage rather than gradient axes reflects a conflation of 'inequality' with narrower notions of health deficit or poverty. Arguably, focusing only on the disadvantaged keeps attention away from the advantaged, and erases the line between them that represents their social connection.

In the next and final results chapter, I turn my attention fully to 'health inequality', and introduce three conceptualisations of health inequality present in these policy settings. First, I describe the 'illness-related economic inactivity' policy frame, which takes the health-as-illness conceptualisation to a population scale, and focuses on its impact on the labour market. Then, I describe the 'healthcare for disadvantaged groups' policy frame, which expands on the health-as-health-policy conceptualisation. Finally, I discuss several issues concerning the 'international consensus' policy frame described by Lynch (2020), which relates to the social injustice of preventable population ill-health, including its apparent rejection by a key Scottish Government policy team.

Chapter 8: Conceptualisations of Health Inequality

8.1 Introduction

Having explored the meanings of 'health' and of 'inequalities' in policy documents and settings in the previous three chapters, in this chapter I shall turn to how 'health inequalities' are conceptualised and framed. Chapters 5 and 6 discussed two key conceptualisations of 'health' found in social and economic policy settings: as a policy area concerned with illness; and as shorthand for 'health policy'. These findings highlight persistent individualisation of 'health' within policy settings, and the difficulty of collaborating for a social approach to health when competitive relational issues interfere. In the last chapter focused on 'inequality', I described the political use of health comparisons as part of broader political narratives; and the routine use of categorical disadvantages or gaps, so that the social gradient in health is excluded, and that a passive form of poverty replaces notions of powerful agency.

This chapter aims to explore 'health inequality' specifically as a policy frame uniting both terms. In doing so, it identifies three distinct policy frames for conceptualising health inequalities that do not depend on comparison groups. Firstly, in section 8.2, I describe the 'illness-related economic inactivity' conceptualisation: this is the use of 'health inequality' by economic policy actors to refer to widespread illness in the population hampering the economy, by removing individuals from the workforce. This conceptualisation of 'health inequality' is described as a high priority in both GMCA and the Scottish Government, and holds clear potential for 'win-win' collaboration between economic and health policy teams. However, as I describe in this section, there are also concerns associated with this understanding of 'health inequality'.

Then, in section 8.3, I explore how 'health inequality' was regularly used instead of 'healthcare inequality' to describe policy attention to healthcare for disadvantaged groups. This framing was more visible in Scottish Government data: it was institutionalised in at least two Scottish Government team names - the Prisoner Healthcare team within the Health Inequalities unit, and the Racialised Health Inequalities team – and was prominently used by the new Scottish First Minister Humza Yousaf within days of his appointment

(Scottish Government, 2023b). Also in this section, I discuss the impact of placing responsibility for health inequality with the same policy teams as for healthcare generally, and the potentially unhelpful competition this positioning produces.

Finally in this chapter, I discuss how Lynch's (2020) 'international consensus' health inequality policy frame[9] fares in both GMCA and in Scotland. Firstly, I propose that the frame could be usefully reconsidered as a 'social injustice' health inequality frame instead. Then I discuss a rejection of 'health inequalities' within the Scottish Government's key programme attempting to promote collaborative working to reduce such socially unjust inequalities in health. Then, I discuss the radical terms used by one senior health policy participant to describe reducing economic inequality, in relation to Lynch's description of a policymaker 'taboo' about redistribution. Finally, I discuss ideas from participants about policy alternatives to a focus on 'health inequality'. Therefore, this chapter problematises all three health inequality policy frames identified in these policy settings, informing the subsequent discussion of implications and alternatives.

8.2 The Illness-related Economic Inactivity Policy Frame: health inequality as population-scale illness

The common conceptualisation among social and economic policy participants of health as illness, described in Chapter 5, meant that 'health inequality' was often used by other participants, particularly economic policy participants, to mean widespread illness. For example, one participant stated that, "*you can have health inequality as an individual*" [SCOP20O], while another described individuals as "*facing health inequalities*" [SCOP21O], rather than either being described as unwell, or as facing inequalities. As described in

[9] The 'international consensus policy frame' identified by Lynch (2020, p50) describes health inequality as avoidable and unfair differences in health status between socioeconomic groups. Because these differences are preventable by government action, the failure to prevent them represents a significant social injustice. This is presented as a research consensus developed since the Black Report in 1980, similarly to my presentation of health inequality in chapters one and two.

section 5.3.3, this meant 'health inequality' was conceptualised as an important impediment to work, and a cause of child poverty.

This is not the 'international consensus policy frame' of health inequalities, as described by Lynch (see section 8.4, below). It is not concerned with socioeconomic groups, avoidable differences in health, or the role of social inequality as a key driver. Rather, this is an illness-related economic inactivity policy frame: the problem is economic inactivity generally, and the causal story is the disabling impact of ill-health on employment. In the policy texts analysed with this frame, and from interviews with relevant policy participants, there is no overt moral responsibilisation, and the policy solution is medical.

Table 8a: The Illness-related Economic Inactivity Policy Frame

Element of policy frame	**Illness-related Economic Inactivity Policy Frame**
Causal Story	Widespread illness is weakening the labour market, leading to unfilled job vacancies and skills shortages.
Problem	Economic inactivity is weakening economic productivity.
Solutions	Quicker access to more effective healthcare reduces illness and allows individuals to re-enter the labour market.
Actors	Healthcare providers must work with state employability services to better target healthcare solutions for individuals.
Moral responsibility	There is no moral responsibilisation for illness, but the state and healthcare actors have responsibility to manage the treatment of illness.

This illness-related economic inactivity policy frame meant that health inequality was described by economic policy participants as a much higher political priority than it had been previously. Several participants in Greater Manchester highlighted an economic report from 2019, the Greater Manchester Independent Prosperity Review (Coyle et al., 2019) as

being key for highlighting the impact of poor health on the economic performance of the city:

> "*I think it's crept up, you know, because I've been there for so long I can detect that it's massively risen up the agenda*" [GMP05O]

> "*I think just generally we need to put more focus on health inequality now generally across all of the work we're doing […] certainly [for] economy [teams], it's becoming more and more important*" [GMP06O]

> "*I think health inequalities have definitely become a much bigger part of all the debate in Greater Manchester across policy areas*." [GMP08O]

> "*Actually we can do all that we want around innovation, around graphene and the new growth sectors, etc., but fundamentally the Greater Manchester economy won't shift to the extent that we would like it to unless we tackle this huge drag on it which was round ill-health inactivity*" [GMP10O]

Scottish economic policy participants also described health inequality – understood in this way - as a much higher political priority:

> *"I think it's probably a higher priority than it has been for quite some time […] I think because of the fact, the impact that the increasing evidence around linkages between health and economy. And I think probably just the reality of what I just said around we've got very low levels of unemployment, we've got 20% of people who aren't participating in the labour market, their health has been seen to be an issue"* [SCOP13O]

> Q: How much of a priority is health inequalities in your team? A: *"It's a huge priority. So we have, within my area I have three different strands of work. One of them is 'tackling inequalities' but that really is health inequalities. Part of the reason for the focus on that now is […] the key health offer for employability sits within Fair Start Scotland [which] ends in March 2024. So we have to make sure that we've got alternative support in place to make sure we really are picking up that health and work offer."* [SCOP21O]

This may seem to be a very positive development for people interested in promoting policy action to reduce health inequalities. In this research, economic policymakers in both polities

discussed how framing health inequality as having a negative economic impact was effective at attracting the interest of other key stakeholders, including the UK Government:

> *"I think that I tend to in practice think more about economic disparities, and that isn't because I don't think health or social disparities are important, it is - being blunt about it - because most of my job is about convincing a right-of-centre national government and usually the economic argument is the one that resonates more."* [GMP07O]

> *"I think it was quite important to be able to demonstrate as well that actually those people within Greater Manchester who may think, you know, health wellbeing is all fluffy nice stuff to do and the real important stuff is around driving the economy, I think it did help to shift some of their thinking… So I think it brought people into a discussion who perhaps ordinarily would be peripheral to it."* [GMP10O]

> *"And the CBI* [Confederation of British Industry]*, so it's interesting, the business organisations themselves recognise not just that it's important, also that they have a role themselves as good employers in tackling some of that."* [SCOP13O]

The additional interest of economic policy teams in health appears to provide an opportunity for collaborative policy development that can produce win-win outcomes. For example, economic policymakers may be keen on workplace interventions that facilitate flexible working if evidence can show how it may boost earnings or limit welfare costs. Similarly, evidence showing how a mental health intervention may improve employability may appeal strongly to economic policymakers with employability priorities.

In each case, that fair work may also benefit the health of low-paid groups, or if the mental health intervention also improves WEMWBS scores for mental wellbeing in disadvantaged groups, for example, may be less interesting to economic teams with economic policy goals. By evidencing the priorities of policy teams with important social or economic levers, health policy teams may be able to contribute to policy which reduces health inequalities without risking health expansionism by trying to persuade those policy teams of the primacy of health. This 'co-framing' approach (Khayatzadeh-Mahani et al., 2018) appears to facilitate joined-up policy (Molnar et al., 2016).

However, there are several plausible concerns about an illness-related economic inactivity policy frame. Firstly, as described in section 5.3.2, participants in both GM and Scotland

confirmed a medicalised approach to health was undertaken by employability services, whose primary method for facilitating employment was facilitating access to healthcare. This may be at least partially justified by the important health impacts of employment or unemployment itself. One participant highlighted that rapid re-employment was a priority because of the long-term scarring effects of ill-health related unemployment:

> "*There was a horrible statistic that was out, must have been 10 years ago now, which was if you're claiming health-related benefits for more than two years, you're more likely to die or go past the retirement age than find work. Which was quite shocking and a damning statistic really* [GMP10O]

This participant described the prioritisation of this group – who "*cost us all money*" through benefits and high demand for acute services – as requiring "*much more a public health approach*" involving keyworkers who could co-ordinate a range of support from different social and medical services. While this approach acknowledging the social determinants of health must be welcomed, many disabling illnesses cannot be quickly or easily improved, and therefore the damage both to the individual and to the economy cannot be undone. Further, a reactive, individual-level approach to ill-health related economic inactivity cannot sustainably manage demand, whereas a preventive, population-level approach may do so.

A second concern about the illness-related economic inactivity policy frame is that it narrows the policy understanding of health or wellbeing to whatever bodily or mental functions are required for employment, excluding aspects of health or wellbeing which may be important to life quality but not important for employment. This binary understanding of 'healthy enough to work' or 'not healthy enough to work' ignores the huge range of potential health statuses both below and above that threshold that may impact an individual's life but be less important to policy focused on employment. As previously quoted in Chapter 5, a health policy participant in Scotland recounted conversations they had had with economic policy colleagues about these first two concerns:

> "*OK so we've got, I don't know, it was like 230,000 people who are economically inactive because of health outcomes so we want to sort that. So we need to address the health problems. And I say actually it's got nothing to do with health problems; it's all to do with the determinants. And I can see them glazing over going 'it clearly has to do with the health problems'. And I'm like it doesn't, it's to do with poverty. You've got people with quite chronic rheumatoid arthritis in really high paid jobs*

because the job's flexible and this that and the other. So I said if you've got a health condition you can maintain a job if it's high enough wages and all that kind of stuff. And I must say that's a struggle for me to try and get non-health folk to see health more than just the thing that you might go to the doctor with. And if you then take away that thing clearly they'll be able to walk into a job. So that's the tricky thing." [SCOP12H]

According to this quote, health is conceptualised as illness, and responsibility for the problem is medicalised. This seems to contrast with the position of the UK government reported in welfare policy literature (e.g. Warren et al., 2013; Lindsay et al., 2015), that those who are economically inactive due to ill-health are in fact 'work shy'. In either case, it is notable that responsibility is not attributed to employers to create cultures of flexibility or to otherwise help individuals to work with health limitations; nor is responsibility taken by policymakers to enforce such allowances or to alleviate poverty. This may represent an example of 'risk shift' (Hacker, 2008): the neoliberal-era transfer of risk burden to individuals, or to the medical profession, rather than business or government.

A third concern about an illness-related economic inactivity policy frame is that it necessarily prioritises the potential labour force, to the potential detriment of policy attention to children and young people, people with caring responsibilities, people with severe disablements, prisoners, asylum seekers, and retirees. For example, a health policy participant in GM described how "*children's and young people's [health] got put almost in the 'too hard box' straightaway"* [GMP11H]. Further, an economic policy participant in GM described how the focus on medical solutions for employment led to tensions with health policy colleagues about the prioritisation of healthcare for some individuals over others, contrary to the widespread belief that NHS access should be prioritised on clinical need:

"One thing which did come up a few times because we were pushing for - I'm not going to call it queue jumping but let's say - we've got people on this programme, really important, it's a GM driver. You know, what can we do to get people's support when they need it? And obviously there's this premise of universal service at the point of access, so we did have some of those types of challenges about, how we can expedite support. And we did some workarounds without ever really getting to the point where there was preferential treatment, let's say, because that was just the antithesis of what many of the health colleagues stood for, I think." [GMP10O]

This participant's voluntary use of "*queue jumping*" in this quote, while being reluctant to agree that is what their "*workarounds*" to "*expedited support*" represented, seems to reflect their understanding of their health policy colleagues' moral opposition. The illness-related economic inactivity policy frame seems to require such 'queue jumping', and to also require careful framing (note also the double use of "*let's say*") to minimise such opposition. Such careful framing was also evident in a response from a Scottish employability policymaker, who described such arrangements as requiring 'creativity':

> Q: So it's about people whose health is acting as a barrier to their employability and helping them to get referrals for treatment and so on, and that's the kind of the main way that you can help to contribute to reducing health inequalities, is that right?
>
> *A: "Yeah. I mean you'd like to think that it was as simple … of, you know, a GP or health visitor, people who are in there and have contacts, actually making the referrals. But in reality that's not going to happen that way because we know how hard pushed professionals are … so it probably requires a wee bit more creativity, which is what we're working through just now."* [SCOP21O]

While any policy focus on one group may be counterbalanced by other policy agendas which focus on other groups – for example, the Scottish Government's present focus on child poverty reduces the harm of excluding children from this conceptualisation of health inequality – a conceptualisation of health inequality which prioritises healthcare for some groups on non-medical grounds risks devaluing groups who are also neglected by other policy priorities.

The present enthusiasm for this version of health inequality within GMCA and the Scottish Government seems to reflect how easily it aligns with prevailing policy paradigms. Firstly, the neoliberal economic paradigm that so many authors have identified as dominant in economic and health policy settings (Rushton & Williams, 2012; Collins et al., 2015; Schrecker & Bambra, 2015; Lencucha & Thow, 2019; Lynch, 2020;) makes the facilitation of business the key – perhaps only – role of government. Similarly, one of two institutionalised ideas identified by Smith (2013a) in her research on Scottish Government policy approaches to health inequality in the 1997-2010 era was the supremacy of economic growth as a policy aim across policy settings.

Therefore, as levels of chronic illness grow in the population, the government is increasingly compelled to take action to ensure the workforce supply and economic growth are unaffected. This was one of Wainwright's (1996) explanations for New Labour's interest in health inequality, with New Labour having otherwise accepted the neoliberal logic of Thatcherism whereby social inequalities are an inevitable by-product of a small government, globally open and marketized economy with limited redistribution. Such an economy requires a healthy workforce, lest global corporations take their business elsewhere.

The second way in which the illness-related economic inactivity framing aligns with prevailing policy paradigms is with the other institutionalised idea identified by Smith (2013a) within the Scottish Government: the medical model of health. In particular, the haste required to re-employ the economically inactive before long-term unemployment further degrades their health seems to justify a prioritised healthcare response. In the present research, participants often understand 'health' to mean 'individual illness'. Therefore, with this framing, there is no time to wait for policy action on social determinants of health to work through long causal chains: illnesses quickly need resolved because "*if you then take away that thing clearly they'll be able to walk into a job"* [SCOP12H].

This leads to fourth and fifth concerns about the illness-related economic inactivity policy frame: it reinforces the two institutionalised ideas about economic growth supremacy and the medical model of health (Smith, 2013a), which both restrict effective policy options to reduce health inequalities, and which resist the challenge of alternative frames or new ideas; such as in Scotland by the 'wellbeing economy' agenda.

8.3 The Healthcare for Disadvantaged Groups policy frame: health inequality as health policy inequality

As described in Chapter 6, the second common conceptualisation of 'health' identified in policy settings was in reference to 'health policy'. This meant, as described in section 6.4, that 'health inequality' was thought of as the inequality of concern to health policy teams: it was "*health's business to fix*". As health policy is dominated by healthcare, 'health inequality' can therefore be used as if to mean health*care* inequalities. In this section, I shall describe the second 'health inequalities' policy frame identified in my data: that health inequality implies the need for better healthcare for disadvantaged groups.

Only three of my 11 health policy participants spoke of 'healthcare inequality' without prompting. All three mentions were from Scottish Government participants, and in each case it was used specifically to distinguish between healthcare and social inequality, as in this example:

> *"So I'm not obsessed by healthcare inequality, and by health inequality I mean something that I don't particularly differentiate from social inequality either."* [SGP07H]

Remarkably, not one of my 23 social or economic policy participants ever used the framing 'healthcare inequality/ies', with participants each interviewed for around an hour about policy approaches to health inequality, including regular discussion about healthcare. Instead, policy participants used 'health inequality' in place of healthcare inequality. This may simply reflect the very common conflation of 'health' with 'healthcare' (Bambra et al., 2005); it may be habitual, due to the common use of the 'health inequality' framing; or it may seek to borrow some of the extra 'moral sting' of the 'international consensus' policy frame, described in section 8.4, below.

This policy frame can be differentiated from both the 'international consensus' health inequalities policy frame, as described by Lynch (see section 8.4, below), and the 'illness-related economic inactivity' policy frame, described in section 8.2, above. It is concerned with socioeconomic groups, but not the role of social inequality in creating avoidable differences in health. Rather, the problem here is inadequate healthcare, and the solution is the better provision of healthcare.

Table 8b: The Healthcare for Disadvantaged Groups Policy Frame

Element of policy frame	**Healthcare for Disadvantaged Groups Policy Frame**
Causal Story	Disadvantaged people have less access to adequate healthcare
Problem	Health inequality is (at least partly) caused by inadequate healthcare for disadvantaged groups
Solutions	Improving access to and treatment from healthcare providers for disadvantaged groups
Actors	Healthcare providers and the government should work to better target healthcare provision and improve outcomes
Moral responsibility	There is no moral responsibilisation for illness, but the state and healthcare actors have responsibility to ensure the treatment of illness is available to all.

This health inequality policy frame was discussed by one GM health policy participant, who described an NHS England 'health inequalities group' which was "*very much about reducing variation in care […] focusing on clinical priorities and deprived populations and making sure they are addressing health inequalities through healthcare*" [GMP12H]. Therefore, the health inequalities group was focused on healthcare inequalities, but did not use that term.

Meanwhile in Scotland, this health inequality policy frame achieved support at the highest level of the Scottish government when new First Minister Humza Yousaf announced an investment of one million pounds in primary care services in deprived areas, under the headline 'Tackling health inequalities' (Scottish Government, 2023b).

Further, policy approaches to healthcare inequalities were institutionalised with the name 'health inequality' within the Scottish Government, in two ways. Firstly, the Health Inequalities Unit within DG Health included three teams, one of which was focused on healthcare provision for prisoners:

> *"In view of the fact that a disproportionate number of prisoners are from low socioeconomic backgrounds […] in a previous life prisoner healthcare policy was, I think, shared between health colleagues and justice, but I think a decision was taken, less because it was directly health inequalities, although there was a link, it's a bit of tenuous link admittedly"* [SCOP02H]

This participant otherwise conceptualised health inequality closer to the international consensus/social justice frame, explaining their comment that this version of 'health inequality' was not "*directly health inequalities*", and "*a tenuous link*". Unfortunately, no further data discussed the prisoner healthcare team.

However, another new team had been instituted within DG Health called the Racialised Health Inequalities team, but its sole focus was on healthcare inequalities. I asked a participant with close knowledge of the team if the name might be changed to be more accurate, but this suggestion was dismissed:

> *"Probably it should be racialised healthcare inequalities, because they're not looking at racialised health inequalities in the round […] obviously like health inequalities there are so many different determinants of health that sit outwith [DG] Health and Social Care [...] really the name should be racialised healthcare inequalities, but it isn't at the moment and they're not minded to change it."*

In both these cases, 'health inequalities' is used to mean 'inadequate healthcare for a disadvantaged group'. This policy frame bears similarities to the illness-related economic inactivity policy frame, particularly if the unwell unemployed are conceptualised as a disadvantaged group. But the focus of the healthcare for disadvantaged groups policy frame is on improving healthcare provision for its own sake, rather than for the sake of achieving employment. Therefore, it does not prioritise those whose economic inactivity is primarily related to ill-health: as seen with the team dedicated to healthcare for prisoners.

Enthusiasm for this version of health inequality likely stems from its coherence with prevailing policy structures and paradigms. As described in Chapter 6, 'health' is used as shorthand for 'health policy', which is dominated by healthcare, so 'health' inequality is easily translated into 'healthcare inequality': this is described clearly in section 8.3.2, below. Further - as shall be explored in 8.4.1 – when health policy teams attempt to tackle broader health inequalities, the structures and levers available to them restrict such attempts.

The particular prominence of this policy frame in Scotland – reflected both in its prevalence in my data and in the support for it shown by the First Minister – may at least partially reflect the advocacy of GPs working in the 100 most deprived communities in Scotland, known as the Deep End group. These GPs have been politically active since 2009, highlighting the Inverse Care Law - that the people who most need healthcare are least likely to receive it (Tudor-Hart, 1971) – and campaigning for the Scottish Government to address it with additional funding for primary care in areas of disadvantage. They frame this as tackling 'health inequalities': a recent major Deep End report, published with the Universities of Glasgow and Edinburgh and with funding from the Health Foundation, mentions 'health inequality' eighty times, but not 'healthcare inequality' at all (Blane et al., 2024).

The inverse care law describes a really important and unjust manifestation of socio-economic inequality which contributes to further inequalities in health outcomes. As one of the most prominent advocacy groups with a focus on health inequality in Scotland, the Deep End group have very admirably and effectively campaigned for policy action to counteract this deeply unfair phenomenon, and have inspired at least eight other similar groups to campaign against its perseverance in other countries (Mercer et al., 2021).

However, one concern with a health inequality policy frame which focuses on healthcare for disadvantaged groups is that it further reinforces the medicalised understanding of 'health' as 'healthcare', to the continuing neglect of the social and economic determinants of health. If policy attention to healthcare inequalities acts as a plausible substitute, what imperative remains to prioritise policy attention to inequalities in the social determinants of health? This dilemma shall be discussed in the next section.

8.3.1 Health inequality's false and unwinnable competition with healthcare

One result of the policy setting conceptualisation of 'health' as health policy is the routine locating of policy responsibility for health inequality within health departments: "*almost by calling it health inequalities it's health [policy]'s business to fix*" [GMP01O]. But this causes at least two problems. Firstly, as described before, health departments do not have the policy levers to address the unequal distribution of social determinants of health, which are

controlled by social and economic policy teams. Secondly, and less discussed, is the false and unwinnable contest with the NHS created by this policy location. This contest manifests itself in two ways, one material and one discursive. Firstly, the contest is unwinnable due to the extremely high political salience of the NHS, so that preventive action to reduce health inequality is almost never prioritised when policy attention to the NHS is requested instead. Secondly, this contest is false because it provides a plausible but flawed justification for why action to reduce health inequalities may be inadequate, as shall be explained below.

In my analysis, the GM health policy document with the most consistent upstream framing of health was the Children and Young People's Health and Wellbeing Framework, as it was obliged to take a long-term view, and was less able to conceptualise children either as hospital patients or as personally responsible for their health behaviours. Unfortunately, one GM-based health policy participant said that policy attention to the health and wellbeing of children and young people was limited in comparison to the main focus on adult-age services and behaviours.

> *"I think children's and young people's [health] got put almost in the 'too hard box' straightaway […] there was like a children's and young people's workstream, but it almost sat off to the side a little bit […] which I suppose is interesting because when we talk about prevention it's always like, you know, we know that from even prenatally, the earlier we can put that support in potentially we're then having healthier children born and children who are healthier from an earlier age, and I think children and young people just wasn't on the agenda."* [GMP11H]

This exemplifies the prevention puzzle that governments have long struggled to solve, particularly in health policy. As Cairney & St. Denny (2020) describe, long-term prevention of future social problems is an idea with broad political appeal, but also a significant policy challenge with politically unappealing trade-offs: namely, more untraceable outcomes in the distant future rather than visible positive outcomes in the near-future. It is easy to publicly support improving the health and wellbeing of children and young people, as it is easy to publicly support reducing health inequalities. But when health policymakers must make choices between highly salient, quickly visible positive outcomes, or less salient, barely visible outcomes, the former are invariably prioritised.

By locating policy responsibility for health inequalities within health departments, health policymakers are arguably confronted with the most unbalanced of these policy dilemmas.

Policymakers in other departments also face trade-offs; but healthcare routinely vies with notions of 'the economy' to be the number one political priority of the UK public (Ipsos, 2024; YouGov, 2024). Therefore, healthcare is always prioritised within its own policy settings in comparison to preventive public health action on health inequalities (Exworthy et al., 2002; Exworthy & Powell, 2004; Orton et al., 2011; Blackman et al., 2012; Alderwick et al., 2024) or, indeed, long-term measures to improve children and young people's health.

This dilemma – established by locating policy responsibility for preventive health inequality policy alongside policy responsibility for healthcare within health departments – was regularly referred to or inferred in my interviews with both health and other policy participants, as shall be discussed below. It is also prevalent in existing health and health inequalities policy literature. It has two impacts.

Firstly, to the extent that public health budgets for addressing health inequalities are in competition with NHS budgets for immediate healthcare needs, the competition is entirely one-sided. Baum et al. (2019a) reported that the South Australian government highly supported its Health in All Policies agenda publicly, while providing it with just 0.009% of the health department's budget. A Health Select Committee inquiry (2001) discussing this balance was told that "a [health] authority with an expenditure on health of about £300 million often will have a health promotional budget of perhaps £200,000 or £300,000": that amounts to around 0.001%. Similarly, Exworthy & Powell (2004) describe an English health authority setting aside £125,000 for health inequality projects out of an annual budget of "*several hundred million pounds*".

Local public health actors in England interviewed by Such (2023) emphasised the importance of finding policy colleagues who "*get it*" - meaning understanding the wider determinants of health perspective rather than taking a narrower medical view of health – to collaborate with for health inequalities. In my research, a GM health policy participant also made it clear that 'getting' the health inequalities agenda was insufficient because it was always secondary to 'hard' NHS targets:

> "*I've got colleagues and friends who are CCG [Clinical Commissioning Group] chief officers, hospital chief execs, and for them, they completely get the integration agenda and the health inequalities agenda, and they know that that's where they should be diverting their attention, but they're like: well at the end of the day when I come into work the thing that NHS England are going to fire me for is my A&E*

> *performance. So everything else gets pushed to the bottom of the pile for that.*" [GMP11H]

This structural explanation of accountability for NHS targets driving action – despite the colleagues "*knowing*" what they "*should*" be doing – was a recurring theme for this participant:

> *"I know I keep coming back to A&E but, you know, things like that and cancer waiting times they're quite high profile. I think most members of the public know that in the English NHS they have a right to be seen within four hours at A&E, or an expectation. People can articulate that, or people are familiar with the two-week wait for a cancer referral. But I don't think we have that same language and that same strictness around health inequalities."* [GMP11H]

This also mirrors data from a Scottish NHS chief executive in Blackman et al. (2009) who says: "*To some extent chief executives have to make sure that they achieve the things that they are going to get sacked for before they achieve anything else*". The same paper discusses Wales's increased focus on healthcare after the 2005 sacking of Jane Hutt, Welsh Minister for Health and Social Services, following unfavourable comparisons in the media between Welsh NHS waiting times and English NHS waiting times.

In short, this de-prioritisation of health inequality in comparison to healthcare is a consistent finding across UK policy settings under both New Labour and Conservative national government. A health authority director in Exworthy et al. (2002, p88) said: "*When you get down to the hard nuts and bolts, all that is really being monitored ... is waiting lists, waiting times and financial balance*". A decade later, a director of public health told Blackman et al. (2012, p54): "*It's pretty clear to me that over time the priorities have shifted evermore towards waiting times and financial balance… the warm words are still there but it's difficult to link that through to a coherent attempt at solving health inequality*". Another decade on, a local authority leader involved with integrated care system work on health inequalities is quoted in Alderwick et al. (2024, p6) saying "*I don't know if they even talk at these meetings about inequalities, you know? It's all about [healthcare] performance*".

This analysis may imply that responsibility for a preventive approach to health inequality might be better located with a different policy team. However, the second impact of this dilemma is discursive: it presents the pressing financial demands of the NHS as a

justification for the continuing de-prioritisation of preventive action to reduce health inequalities. This plausible but flawed justification emerges from a framing effect, obscures more likely explanations, and is not likely to be limited to health policy settings.

There are two flawed assumptions within this justification: that health inequalities may only be reduced by gross financial investment from the state; and that such investment must come from health budgets, and therefore represents a diversion from NHS investment. The first assumption ignores that health inequalities may be reduced by any legislative or regulatory policy option which impacts the distribution or availability of determinants of health to different groups. The second assumption misses that the competition for political attention and resourcing exists between *all* politicised problems, not just those within each department. Therefore, the framing effect of 'health' here is to equate action on health inequality with politically unacceptable losses to the NHS, which are not in fact necessary.

This misleading implication is visible in several quotes in my data. First, a senior health policy participant in Scotland described the political imperative of the recent pay deal struck with Scottish NHS staff as an impediment to further investment to tackle health inequalities:

> "*Let's just be really clear, the reason why we're not investing £1bn in health inequalities is not because we've made some stupid choice, it's because the biggest workforce in Scotland have decided that what they want to value in a way that's politically unavoidable is putting every last penny we've got into increasing their pay*[10] *[...] that effectively creates a further pressure where people then say, well you should be spending a lot more money on tackling health inequalities*". [SCOP07H]

But the Scottish Government may in fact be investing £1bn in health inequalities. As described in section 7.3, its policy programme includes several examples suggested by Benach et al. (2013) of a policy approach to reduce the social gradient in health. It could claim to be investing £1bn, or some other large amount, by totalling up its investments targeted at disadvantaged groups in early years and education, housing, planning and other policy areas with preventive impact. For example, the senior Scottish health policymaker

[10] This refers to strikes called by various NHS groups and the subsequent Agenda for Change pay deals struck in Scotland, which the Scottish Government said would cost an additional £1bn between 2022-2024 https://www.gov.scot/publications/nhs-staff-pay/ [Accessed 11/06/24]

may have argued: “we are investing in health inequalities because we’re investing in child poverty as a priority, and raising taxes on higher earners to fund those aims”. Instead, they invoked a trade-off where the other option was described as “*politically unavoidable*”.

A social policy participant in Scotland made a similar point to the health policy participant, but more succinctly:

> “*Prevention’s a really tricky one because we know public finances are always tight. Which two nurses do you sack so you can have someone intervening earlier?*” [SCOP18O]

It is notable that this participant considered sacking nurses rather than, for example, asking: “Which two taxes do you raise so you can have someone intervening earlier?”. No nurses need be sacked to adjust planning regulations, exclude commercial interests from policy processes, extend 20mph zones, to account for social value in procurement processes, or indeed to make the tax system more progressive. Both these participants’ focus on healthcare rather than tax or other economic or social policy interventions is induced by the framing effect of ‘health’ within ‘health inequality’.

This framing effect is also visible at the highest political level. As aforementioned, one of Humza Yousaf’s first announcements as Scotland’s new First Minister was an investment of one million pounds – a thousandth of the billion pounds suggested by the Scottish health policy participant on the previous page - to primary care services in deprived areas. Under the headline ‘Tackling health inequalities’, the Scottish Government’s press released announced that “*The Inclusion Health Action in General Practice programme provides targeted funding for support to patients whose social circumstances have a negative impact on their health*” (Scottish Government, 2023). Again the focus is on healthcare, rather than the “*social circumstances [that] have a negative impact on their health*”.

In GM, another participant invoked the post-Covid increase in waiting lists as a reason to focus on healthcare rather than prevention:

> “I*t’s a massive machine, health, isn’t it? It’s huge and they do have their direct responsibilities about the crisis in the health system. I mean I know there’s obviously a whole system response to that, but there’s also, that whole system response isn’t going to play through in terms of getting people off waiting lists and all the rest, and getting them out of ambulances queuing outside hospitals, and that is a major,*

it has to be the core focus at the moment […] It was always there, but of course with Covid, it's blown up, yeah." [GMP03O]

This passage features two related assumptions: firstly, that medical interventions will quicker reduce waiting lists than social or economic policy changes; and that the pressure to reduce NHS waiting lists will be eased by reducing waiting lists. The first assumption is difficult to evaluate, but the second is not. Both waiting lists and waiting times fell substantially in the early 2000s, and have risen gradually over the 2010s, before rising dramatically again since Covid-19 (Warner, 2024). But as the sacking of Hutt, the data from Exworthy et al. (2002), Blackman et al. (2009, 2012), Alderwick et al. (2024) and the GM health policy participant above (GMP11H) all demonstrate: the political imperative to focus on NHS targets is always intense, no matter the lengths of the lists. The right time to prioritise preventive public health remains forever beyond the horizon.

These flawed arguments justify the continuing de-prioritisation of health inequality. Whether a government is or is not investing in health inequalities is a matter of the overall political prioritisation of investment and/or regulation to shape the distribution of determinants of health for the benefit of disadvantaged groups; not a straightforward matter of health policymakers prioritising healthcare to appease media or public demand.

Framing policy action on health inequality this way challenges the frame receiver to declare a commitment to poorer treatment provision ('*which nurses do you sack?'*) and more visible suffering. This must seem especially challenging to the huge proportion of the population with experience of needing healthcare, or with relationships to healthcare workers (the NHS is the biggest employer in Scotland and in the UK). Confronted with this apparent trade-off, the invisibility of future prevented illness is easily sidelined so that healthcare *"has to be the core focus at the moment"* [GMP03O].

Equally, locating policy responsibility for health inequality with another policy team is unlikely to free it from the shadow of the NHS, which remains a primary political concern of the UK electorate, and which competes for resources with all policy teams. This dilemma shall be explored further in the Discussion chapter, where I argue for a clearer conceptual divide between policy for healthcare inequalities, and policy to address social and economic inequalities, which impact on health.

8.3.2 The Racialised Health(care) Inequality team

One Scottish health policy participant had close knowledge of the new Racialised Health Inequality team. As described in the quote on p245 above, the focus of the team was on healthcare inequalities, rather than health inequalities in a broader sense. But this took repeated questioning to reveal, because of comments like the below, where the word 'health' is repeatedly used to mean 'healthcare':

> *"There has never before been a focus on race and ethnicity in a health context, like a specific team that focuses on it, and definitely not a focus on the impact of racism on health"*

The impact of racism on health is profound: Phelan & Link (2015) describe it as a 'fundamental cause' of health inequality, as the participant also said. As with other fundamental causes, these impacts are vastly larger than the impacts of healthcare (which are nevertheless significant, e.g. Hamed et al., 2022). But the location of the team within DG Health enforced a focus on healthcare, rather than on broader work on health outcomes:

> *"Because the work is mainly focused on healthcare, it makes sense to sit in health"*

The account of this participant portrayed a relatively new policy frame in a process of construction and attempts to find alignments with other policy teams. The frame had emerged from the creation of a new 'health equity' team, before a think-tank report on anti-racist policymaking in the Scottish Government (CRER, 2021), and a media focus on ethnic health inequalities during the pandemic, determined the focus on race. But the team was described as lacking policy levers, and was not specifically funded. Therefore, much of their work was about influencing others, including promoting particular ideas that were otherwise absent in policy settings:

> "*Racism is a fundamental determinant of health, not race or ethnicity in itself. So 'racialised' just refers to the fact that it's that classification, it's being classified by race [that] is the cause of the health inequalities not race or ethnicity per se*"

The participant described the team's challenge of persuading other policy teams to include the idea of racism within their policy framings:

> "*One of the biggest challenges is just for racism to be named… I guess one of the things that they're trying to do… is to make sure that the work is more visible in policy documents and strategies, just as a starting point. Because as soon as it's more visible you can have a little bit of accountability – 'You said you would, OK have you?' And I think if it's not mentioned and it's not visible there's nothing to hang on to… And it seems to be really hard even getting to that very basic level.*"

In this account, the idea of racism having an impact on healthcare was resisted by other policy teams. This was partly attributed to a lack of understanding, particularly in majority white policy settings:

> "*It's not understood, sufficiently understood. People don't prioritise something they don't understand. Most policymakers are white so this is not on the forefront of their mind [...] I guess we should cut some slack because they don't know the depth of this issue, which is why there are a lot of presentations to raise awareness.*"

Unfortunately, the idea of racism may be one of the most difficult to persuade policy teams to include in their policy frames due to the very strong social norms to deny racism (Van Dijk, 1992; Wekker, 2016; DiAngelo, 2018). This participant's frustration about the team's efforts "*just for racism to be named*" may reflect the negative portrayal of policy or healthcare colleagues perceived in discussions of racism, even when described as unconscious or structural or similar, that may be felt to threaten professional relationships.

The participant also described confusion over the meaning of the 'inequality' part of 'health inequality':

> "*I think one of the challenges is that people think health inequalities and they think socioeconomic and so a reaction quite a lot is 'yeah we're already doing stuff on health inequalities', and it's normally focused on SIMD and areas of deprivation and poverty, etc. … but there are also inequalities that apply to people who are not in poverty or who are not living in areas of socioeconomic deprivation.*"

This reflects an aspect of Lynch & Perera's (2017) analysis of health equity framings in the US, UK and France. According to that analysis, US health 'disparity' or 'difference' framings have overwhelmingly focused on race due to its centuries-long history of racist oppression. But in the UK, framings have been singularly focused on class due to the country's long history of class-based oppression. Therefore, the idea of racism impacting on healthcare

may be familiar in the US, but threatening in the UK; while the idea of socioeconomic influence on health remains excluded or minimised even in the US public health community (Medvedyuk & Raphael, 2024). These findings highlight that it is not only policy paradigms that new ideas or policy frames must contend with; policy paradigms themselves sit within wider social and cultural paradigms that can have profound historical roots.

8.4 The International Consensus 'Health inequality' Policy Frame in GMCA and the Scottish Government

Lynch (2020, chapter 3) describes an 'international consensus policy frame' for health inequality, which consists of five 'stylized facts', as described in Table 8c below.

Table 8c: The International Consensus Policy Frame (adapted from Lynch (2020, ch3)

Element of policy frame	**'International Consensus' Policy Frame**
Causal Story	Social inequality is the key driver of health inequality
Problem	Health inequalities are avoidable and unfair differences in health status between socioeconomic groups
Solutions	Joined-up government policy is required to reduce inequalities in the social determinants of health
Actors	Governments – particularly national governments - are responsible for reducing social, economic and health inequality
Moral responsibility	Economic and social forces – including un-regulated capitalism – that generate social inequality are to blame; and governments for failing to mitigate these forces

According to Lynch (2020, p78): "*Competition with the consensus frame comes from domestic definitions of equality and equity as applied to the health field, from continued medical dominance of many health policy levers, from behavioural approaches within public health, and from a neoliberal policy paradigm that posits the market as a solution to most social problems.*"

As I have described, in my research these are more akin to *challenges* to the consensus frame - in that they restrict its effectiveness as an ideational driver of policy action - rather than competition to it. Instead, I identify two frames which are indeed competing with the consensus frame in these two policy contexts: the illness-related economic inactivity policy frame; and the healthcare for disadvantaged groups policy frame. Those two frames compete in the sense that they are alternative understandings of the same framing: health inequality. But they each have very different implications for policy responsibility and solutions. These three frames compete – with each other and with other claims about social problems - for policymaker attention and resource.

My review of the literature on policy approaches to health inequality agrees that this description of an 'international consensus' policy frame does indeed reflect an international *research* consensus. But it does not reflect an international *policy* consensus. Few countries have made a significant policy effort to reduce health inequalities at a national level, and such efforts that have been made have generally been temporary (Mackenbach, 2019, ch6). For example, the UK is one of the international centres of health inequality research, and had an ambitious strategy to reduce health inequalities under New Labour. But that strategy lasted less than a decade, and ended without replacement more than a decade ago.

Therefore, it may be better to think of this as the 'social injustice' health inequality policy frame. I suggest 'social injustice' to be at the heart of this set of ideas: that health inequalities are unfair and avoidable by government intervention. This problematisation carries with it a particular moral sting because it focuses on humanity's universal enemies: illness and death. This clearly inspires passion in particular research and policy actors – including myself. As described in Chapter 3, I was not deeply concerned about social or economic inequalities until I learned about health inequalities. For me, this version of health inequality represents the social distribution of millions of personal injustices, large and small, like those I felt while suffering from cancer as a child. As I later learned, my

father's class status helped me survive, while friends on my ward did not (Lightfoot et al., 2012).

The moral sting of this version of health inequality is evident in much of the 'moral language' coded in the policy texts. Often the strongest moral language in each policy text related to health inequality. For health inequality, more than for any other type of inequality, words such as 'unacceptable' and 'unfair', and moral modal verbs such as 'must' and 'should', were used to communicate injustice. While I attribute my personal interest in health inequality to my personal history of illness, moral concern for health inequality may also reflect the "*moralization of health*" over recent decades, as described by Crawford (2006, p410) in his exploration of 'healthism'. Some illustrative examples of strong moral language relating to health inequality in policy texts are given in Box 8.4, below.

Box 8a: Examples of strong moral language about health inequality as social injustice

Social or economic policy texts "*Deeply embedded health inequalities, often between communities little more than a stone's throw apart, have blighted individual lives and acted as a drag on our economy*" (Our People, Our Place, GM, 2017, p60) "*The impact [of Covid] has been unequal and unfair, starkly highlighting and deepening the inequalities we know have existed for many years and which we were beginning to change*" (Places for Everyone, GM, 2021, p8) "*As a nation we have a particular obligation to do more to tackle the concentration of poor health outcomes in west central Scotland*." (National Planning Framework 4 (Draft), SG, 2021, p32)
Health texts "*Health in Greater Manchester should and could be better, and there are unacceptable and unwarranted inequalities*." (Transforming the Health of Our Population, GM, 2019, p3)

"*It is unacceptable that people with severe and enduring mental illness may have their lives shortened by 15 to 20 years because of physical ill-health. This is a significant health inequality.*" (Mental Health Strategy 2017-2027, SG, 2017, p29)

"*None of this is acceptable. Despite tremendous progress in life expectancy it is not acceptable that our health is poorer than other parts of Europe, and it is not acceptable that people in Scotland are not able to thrive.*" (Public Health Priorities, SG, 2018, p6)

"*Health inequalities impact on every aspect of too many people's lives. But those inequalities – where they stem from, and the outcomes they have – should not be accepted, and need not be preordained.*" (Programme for Government (Health Chapter), SG, 2021, p32)

The moral perspective conveyed by the above policy text excerpts was also expressed passionately by a senior health policymaker in Scotland as follows:

> *"I fundamentally think that Scotland's challenge is on health inequalities rather than improving population health or in system sustainability [...] There are various reasons why I think that. I think not least that I might mention a moral requirement which is maybe somewhere where you'll get the passion, which is fundamental, if you ask me, what is my basic thought and what gets me up in the morning […] I have no particular interest in just the question of raising the tide of health in the population […] otherwise people like me - health literate, wealthy-ish, wealthy enough, but getting to live on average well into my 80s or 90s, fabulous, yeah great, but there are people dying at 40, there are people dying at all ages, but there are people systematically dying in their 40s and 50s and that's a scandal"* [SCOP07H]

For this participant, it is "*fundamental*" to the country, a "*moral requirement*", to address the "*scanda*l" of "*people systematically dying in their 40s and 50s*". Indeed, this takes precedence, for this participant, over improving population health generally, including for "*people like me*". This heartfelt response articulates the key difference between this health inequality frame and the two others described previously in this chapter: the moral responsibilisation for illness, attributed at least partly to the government.

8.4.1 A Scottish Government rejection of 'health inequalities'

The moral argument made by the above participant was broadly shared by other health policy participants. However, as this section shall describe, health policymakers in the Scottish Government rejected 'health inequality' as an appropriate policy frame to drive policy action to reduce these systematic variations in population health.

Scottish Government health policy participants described a new "*strategic reform vehicle*" within DG Health and Social Care called the Care and Wellbeing Portfolio (hereafter CWP). The CWP includes a variety of policy programmes, such as a Place & Wellbeing Programme, a Prevention and Proactive Care Programme, and a group responsible for NHS Transformation. The CWP was described as attempting to bring "*silos*" together to facilitate more "*cross-cutting work*", and had high-level policy support:

> *"The Care and Wellbeing Portfolio, it purports to present opportunities to renew our approach and […] systematically address health inequalities and improve population health"* [SCOP02H]

The CWP has three 'missions' to guide its work: improving population health; improving health and care system sustainability; and reducing inequalities. The latter mission had just been updated when I spoke to a participant who was closely involved in the CWP:

> "*Up until recent weeks we had the mission read 'reducing health inequalities', and then recently it changed to 'reducing inequalities'. And I think there's a few things that have changed, so health inequalities are seen as more downstream, whereas addressing inequalities was actually targeting more upstream. So I thought that was a welcome change, because it was recognising those broader determinants.*"

Therefore, the Scottish Government's primary policy vehicle aimed at addressing health inequalities rejected the 'health inequalities' framing for being "*downstream*". By removing the word 'health', these policy actors believe they can orient their work "*more upstream*" towards the "*broader determinants*". This is precisely the implication of Lynch's (2017, 2020) work: that the 'health' in 'health inequality' leads policymakers to downstream solutions to health instead of upstream solutions to inequalities.

Initially, this participant reported a positive impact of the change in language:

> "*I think that in itself the wording did help open up more opportunities, and I think that chimes with the literature in DG Communities* [SG's main grouping of social policy teams] *and the briefing notes that they would describe. A lot of their work is obviously supporting local authorities and community planning partnerships and all that articulates the work around reducing inequalities or addressing inequalities. So I think it makes broader connections from a narrative perspective to that work that allows us to link in.*"

Here, the participant suggests that dropping the word 'health' from 'health inequalities' had facilitated more joined-up "*opportunities*" both horizontally with social policy teams within DG Communities, and vertically with local authorities and community planning partnerships that sit outside of national government. Using 'inequalities' instead of 'health inequalities' "*allows us to link in*" by "*mak*[ing] *broader connections"*.

As described in the literature review, this reflects the reasoning of the Scottish ministerial task force on health inequalities in their 2014 review of Equally Well. In that case, the task force lamented that a focus on 'health inequalities' had led much the public sector to attribute policy responsibility fully to the NHS, rather than collaborating across sectors as a focus on 'inequalities' may have achieved. Almost a decade later, the Care and Wellbeing Portfolio seemed to take the ministerial task force's advice.

It also echoes similar findings by Smith (2013), Maybin (2016) and others about influencing or lobbying being a key part of the job of health inequality policy actors; unlike actors within other health teams who often had the appropriate levers to pursue their own goals. One health policy participant in GM described their activities as "*advocacy and lobbying*", adding "*it's an influencing role that we're doing*" [GMP12H]; while a Scottish health policymaker said *"The thing with health inequalities is that we don't always have specific interventions we're taking […] a lot of our work is about relationships and influencing stakeholders, so it's a bit more nebulous in that sense*" [SCOP02H].

However, despite the increasing links and "*broader connections*" facilitated by CWP dropping the 'health' from 'health inequalities', the participant also described how the location of CWP within DG Health and Social Care provided structural limits to the activities the team was able to perform:

> "*My understanding is that the care element of 'care and wellbeing' was very much a kind of traditional approach to services and more so that kind of biomedical model; whereas wellbeing was meant to be more holistic, looking at how do we provide that wraparound support? I guess, again being critical, I think we give more emphasis to the care element and the service element. In many cases that goes back to where we have the most direct lines of control, as we are set up to deliver services. We do so through connections around performance management for health boards. Whereas for wellbeing, a lot of those drivers sit largely outwith the health and social care directorate.*"

Similarly, the participant described how the CWP attempted, but failed, to adapt the policy approach to healthcare inequalities Core20PLUS5 to an approach more suited to its broader 'tackling inequalities' mission:

> "*So a unit within our broader division had been tasked with going away and looking at an expanded model so it's beyond healthcare inequalities, is there something that we could be doing here in Scotland? […] Now the beauty of that model I found was that it did talk about deprivation, that was the Core20 and these are the areas from a place-based perspective that are the most deprived […] But then it gave flexibility to other kinds of key groups […] who might be target groups who experience worse outcomes, and this could be ethnic minority backgrounds, etc., but also it gave the flexibility for local teams to identify who they felt would be priorities as well […] the latest I've seen is we've gone back to that healthcare inequalities stance, and I think the view is it's so difficult to have one that could sit for all of government but we're not well positioned to do that […] But we could do something on the healthcare inequalities element.*"

Therefore, despite some limited perceived improvements in collaborative working facilitated by taking the broader approach of 'reducing inequalities' rather than 'reducing health inequalities', the structural limitations of DG Health and Social Care converted its actors' attempts to 'reduce inequalities' into 'reducing healthcare inequalities'. In other words, health policy attempts to operationalise the social injustice 'health inequality' policy frame by changing the language to focus only on 'inequality' were frustrated by the limitations to health policy structures, which converted the work into a 'healthcare for disadvantaged groups' approach.

This recalls the 'institutional filtering' described by Smith (Smith, 2013b): how "*the division of policy responsibilities relating to health inequalities shaped the influence of research-based ideas*" (p87). In the above account, policy responsibility for health inequality being with a team who "*are set up to deliver services… through connections around performance management for health boards"* re-shapes their idea to 'reduce inequalities' into action to address healthcare inequality. Smith describes this as 'discursive institutionalism' (Schmidt, 2010) - how embedded decisions shaping policy domains then serve to shape the subsequent policy ideas within them – and this was highly visible in the Chapter 5 discussion of other policy texts representing health or wellbeing according to a social model of health, while health policy texts remained prone to individualisation. This analysis therefore opens a new line of enquiry: might other policy domains better facilitate a social injustice approach to health inequality? Would a DG Health Inequalities be conceivable, or desirable? These questions shall be considered further in the Discussion chapter.

8.4.2 Reducing social or economic inequalities from within health policy

In line with this new approach to reducing (non) health inequalities, several participants in Scotland expressed the view that health inequality was fundamentally an issue of social or economic inequality:

> *"By health inequality I mean something that I don't particularly differentiate from social inequality" [SCOP07H]*
>
> *"I don't think it's an exaggeration to say health inequalities is where you end up if you don't deal with inequality" [SCOP09O]*
>
> "*It comes down to inequality, it comes down to politics, it comes down to some folk having money and some folk having none. And that just feels so fundamental to all of it*." [SCOP18O]

However, it is not altogether clear what mandate health teams such as the CWP have to work to reduce other inequalities, for which other policy teams have responsibility. Policymakers outside of health often perceive reducing inequalities in their policy area as a

key part of their role. A housing policymaker in Greater Manchester described the housing market as generating inequalities, so public sector housing professionals had inequalities "*embedded in what they're doing day to day*" [GMP02O]. Two colleagues each with a broader focus said "*I actually feel that the way in which we contribute to the inequalities agenda is in every single area*" [GMP06O], and "*inequalities pop up in every single area of policy*" [GMP08O]. A Scottish policymaker involved in transport said "*So reducing inequalities is another priority of the National Transport Strategy. So I would say that it should be embedded within all our work*" [SCOP08O]. A Scottish planning policymaker explained that inequalities were core to their thinking, as "*inequalities are life, and they are life experience, and they are experienced differently in different places*" [SCOP20O].

These data clearly show that social and economic policy participants believe that reducing inequalities in their policy area falls within their responsibility. Reducing housing inequalities is part of the job of a housing policymaker; reducing spatial inequalities is part of the job of a spatial planning policymaker; and so on. In this case, health policy actors taking on a 'mission' to reduce housing inequalities, and spatial inequalities, and others, may again create the appearance of 'health expansionism' to other policymakers. Why should health policy actors be seated at these tables, if not to assert the imperative of health? This puzzling was perceived by a Scottish health policy participant:

> "*I mean a common thing, not universal, is some non-health people are like 'why are you in this?'. And I think you have to build a little bit more trust and credence in working with them.*" [SCOP12H]

In response to this challenge, one Scottish health policy participant suggested cross-departmental teams for 'wicked problems' such as health inequalities, child poverty and climate change:

> *"I often wonder rather than teams and silos around these divisions, is it more about looking at cross-portfolio teams who are functioning in all those different realms. So rather than having a minister at the top of a pillar or silo, actually saying we're going to have something around child poverty and bring all those functions together and focus on that wicked problem ... but right now I feel that the silos are perpetuating."* [SCOP05H]

Cross-departmental teams have long been suggested and attempted in the decades-long quest to join-up government, including for health inequalities (Exworthy & Hunter, 2011). The 2007 restructuring of the Scottish Government – with a limited number of Directorates-General responsible for a broader range of policy issues – was described by one of its key proponents as "*the idea of 'joined up government' taken to its logical conclusions*", and was partly inspired by seemingly intractable problems including health inequalities (Elvidge, 2011, p31-32).

The rebuttal of health expansionism with the suggestion of more cross-departmental teams implies that collaborative working can minimise tensions over issue ownership, particularly for issues which have no obvious 'owner'. This seems to follow the logic of the senior economic policymaker in GM, quoted in Chapter 6, who argued for 'inequalities in all policies' because: "*It's not putting one type of inequality over and above another… therefore it doesn't exclude in the same way that making health inequality* [sic] *dominant then obviously excludes"* [GMP08O].

However, it is not clear that cross-departmental teams are considered necessary by policymakers interested in the other two 'wicked problems' identified by this participant - climate change and child poverty – which both happen to have statutory targets in place compelling cross-governmental collaboration. One participant involved in policy for climate change had mixed feelings about the climate change targets, as the annual interim targets promoted short-termism; but did acknowledge overall how the targets had "*teeth*" and "*really hold you to account*". Another participant involved in policy for child poverty said the statutory targets "*continue to focus minds*" and provided "*a definite driving force*" for cross-departmental policy action:

> *"So my colleagues, through the work they are doing, have almost an in-built responsibility to be doing their bit. So it's not a case that I say 'well you may have three meetings today but mine is the most important' because they know it's part and parcel of what they need to be doing*." [SCOP03O]

Further, while cross-departmental teams are harder to identify, each of the three 'wicked problems' identified above are institutionalised within the Scottish Government in very different forms. At the time of writing, one of eight Directorate Generals (DG) is for 'Net Zero', which includes five Directorates and dozens of smaller units or teams; within DG Communities are six Directorates including the Directorate for Tackling Child Poverty and

Social Justice, which itself contains over a dozen teams with over a hundred staff; and within DG Health & Social Care are eleven Directorates, one of which contains over fifty teams, one of which is the Health Inequalities Unit, comprising four staff focused on socioeconomic inequalities. The 28-person Care and Wellbeing Portfolio Board itself appears to be dominated by health policymakers, with only two or three job titles appearing to relate to issues other than health, despite its mission to 'reduce [social or economic] inequalities'.

Therefore, while there may well be benefits to cross-departmental teams working to address health inequalities, there is also a long history of challenges (Pollitt, 2003; Davies, 2009). Meanwhile, specific policy attempts to reduce socially unjust health inequalities do not appear to be highly prioritised within the present Scottish Government, evidenced by the small team dedicated to it and the lack of a statutory target, plus signs that "*the silos are perpetuating*".

8.4.3 Is redistribution "political suicide"?

Despite this challenging imperative to reduce social or economic inequalities, the idea of reducing economic inequality by redistribution was notable by its almost total absence from my data. Across almost 2,500 pages of policy strategy texts included in this research from GMCA and SG, only the Scottish Government's Delivering Economic Prosperity (NSET) (2022) mentioned the idea, and that was specifically to reject it: "*The principles of a wellbeing economy can't be achieved through simply redistributing wealth, they need to be hard-wired into everything we do in this strategy*" (p13, Box A).

Similarly, across my 33 interviews with 34 participants, each of around one hour, the word 'redistribution' was used just once, this time by an economic policy participant in Scotland wondering how redistributing wealth might be part of a 'wellbeing economy' agenda:

> "*I think a large part of that will be how we just implement the National Performance Framework properly, but there'll be other elements, how do we bring in that participatory bit more; how do we focus on prevention policies more; how do we redistribute wealth and power more? And so that'll maybe bring in other areas of SG a bit more. But all that stuff is still quite early days of development.*" [SCOP04O]

This exclusion of an important potential policy solution from repeated in-depth discussions about policy approaches to health inequality is reflective of similar findings from previous literature. For example, Qureshi (2013, p6) quotes a senior civil servant involved in developing New Labour's health inequality strategy saying: "*We're not going to suggest redistribution. I know there's Richard Wilkinson's work, the examples of Cuba, the monkeys and all that*[11]*. But this government is not about that*." Stevens (2011) reports very similarly: that after Wilkinson gave an internal presentation linking a range of social problems to social inequality, it was described by civil servants as 'compelling' and 'convincing' and then entirely ignored. Stevens describes civil servants as being part of an institutional 'thought world' (Douglas, 1986), which excludes ideas about directly tackling inequality. This psychological description is similar to that of the ideational construct of policy paradigms: shared mental frameworks, socially embedded in policy settings, which shape the interpretation, inclusion or exclusion of new frames or ideas.

In Lynch & Perera's (2017) analysis of twenty policy strategy texts from the United Kingdom, United States and France primarily concerned with health inequalities, they found much differentiation and one unifying feature: "*not one of these reports - not even those explicitly recognizing the role of income inequality in shaping health inequalities—made a policy recommendation that would entail significant redistribution of economic resources or power*" (p830). For Lynch's (2020) New Labour participants, the logic of adopting the 'health inequality' policy frame was accepted overtly to avoid addressing economic inequality: one of her participants said: *"[they] 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*" (p103). This quote is mirrored in my research by a senior health policy participant in Scotland:

> "*I'm not putting forward advice to recommend to ministers … as I say, socialist revolution or whatever, political suicide. These just don't feel like reasonable things that policymakers can recommend even if from an external perspective they seem like the things that are required.*" [SCOP07H]

[11] Richard Wilkinson is a prominent researcher on social inequality, co-author with Kate Pickett of the influential book The Spirit Level (2009); Cuba, a socialist state since 1959, has impressive population health outcomes (Cooper et al., 2006); research on social hierarchies in monkeys discussed by Wilkinson & Pickett finds low-status monkeys to be at higher risk of both heart disease and cocaine use than high-status monkeys.

This quote seems to acknowledge that solutions aimed at reducing economic inequality may seem necessary outside of policy settings. But within policy settings, these solutions don't "*feel like reasonable things that policymakers can recommend*". This description of policy setting ideational constraints closely reflects Stevens' description of civil servant 'thought worlds' excluding inequality, explained by Lynch as a 'taboo' caused by the dominance of the neoliberal policy paradigm.

Interestingly, the Scottish policymaker returned to 'Marxist' and 'socialist' critiques several times. Twice they referred to "*overthrow[ing] capitalism*", twice to Marxism, and five times to "*socialist revolution*", as in the following passages:

> "*So I do find a methodological problem we have is that if you don't look at this as a whole you don't get the problem, but if you look at it as a whole it can sometimes be quite difficult to break in to that cycle and you end up in a position which I don't find particularly helpful which is that, short of a socialist revolution or whatever this problem is insoluble, typically expressed in statements like 'until we solve poverty we can't…'.*

This quote discusses the tension between dealing with health inequality in small, manageable portions, which may obscure the common root causes, or attempting to view it as a whole, and potentially being overwhelmed by the size or complexity of the issue. A similar dilemma is discussed by Chakrabortty (2021), in an article discussing the various sub-types of poverty – food, fuel, child, period – which obscure the upstream common cause. Notably, the Scottish Government has statutory targets for two sub-types of poverty: fuel poverty, and child poverty; and the participant above pivots from a discussion of inequality to "*solv*[ing] *poverty*".

But poverty is not inequality, and reducing fuel or child poverty are likely only partial solutions for reducing health inequalities because of the psychosocial pathways that connect stratified societies with health outcomes (Bottero, 2005; Wilkinson & Pickett, 2009, 2020), and because of the political risks posed by the concentration of wealth and power among elites (Robeyns, 2019; Piketty, 2020; Barros & Wilk, 2021). Chakrabortty argues that the upstream idea excluded by food-, fuel-, child- and period poverty frames is poverty, generally; but as poverty is part of each frame, this may not quite be right. As described in sections 7.3 and 7.4 above, the key ideas excluded by a focus on the specific disadvantages of poverty may be those that connect such disadvantages to society as a collective.

The Scottish health policymaker continued about Marxism, socialism, and overthrow[ing] capitalism:

> *"Now that leads to paralysis because you end up in a position with effectively a Marxist critique of the issue, which I don't see as inevitable. I don't mean to suggest I wouldn't agree with it intellectually, but I'm just saying it's not inevitable. So if you look at the work of Gerry McCartney or whoever else, it's coming from that perspective that you've literally got to take the whole thing and overthrow capitalism and health inequalities is an inevitable logical conclusion … Now that creates an enormous dilemma for policymakers because I'm constrained to believe not just the evidence but also my political authority, I much prefer to make this manageable. Because I think if that was what I believed in fundamentally I would have to leave the Scottish Government and go and campaign for a socialist revolution. But I see it as advantageous to ask yourself the question, with the hand you're currently dealt what's the best you can do? I find too many people on this agenda spend too much time redefining the hand. And to be honest I think the politics is doing that.*" [SCOP07H]

This passage has a few interesting aspects. Firstly, it broadly argues that 'Marxist critiques' that lead to arguments for 'socialist revolution' are unhelpful, while also specifically refusing to disagree with them: "*I don't mean to suggest I wouldn't agree with it intellectually"*. Instead, the participant takes a pragmatic position, that this position "*leads to paralysis*". This recalls the similar comment from a Scottish health participant concerning the Public Health Scotland framing dispute, discussed in Chapter 4, between framings of health inequality that highlight 'inequalities in power and wealth' or framings that describe 'building blocks of health': "*we're not saying that's not true, what we're saying is that's not engaging people and leading to the types of action that we want*" [SCOP14H]. In both cases, the participants appeal for presentations of ideas which are appropriate for policy actors, rather than presentations which may be 'compelling' or 'convincing' and then entirely ignored because they don't "*feel like reasonable things*" within policy paradigms or thought-worlds.

The quote shares notable similarities to one given to Baum et al. (2013) by a 1990s Federal health minister in Australia, who also criticises the impracticality of outsider calls for Marxism to reduce health inequalities:

> "*The public health community has done nothing that I can see to dispel the myth that this desire, to have a Marxist command economy, and I'm being extreme. If anything it's potentially counterproductive and it comes back to, I think – you know, public health is not enormously practical and, yes, there's this great world movement on social determinants of health but, you know, to what end?"*

This discursive strategy, evident both from the Scottish health policymaker I interviewed and the Australian policymaker interviewed more than a decade ago, is reminiscent of the 'red scare' language of 20th century geopolitics: characterising the reduction of economic inequality as 'socialist revolution', 'Marxist' or requiring a 'command economy', and therefore being impractical, paralysing, and/or extreme (Baum et al.'s Australian participant even confesses to "*being extreme*"). In particular, the senior Scottish health policymaker's comment that "*these just don't feel like reasonable things that policymakers can recommend*" seems to support Lynch's description of redistribution being 'taboo', by which she means "*partially internalized*" and requiring "*little enforcement above and beyond social actors' own desire to avoid breaking the taboo*" (2020, p38).

However, despite specifically refusing to disagree with 'Marxist critiques', the Scottish policy participant quoted above also reveals the structural constraint on their agency to "*believe the evidence*": the political impartiality required of civil servants means that this participant may be forced to quit their job if they accepted such ideas. Describing their internal dialogue, the participant describes asking themself "*with the hand you're currently dealt with, what's the best you can do?*". Therefore, the policy paradigm that excludes the 'compelling', 'convincing' and un-disagreeable ideas about inequality appears to be that civil service imperative for political impartiality, which acts as a background framework through which ideas must be interpreted, is shared among policymakers and rarely contested, and which threatens the employment of policymakers. For this participant, adherence to the imperative for impartiality means limiting the extent to which they can believe evidence for reducing inequality.

The final interesting aspect of the passage above from the senior health policymaker is the final comment: that "*the politics*" may already be "*redefining the hand*", meaning the context in which policymakers can act. Any discussion of a continuing taboo on redistribution in a Scottish context must account for the Scottish Child Payment (SCP). First introduced in 2021 at £10 per week for children under six years of age in low-income

families, the payment has since been expanded to all under-16s in qualifying households, and increased on three occasions, now standing at £26.70 per week. After the resignation of First Minister Nicola Sturgeon in 2023, all three candidates to be the new SNP leader and First Minister committed publicly to increasing the payment (CPAG, 2023). Humza Yousaf, who had proposed during his campaign to increase tax on high-earners to pay for an increase in the SCP (Whyte, 2023), was then elected, and followed through on his proposal (BBC, 2023).

Therefore, there was no 'political suicide' evident in this case; in fact, redistribution appears to have been politically popular. The child poverty agenda in Scotland appears to have facilitated political and public approval of additional redistribution in a way that the health inequality agenda has not. The implications for analysis of the health inequality agenda and perceptions of redistribution shall be discussed further in the following section, and in section 9.4 of the next chapter.

8.4.4 "It doesn't have to be 'health inequalities'"

A key difficulty encountered throughout this thesis has been differentiating between specific policy intentions to reduce health inequality, and policy which may reduce health inequality as a side-effect of its other intentions. For example, specific policy attempts to reduce socioeconomic health inequalities in the Scottish Government are spearheaded by a Health Inequalities Unit of just four staff; but over a hundred staff work in the Directorate for Tackling Child Poverty and Social Justice. Further DG Health staff work on policies which may reduce inequalities in health without being in the Health Inequalities Unit; such as those on the Care and Wellbeing Portfolio Board, for example. Some unknown portion of the work conducted by DG Economy, and the Directorate of Social Security, and other teams in DG Communities, and other policy teams, may also contribute to reducing socioeconomic health inequalities, without ever intending to do so, or measuring how it does.

Policy intentions to reduce health inequality are identifiable by a health inequality policy frame. By this measure, the Scottish Government is not prioritising the reduction of the social injustice of health inequality, but is addressing some healthcare inequalities, and is increasingly interested in reducing illness-related economic inactivity. But health inequality outcomes may worsen or improve via a range of different political agendas acting

simultaneously. This is encapsulated in a comment from a Scottish health policy participant, who said:

> *"I think when I look at the focus on child poverty and cost of living I'm going, that's great because that's about health. It doesn't have to be 'health inequalities'."* [SCOP14H]

This comment separates the policy intention to reduce health inequality – identified by the policy framing 'health inequality' - from other policy intentions that may also be expected to reduce systematic variations in population health outcomes, such as policy attention to child poverty or the cost of living. For this participant, the policy frame is not necessary to achieve the goal of reducing the social injustice.

Further participants in both health and other policy teams criticised 'health inequality' as an appropriate policy frame to achieve reduced inequalities in health outcomes. Scottish health policy participants seemed particularly aware of the deficiencies of the policy frame. The senior health policy participant who expressed the strong views about the social injustice of inequalities in health (quoted above) was also directly critical of 'health inequalities' as a policy frame:

> "*I do think health inequalities as a framing generally is tired and risks having run out of road. So I think wellbeing might be a way to unlock some things […] I'm very mindful that that whole health inequalities thing and the public health approach including surveillance maybe has within it some deep assumptions about medicalisation, patrician and paternalistic approaches.*" [SCOP07H]

Several Scottish participants seemed to agree with the perspective that the 'health inequality' framing was not presently prominent or politically effective:

> *"But health inequalities as an inequality if you like is I would say a little bit less obvious. I'd say it flies a wee bit more under the radar and probably, maybe partly, it's not one of the protected characteristics if you like, so maybe that's why it's not treated in that way."* [SCOP04O]

> "*We are acutely aware that people are not talking in the policy space around falling life expectancy, widening healthy life expectancy* [gaps] *or the gradient"* [SCOP14H]

This is also evidenced by the single use of 'health inequality' in the 156-page Tackling Child Poverty Delivery Plan, described in Chapter 5. But even when 'health inequality' was used in policy documents, another Scottish health policy participant was critical of its loose use:

> "*I guess what I would say is it feels that for quite a long time, although there are efforts across government to reduce inequalities, 'health inequalities' in particular seem to just be added into policy documents haphazardly. So they're not necessarily thinking through what process is going to be undertaken to actually address them.*" [SCOP05H]

This comment recalls the allegation surfaced in the literature review (section 2.4.2) that 'inclusive growth' and 'wellbeing' are used liberally in policy texts for presentational reasons, without having been fully thought through. It is also reminiscent of the GM health policy participant quoted in Chapter 5 who said that policymakers "*didn't write anything about population health without bunging something that you'd copied and pasted from Michael Marmot in there*".

As described in section 6.4, several participants commented that the word 'health' implied the healthcare system. Further, in section 8.4.1, I described the decision of the Scottish Government's Care and Wellbeing Portfolio – which notably omits 'health' from its name - to rename its mission 'reducing inequalities' instead of 'reducing health inequalities'.

Other participants equivalised 'health inequalities' with social inequalities:

> *"So in my mind it doesn't matter whether a recommendation came through IIC [Independent Inequalities Commission] or Marmot they're both seeking to attain the same things." [GMP01O]*

> *"It's really interesting when you talk about health inequalities, because sometimes if you take the word health out we're talking about the same thing, but it's a different way of framing it, isn't it?" [GMP12H]*

These critiques of the 'health inequality' policy frame all related to the 'international consensus' or 'social injustice' conceptualisation. In contrast, as described previously, 'health inequality' was enthusiastically supported as a policy frame by Scotland's First Minister Humza Yousaf and others who used it to mean 'healthcare for disadvantaged groups', and by economic policy participants, who used it to mean 'illness-related economic

inactivity'. Therefore, the 'international consensus' or 'social injustice' policy frame appears less compatible with policy paradigms than the 'healthcare for disadvantage groups' frame or the 'illness-related economic inactivity' frame. But several participants had suggestions for alternative policy frames which might more successfully address similar social injustice aims.

As described earlier, a policy focus on child poverty was supported by several Scottish-based participants as an alternative to 'health inequality':

> "*If you can resolve the problem of child poverty, then in some respects you've also resolved a lot of the concomitant health related issues that they face and that affect communities disproportionately*" [SCOP02H]

> "*I think it [cross-departmental responsibility for health inequality] doesn't work very well at the minute, so that's why where we do see those nuggets of good progress being made, or where we're focusing on something like child poverty, that's great.*" [SCOP14H]

'Levelling Up' attracted both support from GM and Scotland as a policy frame, and opposition, due to its close links to the national government of the time:

> "*Distinctive framings that unlock more than just re-describe, that's the key thing. We can reframe all we like, but the trick is a reframing that unlocks something, that unlocks passion or momentum or action, and I actually thought that the 'levelling up' reframing was a good one and hence part of my restatement to myself that that is the right agenda.*" [SCOP07H]

> "*I think it does cut through to some degree as something that people have an instinctive feel for what it means to them.*" [GMP02O]

> "*I remember early on a debate about should we be using the phrase 'levelling up' in the Greater Manchester Strategy. And it's like no, because national governments come and national governments go, this is our document about what we care about, and it should be framed in the way that we think about things, rather than whatever the phraseology of the day happens to be nationally*." [GMP07O]

Despite that opposition, it was used twelve times in the GM Strategy Good Lives for All (2021), including in headings and pull-quotes.

'Prevention' was supported both in GM and in Scotland, in the latter prompted by a recent PHS paper on prevention (McAdams, 2023) which led to a series of high-level meetings:

> "*Rather than coming from a health inequalities angle, it's come from the inequalities angle, and then badged partly as prevention. And that really seemed to help because it has given common language across the piece, and it's stuff like that that's quite key and critical to try and get people all on board and signed up to it.*" [SCOP05H]

Another policy frame being mobilised in Scottish health policy was based on 'sustainability', which has been described elsewhere as a 'collaboration magnet' (Khayatzadeh-Mahani et al., 2019) for a social determinants approach to health. In this case it was applied to the health(care) system specifically to appeal to the priorities of political leaders:

> "*That's our message at the minute, is that the sustainability of the health system is dependent on the health of the population and health inequalities are a major driver of demand into the health system. So then you then step back from there and go, what do we need to do to address health inequalities? […] If you're engaging with the [Deputy First Minister] or the [First Minister], health [care] policy is never not going to be a priority, so we have to play that card*" [SCOP14H]

Two participants in Scotland encouraged more use of the idea of 'thriving'. One participant, who had been involved in Scotland's public health reform process that led to the creation of Public Health Scotland, explained the reasoning behind PHS's vision statement of "*a Scotland where everybody thrives*":

> "*It was anodyne enough that people wouldn't get their hackles up about something, but it was ambitious enough, and you can put meaning to it yourself. So you have a sense yourself, about what thriving means to you, and a local authority will have a view and its political leadership, senior leadership team will have a view on what thriving means to them, and similarly public health, etc. So that's the purpose of it, was to have something to coalesce around, which you can interpret and apply your meaning to it, but the ambition there to be egalitarian and focus very much on equity.*" [SCOP17H]

This description highlights the value of ambiguity in attracting support from actors who may have slightly different interpretations of what the term might mean. This ambiguity is also a

quality of 'wellbeing', which was widely supported in my data, from both GM and Scottish participants.

> "*I do think health inequalities as a framing generally is tired and risks having run out of road. So I think wellbeing might be a way to unlock some things* [SCOP07H]
>
> "*That's why I like the concept of the wellbeing economy. We're not saying a health economy. So yeah I think wellbeing does allow you to bring in different metrics. You can thrive with a long-term health condition. So yeah if you're talking about wellbeing, it is much better and it's not so reductionist.*" [SCOP12H]
>
> "*In a wellbeing approach you're allowing people and communities to take the action that they feel is needed to take within their place to achieve the things that they want to achieve as a community. And then I think that moves you slightly on from the idea of health just being that individual thing that affects you, that you might go to the doctor for or that you might be receiving treatment for or whatever and it moves you on from that to that broader sense of community.*" [SCOP20O]

Each of these suggestions avoid the word 'health', and therefore the implications that health concerns only individual illness, and that it is a matter only for health policy actors. They also avoid the charge of healthism (Crawford, 1980, 2006): of unreasonably prioritising 'health' above all else that makes life worth living. But each of them have a range of other implications too: 'child poverty' is only aimed at families; 'levelling up' is strongly associated with an unpopular national government; 'sustainability' has been co-opted by commercial interests (Scoones, 2007). If the health inequalities policy frame is unconducive to preventing socially patterned health outcomes, what policy frame might those moved by such injustices support instead? This quandary shall be discussed in the next chapter.

8.5 Conclusion to chapter 8

In this chapter, I have discussed three different versions of health inequality which were apparent in my data: health inequality as population-level illness impeding economic activity; health inequality as healthcare inequality for disadvantaged groups; and health inequality as social injustice (the 'international consensus' policy frame (Lynch, 2020)). The former two understandings of health inequality were achieving political support during the

period of study; while the latter, preferred by public health researchers and activists internationally, was not. Several important issues were raised in this discussion from that perspective: how can the social injustice version of health inequality best be promoted in policy settings?

One particular issue discussed in depth in section 8.3 was the continuing policy choice to locate responsibility for health inequalities within health policy teams, creating a false and unwinnable competition with healthcare. In my analysis, it is false because health policy cannot significantly impact inequalities in social or economic determinants of health; and it is unwinnable due to the constant media and electoral pressure to prioritise healthcare. Can 'health inequality' plausibly be decoupled from health policy? This awkward question shall be discussed further in section 9.2 of the next chapter.

Then, section 8.4 discussed the 'international consensus' policy frame (Lynch, 2020), which in my research was characterised by the presence of strong moral language about social injustice. Further, in section 8.4.1 I discussed SG's Care and Wellbeing Portfolio's rejection of 'health inequality' as a useful framing to reduce health inequalities. This represents a high-level policy acknowledgement of the downstream impacts of the word 'health' on 'inequalities'; exactly as argued by Lynch (2017, 2020). This change in language was reported to have had beneficial impacts on relationships, which I attribute to the understanding of 'health' to mean 'health policy' (discussed at length in chapter 6), and therefore removing 'health' has the effect of downplaying competitive health policy interests. But this reframing was not sufficient to facilitate a move away from healthcare inequalities, due to the structuring of the health policy domain. This is an important reminder not to exaggerate the impact of language; structural limitations may persist from historical framings and the path dependencies that followed. Therefore, if policy silos are to persist, can silos be built to work for cross-cutting policy interests, rather than against them? This shall also form part of the discussion of section 9.3.

Then, I explored the description by a senior health policymaker in Scotland of the 'political suicide' of redistribution in relation to health inequality. This reflects similar comments by health policymakers in various settings in previous research, who have also used extreme terms like "*political suicide*", "*socialist revolution*" and "*Marxist command-economies*" to associate reducing economic inequality with radicalism or danger. In my data, the senior

health policymaker contrasted what they might do with the straw man of "*socialist revolution*" five times.

Yet, redistribution in the shape of the Scottish Child Payment (SCP) unified all three candidates for SNP leadership following the resignation of Nicola Sturgeon, including the winning candidate Humza Yousaf. My participant suggested that 'politics', rather than academic arguments, may now be redefining the context for action on economic inequality. In section 9.4.1, I shall argue that this refers to a political narrative of distinctive Scottish egalitarianism that is now enabling redistributive policy.

Finally, I addressed the possibility that policy frames other than 'health inequalities' might be more effective at preventing unfair variations in health. Many of my participants offered alternative suggestions, which all excluded the word 'health'. How best to assess these alternatives for their likelihood of success? In the next chapter, I attempt to work through some of these policy puzzles.

Chapter 9: Discussion

9.1 Introduction

This thesis has explored conceptualisations and framings of health, inequality, and of health inequality, among social, economic and health policy actors, at Greater Manchester Combined Authority and at the Scottish Government, as expressed both through published strategy texts, and through interviews. This chapter will aim to unpack some of the policy puzzles surfaced over the course of this research, with a view to developing and deepening our understanding of its application to real world policy, practice and research futures. In this way, it aims to contribute substantially to my fourth research question about the implications of this research.

Firstly, section 9.2 addresses a key question that has informed this thesis: if health department-led approaches to health inequality are inevitably susceptible to downstream drift due to institutional limitations, might efforts to reduce health inequalities be more effective if policy responsibility was situated in a department other than health? As this section explores, no single vertical line of accountability will ever be satisfactory for systemic variations in health: responsibility must be dispersed across that system.

Further, section 9.3 assesses whether the straight-forward solution to this policy conundrum is a new national health inequalities strategy. When I started this research project, New Labour's health inequalities strategy was generally considered to have failed: as described at the very start of this thesis, and in section 1.6.1. However, newer research and analysis has produced increasingly positive evaluations of the strategy. The answer to Mackenbach's 2011 question – "*Can we reduce health inequalities?*" – may now be a cautious 'yes' (see also Bambra, 2021). This section discusses what this means for the 'health inequalities' critique, and whether researchers and activists should renew calls for national-level strategies.

Finally, section 9.4 discusses alternative policy agendas that may act to minimise similar injustices to those targeted by 'health inequality' agendas. This section combines elements of chapter 7 and 8, and seeks to contextualise the discussion within specific political narratives in Scotland and in GMCA. Firstly, I discuss the construction of a 'myth' of distinctly Scottish egalitarianism, particularly around devolution and independence debates

which require advocates to differentiate Scotland from England in meaningful ways. How might 'health inequalities', 'child poverty', 'levelling up', or 'wellbeing' fare in this political context? Finally, this chapter concludes by considering how the ongoing construction of 'Greater Manchester' may inform GMCA's interest in similar agendas.

9.2 Who should have policy responsibility for health inequalities?

This thesis has described several problems contributed by the word 'health' to policy attempts to reduce unfair variations in health outcomes. In chapter 5, my findings implied an individualising tendency expressed in health policy texts that runs counter to the social model of health. In Chapter 6, I described how 'health' was often used by social and economic policy actors to mean 'health policy' and surfaced particular issues with health policy that may hinder the cross-departmental policy collaboration required to reduce inequalities in the social and economic determinants of health. In chapter 8, I described how the location of responsibility for health inequalities within health policy created three more specific problems: it falsely implied competition between investment in health inequalities and investment in healthcare services; it caused confusion within policy settings about action to reduce health*care* inequalities; and thirdly, it further invited health expansionism by giving health policy teams responsibility for reducing social and economic inequalities. All of these findings suggest that policy responsibility for health inequalities should not lie with health policy teams, and prompts an awkward question: can 'health inequalities' plausibly be decoupled from health policy?

A related question that may illuminate the nature of this dilemma was discussed by the second report of the House of Commons Health Select Committee in 2001: 'where should the Minister for Public Health be located, and should public health be a matter for the Department of Health at all?' Several participants proposed that the Minister for Public Health should be a Cabinet member with cross-governmental remit. Others suggested cross-departmental Units or Advisory Groups, or sought greater commitment across departments. The Minister herself, Yvette Cooper MP, argued that the huge spending power

of the Department of Health gave her more opportunities to find investment, though the Committee were unconvinced by this:

> "*We conclude that the present arrangements do not adequately promote cross-government working. Given the undesirability of change for its own sake, we recommend that the public health function remains with the Department of Health for the present. We would, however, like to see far greater evidence that it has assumed priority within that Department. If that is not forthcoming, we think the case for relocation would be much stronger*." (Health Select Committee, 2001, para. 237)

This debate from two decades ago is helpful, in my view, for demonstrating the long-term inadequacy of health policy structures and practices for a preventive agenda, at least partly because health policy budgets are overwhelmingly prioritised towards reactive healthcare services. Testimony from a Sport England participant that health promotion budgets may comprise, at best, 0.001% of a health authority's budget illustrates the absurdity of the imbalance.

But what would a sizeable shift in resources from the NHS towards public health or health promotion achieve? The likelihood is such resources would primarily be invested in lifestyle-behavioural interventions, therefore advancing the preventive agenda at the individual level, and at risk of widening inequalities (Baum & Fisher, 2014). Health promotion and public health remain within health policy, which my results show tends to individualise health, hinder cross-departmental collaboration, and has limited policy levers in relation to systematic variations in population health.

As described in the literature review, we are again confronted with the basic conceptual incongruence between dominant understandings of 'health', policy structures, and the social model of health. If responsibility for a preventive approach to unfair variations in health should not lie with any health policy team, should it lie with any other team?

My findings in chapter 5 show that the social model of health is described well across social and economic policy strategy texts. But it is not described in its entirety within any single one of them. The social model of health emphasises that healthcare is responsible for a small portion of health outcomes (Kaplan & Milstein, 2019); but no individual policy domain is responsible for the rest. Two candidate domains may be economic policy, and spatial

planning. Both materialist and psychosocial explanations of health inequality imply a dominant role for economic policy; and spatial inequalities in built environment determinants of health are a central concern of planning policy. But both domain frames exclude important ideas about the social determinants of health, and both domains feature continuing contestation about inequality (e.g. Peterson, 2017; Lobao et al., 2007). Therefore policy actors in both domains are unlikely to accept responsibility for health inequalities.

In my view, there is an argument for more precise language to reflect the cross-cutting causes of health inequalities and to clarify what health policy actors should have responsibility for. Perhaps the relentless political imperative to improve healthcare performance could be harnessed to give healthcare actors policy responsibility for healthcare inequalities, which would also bring greater conceptual clarity to actors concerned with – but unable to achieve – 'solving poverty' (Alderwick et al., 2024).

For example, in section 6.3.2, I described how healthcare actors ("*clinicians*" and "*the NHS*") were criticised for apparently resisting efforts to consider the wider determinants of health, while population health teams were criticised for being "*evangelical*" in crossing policy boundaries to promote 'Health in All Policies'. A clearer conceptual divide – perhaps between 'healthcare' and 'wellbeing' – would enable clinicians to focus on the clinical needs of patients, as they are most able to do; while also allowing population health teams to disassociate themselves from healthism and from the resented budgets and status of the NHS, to facilitate better relations and cooperation with other policy colleagues.

Similarly, organisations or teams with levers for physical activity, smoking or substance use programmes may reasonably be given responsibility for reducing inequalities in access to physical activity, smoking or substance use programmes. While social and economic policy teams take responsibility for inequalities in their own determinants of health, the combined impact is cross-cutting policy responsibility for inequalities in determinants of health. In this way, responsibility for systematic variations in population health is appropriately dispersed across the system, rather than being unfairly attributed to single teams or actors with necessarily limited levers.

Several of my research participants described responsibility as already dispersed in this way, but that this led to an unfortunate lack of accountability: as one GM health policy participant said, "*when it's everyone's business it becomes no one's business.*" But this may represent further conceptual confusion and a misplacement of accountability. This

participant, quoted in section 8.3.1, referred to colleagues who prioritise A&E performance rather than health inequalities because they fear being fired for failures in the former, but not the latter. But actors with effective control over A&E performance do not have effective control over inequalities in social or economic determinants of health. It would plainly be unfair to burden these actors with responsibility for inequalities in health outcomes more broadly.

This dilemma may be illustrated with an analogy: who should have policy responsibility for climate change? Like health inequality, climate change has often been described as a 'wicked problem' (Incropera, 2015; Sun & Yang, 2016) and even as a 'super-wicked problem' (Levin et al., 2009), due to various characteristics reflective of conceptual complexity, long causal chains and lag times, and profound political disagreements. The Scottish Government has one of its eight major departments (Directorate Generals (DG)) dedicated to 'Net Zero', and passed legislation in 2019 to create statutory targets for net zero emissions by 2045. GMCA has declared climate change one of its two major cross-cutting priorities, and given its teams shared responsibilities for indicators leading towards a target of carbon neutrality by 2038.

In neither case does any policy team have responsibility for 'climate change', which requires global public and private sector action far beyond that of GMCA or SG's jurisdiction. There is no conceivable future in which GMCA or SG are able to stop climate change. But it is conceivable – and indeed planned – for GMCA and SG to stop Greater Manchester or Scotland contributing further to climate change, by achieving carbon emission neutrality. While health inequality or climate change represent highly complex problems, goals for carbon neutrality or net zero emissions represent measurable policy solutions. Achieving these solutions may contribute only a tiny fraction to the global challenge of climate change, but these tiny fractions are all that are within GMCA and SG's competence. Just as it would be unfair to burden an A&E manager with responsibility for wider inequalities in health outcomes, it would be unfair to burden GMCA or SG for responsibility for climate change beyond their own small contribution to the problem. Therefore, on the principle that policymakers should not be accountable for outcomes over which they have limited control, policy responsibility for health inequality must necessarily be dispersed to those able to minimise the contribution to the problem of their part of the system.

The findings of this thesis pose the question of whether a policy domain or silo facilitating a social injustice approach to health inequality is feasible. Would a hypothetical 'DG Health Inequalities' make better progress towards reducing systematic, avoidable and unfair differences in health outcomes? I asked a research participant whether DG Net Zero was preferable to the previous arrangement of a Directorate sharing responsibility for 'Energy and Climate Change', all within DG Economy. In their view, the 2019 legislation, having a leader for the agenda at Director General level, and "*the fact that the government have become much more clear that this is a priority*" all helped, but the change in organisational structuring "*didn't really make that much difference*" [SCOP19O].

This participant also highlighted the difficulty of uniting all policy teams with impacts on carbon emission within DG Net Zero, noting in particular that Transport Scotland remained distinct. Which policy teams might be included within a DG Health Inequalities? Is it clear that policy teams for affordable housing supply, homelessness or fuel poverty should be divorced from other housing teams; or that policy teams for fair work, employability or skills development should be decoupled from DG Economy? Framing excludes as well as includes; and it is this unavoidable boundary-setting to direct attention that also creates inevitable inattention.

Therefore, it seems to be the political prioritisation that the legislation and creation of DG Net Zero represents, rather than the ambitious but inevitably incomplete organisational restructuring, that has most benefited the Net Zero agenda. This analysis suggests that it is political interest in avoiding unfair health outcomes that is most required to reduce the social injustices targeted by the international consensus health inequality policy frame; rather than hypothetical repositioning of policy responsibilities, or restructurings of policy domains to create new silos. But this political interest may be hampered by the apparent lack of political incentive demonstrated by the fate of New Labour's health inequalities strategy, as I shall now discuss.

9.3 Do we need a new Health Inequalities Strategy?

Julia Lynch's suggestion that the 'health inequality' framing has harmed policy attempts to reduce health inequalities because 'health' distracts policymakers from 'inequality' is largely supported by the findings of this research. However, part of her explanation for the 'failure' of the 'health inequality' framing rests on a conclusion that: "*Taken as a whole, Labour's [English Health Inequalities] strategy was not a success*" (2020, p180). This conclusion is based on the announcement of the Department of Health in 2009 that both targets had been missed, Mackenbach's (2011, p574) conclusion that "*in terms of its own targets, the English strategy has failed*", and the findings from four longitudinal studies (Bennet et al., 2015; Newton et al., 2015; Buchan et al., 2017; de Gelder et al., 2017). Data for these four studies ended in 2012 or 2013.

But, as described in the Introduction chapter, other studies told a different story, particularly those with access to later data. Buck and Maguire (2015) found that the social gradient in life expectancy had improved during the late 2000s. Hu et al. (2016) found that education-based gaps in all-cause mortality narrowed more in the 2000s than in the 1990s. Barr et al. (2017) found that both relative and absolute inequalities in life expectancy had decreased during New Labour's government, having increased before it, and resumed increasing afterwards. For males (but not for females), that target had in fact been achieved. Robinson et al. (2019) found that absolute inequalities in infant mortality had increased before the strategy, then decreased during the strategy, and then began increasing again afterwards. Vodden et al. (2023) found absolute inequalities in various health outcomes were stable before the strategy, decreased during the strategy, and then improvements slowed again afterwards. Most recently, Bennett et al. (2024) found a significant reduction in absolute inequalities in mortality at age 65-69 during the strategy, followed by significant increases since its end.

A systematic review published in 2022 concludes that:

> "*There is evidence that the strategy met the infant mortality target, while the life expectancy target was reached for men but not women. Absolute health inequalities in life expectancy, mortality, infant mortality and multiple major causes of death reduced. While the impact on relative inequalities is less clear, there seemed to be a*

narrowing of relative health inequalities in at least life expectancy and infant mortality." (Holdroyd et al., 2022, p7)

Therefore, more recent findings show reductions across many measures of absolute health inequality, and some measures of relative health inequality, compromising any straightforward assessment of the strategy as having 'failed'. Nevertheless, for many years after its conclusion it left researchers and activists disappointed (see e.g. Garthwaite et al. 2016); and it took many further years for more encouraging data to emerge, during which time inequalities widened again. Further, any positive conclusions drawn from later data have been roundly ignored by the media and the public. There appears to be no political incentive for a national government to commit to such an undertaking again.

Again, this is not to say that there is no demand for action of the type that would reduce unfair variations in health. New Labour were not politically rewarded for their effective health inequality strategy, but they were politically rewarded in 2004 and 2008 elections for their ongoing policy platform, including many of the ideas framed within the health inequality strategy. This includes, for example, a range of pre-school development initiatives within Sure Start centres; a National Strategy for Neighbourhood Renewal; a UK Fuel Poverty Strategy; increases to pensions and the winter fuel allowance; a targeted education initiative called Excellence in Cities; a Teenage Pregnancy Strategy; Regional Development Agencies to drive regional economic development; a Child Poverty Strategy; a national Adult Literacy and Numeracy Strategy; and a National Minimum Wage. Each of these policy initiatives and strategies is framed as part of New Labour's Tackling Health Inequalities' Programme for Action (Department of Health, 2003), not as distinct from it.

Therefore, it is not the health inequality strategy *per se* that is important, but the whole social, economic and health policy platform and the extent to which it acts to reduce inequalities in important determinants of health. My analysis of social, economic and health policy texts, particularly as described in chapter 5, suggests that both GMCA and the Scottish Government could compile a package of existing social, economic and health policies, and frame it as a 'health inequalities strategy'. Further, my discussion of the social gradient in health, in section 7.3, suggests that the Scottish Government could claim its 'health inequalities strategy' was addressing the gradient. But there is very little political incentive for either polity to do so, given the very long timescales over which such

strategies can be assessed, the high risk of an evaluation of failure, and the lack of reward for an eventual assessment of success.

My research supports the main finding of Lynch (2017, 2020) that the 'health' in 'health inequality' tends to distract policymakers from a focus on 'inequality'. It also implies that health policy should not be responsible for a policy agenda to reduce health inequality: as health inequality is generated by determinants in a range of policy domains and teams, each team should be responsible for inequalities in such determinants that it can affect. But evidence now shows that a national health inequality strategy such as New Labour's can be effective. The key remaining concern is that such effectiveness relies on sustained political support, takes decades to evaluate, and appears to have been entirely ignored by the media and the electorate. Therefore, alternative strategies which can sustain political will over long periods must be explored.

9.4 Alternative agendas to reduce the social injustice of health inequality

In this section, I wish to explore and contextualise further several findings from the results of this research: about the role that framings of inequality play in broader political narratives around devolution (chapter 7); about the idea that economic redistribution might be "*political suicide*" (chapter 8); and the prospects for agendas other than 'health inequality', such as for 'child poverty' or the 'wellbeing economy', to reduce unfair variations in health outcomes in Scotland and elsewhere. The latter was discussed in chapter 8 ("*it doesn't have to be 'health inequalities'*") and is further informed by chapter 6 and chapter 7 findings that 'wellbeing' aligns with the social model of health, and is preferred to 'health' as a common policy aim by social and economic policy actors.

The connection between each of these findings is their dependence on social and political contexts, which I aim to explore with reference to previous work by Julia Lynch (2016) on the framing of health inequality in Belgium, as well as broader political, geographical and sociological literatures. Specifically, narratives of comparison or inequality are particularly important to devolved sub-state entities such as GMCA and the Scottish Government because their devolved status depends on a shared belief in differentiation. Therefore, my

analysis of GMCA and SG health inequality framings must also consider the political identity of each within or compared to England or the UK. This requires some articulation of the shared beliefs that form much of the political context and that therefore strongly influence which policy frames are likely to be prioritised by political leaders over others.

Chapter 7 demonstrated the role of health inequality framings in narratives to justify and embed devolution within Greater Manchester. According to my participants, across social, economic and health policy teams, health disadvantages of Greater Manchester as a whole compared to English or UK averages were purposefully highlighted as part of a broader political "*story*" of "*how as a place we differ from the UK*" [GMP06O], for "*persuasion*" [GMP02O] or to "*extract more from central government*" [GMP09O], and because "*there was always the understanding it could be taken away from us at any point*" [GMP11H]. In chapter 7 I contrasted this with the almost total lack of Scottish-disadvantage framings in the SG corpus, which was not explained by Scottish participants. The key difference, I suggested, is that GMCA's devolution is recent, while Scottish devolution is more than two decades old. In this section I shall also explore some of the key differences of political context that emanate both from that fact, and from the broader history of Scottish relations with England.

In Chapter 8, I discussed the persistent perception that economic redistribution is politically unacceptable (e.g. "*political suicide*") in the context of health inequality, found both in my research in Scotland, and in prior research in Australia (Baum et al., 2013) and in England (Stevens, 2011; Qureshi, 2013; Smith, 2013; Lynch, 2017). But redistribution does not appear to be so politically damaging in Scotland in relation to child poverty. As described in chapter 8, all three candidates for the SNP leadership and role of First Minister committed publicly to increasing further the Scottish Child Payment (CPAG, 2023), and the winner, Humza Yousaf, followed through on his campaign proposal to increase tax on high-earners to increase the SCP (Whyte, 2023; BBC, 2023).

In this section, I shall describe a distinctive aspect of the Scottish political context that has been intentionally shaped, particularly since devolution, in ways that have facilitated this policy move. Further, I will argue that there are advantages to the child poverty framing, in this context, in comparison to the health inequality framing, and also in comparison to 'levelling up' or 'wellbeing'. In the following section, I shall further consider the ongoing

construction of Greater Manchester and how this may influence policy frames concerned with unequal health outcomes.

9.4.1 The role of distinctly Scottish egalitarianism

9.4.1a The political construction of a distinctly Scottish egalitarianism

Just as my results in Chapter 7 demonstrate the role of health inequality framings in narratives that justify and embed devolution within Greater Manchester, Scottish devolution was accompanied by political ideas asserting a Scottish distinctiveness to justify devolution. These ideas were far from new: discussion about Scottish national identity and the union with England have dominated Scottish politics for hundreds of years (Devine, 2008). But a growing sense of hostility to the Conservatives emerged during Thatcher's neoliberalisation of the British economy in the 1980s; opposition to Thatcher's reforms and apparent disregard for Scotland became intertwined with Scottish national identity (Mooney & Johnstone, 2000; Keating, 2005). Mitchell (2005, p23) describes the devolution that followed as the outcome of the mobilisation of a "*wider, progressive political movement*" against an 'Other': "*the 'other' that threatened the Scottish base might best be described as Thatcherism*".

Subsequently, Labour and the SNP became Scotland's two preferred political parties, and expectations of increased state intervention accompanied constitutional change. At the very first session of the New Labour-created Scottish Parliament, the Scottish Labour First Minister Donald Dewar said that "*social justice and fairness are the hallmarks of Scottish society*" (quoted in Rummery, 2016, p140). Dewar continued to publicly speak in such terms, to the extent that a contemporaneous Child Poverty Action Group report stated that the new devolved government had "*sought to present that attack on poverty as a central organising principle of the new Parliament*" (Brown et al., 2002, p6-7).

Around the same time as Scottish politicians were emphasising the distinct Scottish focus on social justice, fairness and poverty, policy texts focusing on health in Scotland were emphasising Scottish distinctiveness in a different way: as Scottish health disadvantage. As described in section 7.2.1, this is apparent in very prominent quotes in New Labour health policy texts which characterise Scotland as being at the bottom of the 'health league' (or the top of the 'disease league'). Therefore, the advent of Scottish devolution was accompanied by differentiation from England, sometimes described as a particular interest in poverty, social justice and fairness, and sometimes described in terms of specific health

disadvantage. This is the 'poor us' position, as described in Chapter 7, or in the words of my GMCA participant, it is "*how as a place we differ*".

Yet, my analysis finds an almost total lack of Scottish health disadvantage framings in the current corpus of policy texts. Only a single sentence in the Public Health Priorities for Scotland (2018) text compares Scotland's average life expectancy unfavourably with that of 'Western Europe' and 'other UK countries'. Scotland remains at the foot of the 'health league', but policy texts seem reluctant to mention it. Why might this have changed?

In chapter 7, data from Greater Manchester participants implied that the Scottish Government may now have the 'confidence' of its established devolved status to focus on internal inequalities; and a Scottish participant suggested there may be a geographical focus within Scotland to satisfy the political representatives of different areas. I would argue that the political context has also changed.

Such emphasis on differentiation as was apparent at the time of Scottish devolution was not immediately followed by highly divergent policy agendas (Keating, 2005; Smith et al., 2009). This must substantially be attributable to English and Scottish governments both being led by the Labour Party. But the rise of the SNP in the mid-2000s, who won a single-seat victory in the 2007 Scottish election on a platform of inclusiveness and competence, created a new imperative for differentiation as they sought to hold and to win a referendum for independence.

That election victory and the subsequent referendum catalysed further identity-building by the SNP of a Scotland distinguished from England by social egalitarianism. The electorate for the referendum was defined on an inclusive, chosen basis of residency, rather than an exclusive, unchosen basis such as birthplace or ethnicity. This construction of an ethnically inclusive Scottish in-group can be traced at least as far back as 1995, when leader and future First Minister Alex Salmond told a party conference speech "*we see diversity as a strength not a weakness of Scotland*" (quoted in Reicher et al., 2009, p34), and is clear in the many further statements of Nicola Sturgeon analysed by Nicolson and Korkut (2022). But this inclusive perception of Scottishness is at least partly predicated on differentiation with England. Reicher et al. (2009, p31) have found experimentally that Scots minimise racism in comparison to England, but not in comparison to Scandinavian countries: "*When measured against the English, the attitude seems to be 'they have got a problem, don't say we have got a problem'*". As Davidson and Virdee (2018, p8) write, this ethnically inclusive

nationalism is welcome in many regards, but it also contributes to a "*myth that Scotland does not have a serious racism problem*".

Further, a key part of the pro-independence referendum campaign was the promotion of optimistic visions of a future Scotland able to act radically on issues of social justice. Both Salmond and Sturgeon made many statements and claims about Scotland's particular progressiveness and that an independent Scotland would pursue social justice (Mooney & Scott, 2016). The claimed connection between Scottish independence and a socially just future is clearly visible in the remit of the 'Social Justice and Fairness Commission' (Social Justice and Fairness Commission, 2019), established by Sturgeon: "*The aim of the Social Justice and Fairness Commission is to deliver a route map to the real prize of independence - becoming a truly rich society, where we ensure that no one has to rely on a food bank to eat*". For Morelli and Mooney (2023), this represents an affective polarisation with England, and the prospect of a further independence referendum relies on the continuance of this polarisation focusing on "*an optimistic vision of a radically different independent Scotland*" (p209).

9.4.1b Health inequalities in the distinctly Scottish egalitarian context

As the above section describes, the Scottish response to Thatcher, the devolution referendum and the creation of the Scottish Parliament, and the independence referendum and movement, have all promoted ideas about Scottish egalitarianism in comparison to England. Therefore, it is clear why unfavourable comparisons between Scotland and England in health terms may be suppressed: to borrow Reicher et al.'s (2009) characterisation of the in-group attitude to unflattering comparisons to the out-group, 'don't say we have got a problem'. This may be what the senior civil servant in Blackman et al. (2009) was referring to when saying, in 2006, that comparisons with England or UK health would not be acceptable to a Scottish Government.

There is also a key parallel here with Belgium, according to previous research by Lynch (2016). This research found that Belgian policy framings of health inequality were dominated by social class, rather than as a regional divide between Wallonia and Flanders, even though that divide showed stark inequalities. Policy document analysis and interviews with Belgian policymakers led Lynch to argue that devolution within Belgium giving regions more policy responsibility had made regional inequalities politically dangerous to highlight.

Emphasising Wallonia-disadvantage compared to Flanders would highlight the failures of Walloon politicians since devolution. This is analogous to the Scottish situation: highlighting Scottish disadvantage compared to England could highlight the failures of Scottish politicians since devolution.

Therefore, in the late 1990s, when it was highly visible in Scottish policy texts, framing the issue of health inequality as a matter of Scottish disadvantage supported a pro-devolution case. But twenty years after devolution, it could function as an argument against the further step of independence. Lynch also argues that political debates about healthcare are key in Belgium, as health inequality is so often conflated with healthcare (see Chapter 6). In Scotland's case, despite the long-term effects of social and economic policy from Westminster on health and health inequalities (Walsh et al., 2016), the risk of political opponents to independence framing Scottish health disadvantage as an indicator of the long-term failure of devolved Scottish health policy seems high. This seems to be a key discouragement for Scottish health disadvantage framings ('poor us').

Nevertheless, the promotion of Scottish egalitarianism might be expected to encourage within-Scottish health disadvantage framings ('poor among us'). One of the new SNP government's first actions in 2007 had been to establish a ministerial task force on health inequalities, which reported the following year. Equally Well (Scottish Government, 2008) aligned closely with the social justice/international consensus policy frame, even neatly summarising it as follows: "*there is international agreement that reducing unfair and unjust inequalities in health needs a cross-governmental approach*" (p2). A pull-quote dominating its cover and which also leads its Introduction chapter demonstrated the shift from devolution-era Scottish disadvantage to the within-Scotland disadvantage of Scottish egalitarianism:

> "*Scotland's health is improving rapidly but it is not improving fast enough for the poorest sections of our society. Health inequalities… remain our major challenge*" (Annual Report of the Chief Medical Officer, Health in Scotland 2006; quoted in Equally Well, 2008, cover and p9).

In section 7.2.1, one of my Greater Manchester-based health policy participants, who was involved in drafting policy texts, described the "*fine balance*" four years after devolution of "*justify[ing] remaining devolved*" without "*say[ing] we'd fixed it all*". Such a balance is evident in the quote chosen for the cover of Equally Well, which both asserts that Scotland's

overall health is improving rapidly (after eight years of devolution), and takes a normative stance to suggest more attention is given to the poorest within Scotland. It is this 'poor among us' position that my research suggests remains dominant in Scotland, and which my GM participants suggested was emerging there.

The third pull-quote in the Introduction of Equally Well – but not featuring on the cover – is from future First Minister, but then-Cabinet Secretary for Health and Wellbeing, Nicola Sturgeon: "*We have made tackling health inequalities our top priority*" (p9). Such prioritisation appears to have been facilitated by the new SNP government's intent to distinguish Scotland from England ahead of a push for independence. Indeed, an SNP official told Fox (2013, p507) that reducing health inequality was a government priority "*as part of national identity*". Advocates for policy action on health inequalities could hardly envision more favourable political circumstances than such a declaration of priority ahead of sixteen further years (and counting) in office by a governing party continually promoting egalitarianism and social justice, with this health secretary becoming party leader and First Minister for almost nine of those years. So, understanding why Equally Well failed must be key to assessing future plans to reduce health inequalities.

A policy review conducted by NHS Health Scotland (a predecessor to Public Health Scotland) described Equally Well's implementation as suffering from the 'lifestyle drift' of a focus on behaviours rather than upstream determinants, and of being "*delivered as a health and wellbeing initiative with limited spread into [other] policy areas*" (Beeston et al., 2013, p1). The same year, an official review by the original ministerial task force copied the cover design of the original, but replaced the dominant quote. Both covers are replicated side-by-side, below, to demonstrate the contrast in the quotes chosen to represent each report:

Fig 9a: Covers of *Equally Well* and *Equally Well Review 2013*

The quote chosen for the cover of the review says: "*it is insufficient to try to prevent disease if the intention is to create health*". This pointed criticism seems to imply a disease-focused, downstream approach, rather than one aimed at the upstream social and economic determinants of health. As described in the literature review, this document also referred to an inadvertent framing effect in the term 'health inequalities':

> "*All members of the Task Force were clear that the focus of all our efforts should be on tackling* inequalities*. Moreover, they reflected that by targeting* health *inequalities we may have inadvertently allowed different parts of the public sector to think that… responsibility to resolve the problems arising from inequalities lies only with the National Health Service (NHS).*" (Scottish Government, 2014, p6, emphasis added)

This paragraph alleges that the distraction of 'health' from 'inequalities' contributed to a focus of responsibility on the NHS, in a programme failed by a disease-focused, downstream

approach: a precursor to the similar criticism by Lynch (2017, 2020) of New Labour's health inequalities strategy in England; and supported by various findings of the present research.

9.4.1c Why does 'child poverty' align better with distinctly Scottish egalitarianism?

Although there have been no further health inequality strategies in Scotland since Equally Well, the Scottish Government has not abandoned its interest in reducing inequalities. Perhaps the paragraph quoted above – that the focus should be on tackling inequalities, not health inequalities – was taken very seriously by the Scottish Government leadership. The ineffectiveness of the Equally Well programme must also have been a factor. As demonstrated by New Labour's Health Inequalities Strategy in England, positive signs of effect appear too late, and too unclearly, to provide a political incentive for action.

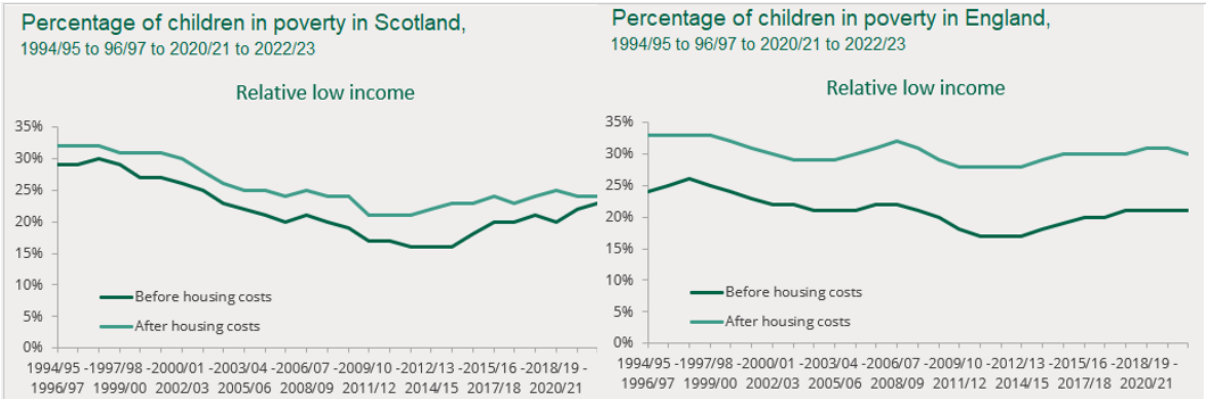
Instead, the Scottish Government's egalitarian focus moved to child poverty. It was required to publish a Child Poverty Strategy in 2011 and in 2014 by the Child Poverty Act passed by the New Labour government shortly before their election defeat in 2010. After the Conservative government of David Cameron abandoned the statutory targets in 2015, Sturgeon responded with a Child Poverty (Scotland) Act to reinstate such targets for Scotland. Introducing the Bill in 2016, Sturgeon emphasised distinctly Scottish egalitarianism:

> "*The UK Government has signalled that they do not see child poverty and the incomes of poor families as priorities. With the introduction of this new legislation, the Scottish Government is sending the message, in the strongest possible terms, that we profoundly disagree*." (quoted by Keyden, 2016)

In my analysis in section 7.2.2, I contrasted the potential political damage of highlighting Scottish health disadvantage, with drug policy and the political prioritisation of the 'drug deaths crisis': a specific form of health disadvantage, which the media often describes in terms of comparison to other countries. The Misuse of Drugs Act is reserved to central government, so the Scottish Government has limited powers to act. Comparisons with England are unfavourable, but this provides nationalists with a pro-independence argument: the uncaring UK government, led by English Conservative politicians unelected by Scots, are responsible for Scottish deaths (Garavelli, 2020; Robertson, 2020; Harrison, 2023).

The devolution of policy for poverty is similarly mixed, with the Scottish Government having limited levers over tax and social security, but with the strongest levers remaining with central government. Here, comparisons with England are favourable, thanks to a specific SNP choice. As shown in Figure 9b below, child poverty in Scotland – when measured relatively and before housing costs, as the Child Poverty Act 2010 had specified - has often been higher than in England, but is now roughly similar. But when measured as relative poverty after housing costs, as specified by the Child Poverty (Scotland) Act 2017, child poverty in Scotland has been consistently lower than in England for around twenty years (Francis-Devine, 2024). So even though this lowering pre-dates the SNP's ascent, these comparisons are also used to formulate pro-independence arguments: the Scottish Government is making a real difference to children's lives despite its limited devolved powers, imagine what it could do with more (Believe in Scotland, 2024; SNP, 2024).

Fig. 9b: Children in relative poverty in Scotland and England, 1994-2023 (Francis-Devine, 2024)



Part of Lynch's (2020) argument is that health inequality is a useful agenda for politicians who wish to present themselves as interested in reducing inequality without implying redistribution. She quotes an English New Labour activist (p93): "*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*". For the SNP, signalling interest in reducing child poverty is also a way to 'kick' the government in Westminster, whether Tory or Labour (Swinney, 2024a), to 'say you are child harmers'. In this way, the SNP can talk about the UK government killing Scots with their inadequate drug policy, and harming children with its inadequate economic policy, to

enhance its portrayal of distinctive Scottish egalitarianism, and to bolster its pro-independence arguments.

But the SNP and independence supporters are less able to 'kick the Tories' about health inequalities, because English health outcomes tend to be better than Scottish health outcomes, because health inequalities within Scotland have generally not been reduced, and because 'health' is fully devolved to Scottish control. In this context, therefore, 'health' is a hindrance to a political agenda aimed at reducing inequalities, or at 'kicking the Tories'.

Further, if Lynch is correct that health inequality is a useful agenda in an English context because it does not imply economic redistribution, Scottish egalitarianism means this is less useful in Scotland. Although distinctly Scottish egalitarianism may often be exaggerated (Law & Mooney, 2006), Scots survey respondents do claim to be in favour of redistribution in greater numbers than English survey respondents. In a 2001 survey, 61% of Scots were in favour of economic redistribution compared to just 36% of respondents in England (Lindsay et al., 2001). In 2020, 72% of Scots agreed that the distribution of income in Britain was unfair, compared to 64% in England (Curtice, 2020). Therefore, in a context where economic redistribution is less frightening, health inequality may lose part of its political 'usefulness'.

9.4.1d How might Levelling Up or Wellbeing fare within distinctly Scottish egalitarianism?

It is this context, where redistribution is less taboo, and where egalitarianism is strongly promoted alongside national identity by the ruling SNP party, in which all three candidates for the SNP leadership and role of First Minister (FM) were able to commit to redistributing increased taxes from higher earners to children in low-income families; and in which new FM John Swinney described 'eradicating' child poverty as his *"foremost priority in government*" (Swinney, 2024a). It seems clear that distinctly Scottish egalitarianism has facilitated the highest political prioritisation of child poverty, which could have highly beneficial impacts on child health outcomes and on health inequalities (McCabe et al., 2024). As welcome as this may be, political attention to child poverty should not preclude attention to other important determinants of systematic and unfair health variations. Therefore, it is worth asking how additional alternative agendas to reduce systematic variations in population health, as suggested by my interview participants in section 8.4.4, might fare in this political context.

One senior health policymaker in Scotland was very positive about 'levelling up', crediting it as having the potential to "*unlock passion or momentum or action*", rather than merely re-describing the problem. 'Levelling up' even has a history of representing policy approaches to health inequality, as it was the title of a widely-cited duo of reports for the European office of the WHO (Whitehead & Dahlgren, 2006; Dahlgren & Whitehead, 2006). Further, 'levelling up' proved that it could be politically attractive by being a prominent part of the winning Conservative manifesto in the 2019 UK general election. Conservative leader Boris Johnson promoted 'levelling up' as the solution to the problem of 'left-behind' communities suggested by analysis of the motivations of those who voted for Britain to leave the EU (Wright & Case, 2016).

But 'levelling up' may presently be unusable by an SNP government who wish to differentiate, not associate, themselves with the Conservatives. Rather than agreeing with the agenda as matching their own promotion of egalitarianism, the SNP have specifically sought to associate 'levelling up' with the Conservatives and corruption (SNP, 2023). The UK Labour government elected in 2024, who may also be expected to agree with the principles behind 'levelling up', also sought to differentiate themselves from the Conservatives within days of their election victory by changing the name of the 'Department of Levelling Up, Housing and Communities' to the 'Ministry of Housing, Communities and Local Government'.

Participants in my data also widely supported 'wellbeing' rather than 'health', or a 'wellbeing approach' or 'wellbeing economy', more broadly. In my analysis, 'wellbeing' is preferred to 'health' for two key reasons: it closely aligns with the social model of health, whereas 'health' is regularly accompanied by biomedical and individualistic assumptions; and it bears no relational baggage within policy settings, in contrast to 'health', which is closely associated with 'health policy' and various competitive and resentful perceptions. These findings support the contention of Walker and John (2012) that 'wellbeing' is a preferable term to describe the aims of public health as it is more likely to engage a broad range of policy actors and stakeholders, with less risk of medicalisation or individualisation.

The Scottish Government has already been promoting the development of a 'wellbeing economy' (see section 3.5), so it must be considered to be at least somewhat compatible with the SNP's promotion of a distinctly egalitarian Scotland pursuant of social justice. However, 'wellbeing' was variously described by my participants as "*a broad brush*", "*a*

tricky customer", "*very fluffy*" and twice as "*nebulous*". It faces the same challenge as 'inclusive growth' of needing definition for operationalisation, while also needing to retain support which may be based on varying understandings of the idea (Hill O'Connor et al., 2023).

As of summer 2024, new FM John Swinney has renamed the Scottish Cabinet Secretary post from 'Wellbeing Economy, Net Zero and Energy' to 'Net Zero and Energy'; and in a speech to parliament outlining his four priorities for government, described his second priority as "*to grow Scotland's economy*", which goes "*hand in hand*" with eradicating child poverty, without using the term 'wellbeing' at all (Swinney, 2024b). This seems to be a return to earlier SNP values, articulated by then-leader Alex Salmond in 1998 as "*the twin values of compassion and enterprise"* (quoted in Henderson & McEwen, 2005, p185), and a step back from ambitious Wellbeing Economy plans. Coupled with the strong emphasis on growth of the newly elected UK Labour government (Labour, 2024), it seems that the struggle to conceive of 'prosperity without growth' (Jackson, 2016) or to move 'beyond GDP' (Stiglitz et al., 2018) remains deeply challenging in the UK political context.

Despite this apparent retraction of support for 'wellbeing' as a core driver of government action, it may still play an important role in Scottish policymaking. 'Wellbeing economy and fair work' is one of thirteen proposed National Performance Framework outcomes, while a Wellbeing and Sustainable Development (Scotland) Bill is in development. Moreover, the conceptual distinction made by the 'Care and Wellbeing Portfolio' seems to me a useful one; although it may be useful as two distinct Portfolios, rather than just one dominated by health actors. When healthcare and public health functions are united within 'health policy', there only appears to be one possible winner; while public health teams face resentment-by-association with powerful healthcare teams. Any new approach which is able to clearly distinguish between healthcare policy, and policy for wellbeing, seems more likely to create space for the social model of health, and for cross-departmental collaboration.

9.4.2 "*This is Manchester, we do things differently here":* How might 'health inequalities' fit with key narratives in Greater Manchester?

The key finding of Chapter 7 of this thesis was that the dominant axis of health inequality in GM policy texts – the health disadvantage of GM residents compared to external others –

was part of an organisational strategy of promoting differentiation to enhance arguments for devolution. Taylor (2020, p1) describes the "*political narrative of difference*" constructed by GMCA mayor Andy Burnham, who launched his first manifesto with the slogan "*This is Manchester, we do things differently here*". Health inequalities were also framed as part of this narrative, emphasising GM's difference from England to national government as part of efforts to gain additional powers and resources.

I then compared this GM differentiation to similar narratives of distinction around the time of Scottish devolution, as part of arguments for those new constitutional arrangements, which were then further emphasised by the SNP in its promotion of full independence for Scotland. But this process of distinction between Scotland and England extends through hundreds of years of debate, several battles or wars, different languages, a separate legal system and more. The process of distinction between Greater Manchester and England, the identity-building of a "*mental construct called Greater Manchester*", has emerged over fewer than 40 years (Harding & Peake-Jones, 2023, p12). This makes it much less likely that a political identity shared by Greater Mancunian voters can be specified which shapes policy agendas in a similar way as in Scotland, beyond the long-held tendency of voters in Greater Manchester to favour Labour over Conservative representatives.

Instead, it seems likely that the political project of constructing and embedding Greater Manchester will continue to have a strong influence on which policy frames are adopted or not by GMCA. Harding and Peake-Jones' description of Greater Manchester as a "*mental construct*" highlights that places are also subject to framing processes, which are contingent and changeable, and which both include and exclude ideas of place, function, history and identity. As Hoole and Hincks (2020) describe in a case study of nearby Yorkshire, policy actors competed to frame spatial-economic imaginaries to align with UK central government criteria for devolution: the Sheffield City Region (SCR) was originally successful against the One Yorkshire region supported by Doncaster, Barnsley and other local authorities who rejected Sheffield's dominance. But the opposition to SCR persisted and now the devolved regional authority is known as the South Yorkshire Mayoral Combined Authority.

Greater Manchester appears to have a much surer footing as it moves towards hegemony, being built on decades of stable leadership and collaboration among neighbouring local authorities (Haughton et al., 2016; Kenealy, 2016), and having already resisted challenge

from alternative framings such as 'Mersey Belt', 'Northern Powerhouse' and 'Core Cities' (Hoole & Hincks, 2020). For one of my GM participants, quoted above in section 7.2.1, Burnham's public prominence was a key factor in their prediction that Greater Manchester would now 'stick':

> *"It's harder to churn an actual organisation with a political head who's got their own mandate […] you can't abolish the Scottish Government now because it's got its own independent civic identity […] we've now got a relatively prominent politician with a city-wide mandate who's done two terms, it just sort of sticks, is my feeling"* [GMP07O]

In section 7.2.1, I described more recent GMCA texts as showing concern for *both* the health disadvantage of GM residents compared to England, *and* within-GM health disadvantages. GM interviewees described a change in the "*local political conversation*" that encouraged more of an inward focus. This tension is described by Deas et al. (2021) as leading to "*a range of locally distinctive approaches*" (p188) to economic development, particularly by local authorities who perceive few benefits to the dominant agglomerative approach which tends to favour more central and affluent areas. For Deas et al., "*there is no longer such a thing as a singular uncontested Manchester model*" (p192), which poses obvious risks to a singular model of Greater Manchester.

Therefore, the question is whether the deepening establishment of Greater Manchester as a spatial-economic imaginary, and of GMCA as its corollary political institution, will lead to a long-term focus on GM-disadvantage to embed the differentiation with England; or to within-GM inequalities, to maintain the support of local policy actors, particularly those representing more deprived areas. There is reason to suspect both axes shall remain important for the foreseeable future, and a balance shall have to be sought as new narratives and conversations develop to shape political agendas.

In this context, the commissioning of both a health inequality strategy in 'Building Back Fairer in Greater Manchester' (Marmot et al., 2021) and an Independent Inequalities Commission report (Pickett et al., 2021) signals a strong interest in tackling inequality to the largely pro-Labour Greater Manchester electorate, despite GMCA's highly limited levers. It also fits with Burnham's narrative of difference with national government. An important part of that narrative is that national government is siloed and out-of-touch, while

Burnham's GMCA is unified and collaborative, as he explained in a speech after commissioning Marmot's Greater Manchester work:

> "*Back in February 2010, I received the Marmot Review into health inequalities. Even if I had remained Health Secretary long enough to agree to full implementation, I wouldn't have been able to do it. As the review itself acknowledged, many of the policies that would determine people's health were not in the control of the Department of Health. Implementing the review's recommendations… would have required the full buy-in of the entire Whitehall machine. Knowing that world as I do, I am confident in saying that it would never have come. Whitehall departments like nothing more than fighting turf wars. Instead, we have a much better chance of implementing the Marmot Review from the bottom-up rather than top-down.*"
> (Burnham, 2018)

Early evidence suggests that GMCA's approach is both reducing GM's life expectancy disadvantage compared to England, and increasing life expectancy faster in more deprived areas (Britteon et al., 2022), driven by improvements to healthcare services and to social determinants of health (Britteon et al., 2024). Therefore, Burnham's prediction of 'bottom-up' success looks supportable, and could be used to make a case for other devolved city-regions to take similar approaches to health inequalities, particularly if they wish to both differentiate themselves from national government, and coalesce support for their new spatial-economic imaginaries. As this thesis has demonstrated, health inequalities are not only measures of systematic injustice, social problems to be earnestly addressed; they can also function as strategic presentations designed to invoke other political ideas lurking nearby in the frame.

Chapter 10: Conclusions

10.1 Introduction

This thesis sought to explore how policymakers in different teams within the devolved policy settings of Scotland and Greater Manchester consider systematic variations in population health. Within this broad aim were the following more specific questions:

- RQ1: How is health conceptualised by social, economic and health policy teams in these devolved settings?
- RQ2: How are inequalities conceptualised by social, economic and health policy teams in these devolved settings?
- RQ3: How is 'health inequality' conceptualised in these social, economic and health policy teams in these devolved settings?
- RQ4: What are the implications of these findings for efforts to reduce systematic variations in population health in these devolved settings?

In this final chapter, I shall summarise my findings in direct relation to my research questions. The first three research questions align neatly with previous chapters: RQ1 is explored across chapters 5 and 6; RQ2 is mostly discussed in chapter 7; and chapter 8 is most relevant to RQ3. On the other hand, RQ4 does not map so neatly to one chapter: implications of RQ1, RQ2 and RQ3 findings are distributed across all those chapters as part of their analysis, and further implications are discussed in chapter 9. Therefore, the final section of this chapter shall draw together some of those more important implications for further research and policy development.

10.2 How is health conceptualised by social, economic and health policy teams in these devolved settings?

On this question, the findings of this thesis broadly agree with previous literature – described in the literature review - that individualised conceptualisations of health are prevalent in health policy. Of the eight health policy texts analysed in chapter 5, half framed health or wellbeing individualistically, two contextualised health or wellbeing consistently, and two contained a mix. Chapter 5 illustrated these findings with analysis of 'lifestyle drift' in GM's Taking Charge: the Next 5 Years and of 'downstream drift' within the Scottish Government's Mental Health Strategy and PHS's Strategic Plan. Further, on three occasions, interview participants identified individualised conceptualisations of health in social or economic policy texts as being contributed by health policy strategies or colleagues. Despite this apparent individualising effect of health policy on conceptualisations of health, health policy interviewees resisted such conceptualisations.

In contrast to my findings from health policy settings, I found that individualised conceptualisations of health were infrequent in social and economic policy texts. Within the twenty-two social and economic policy texts analysed, just four repeatedly framed health or wellbeing individualistically, six others combined individualistic and contextual ideas, while twelve framed health or wellbeing consistently within socio-economic contexts. In both Scottish and Greater Mancunian contexts, social and economic policy texts featured conceptualisations of health or wellbeing that were more consistent with the social model of health than health policy texts.

Nevertheless, in interviews, social and economic policy participants often used 'health' to mean 'illness', 'ill-health' or 'disease', while no health policy participant used 'health' in this way. Therefore, while social or economic policy texts may contextualise health or wellbeing according to a social model of health, social and economic policy participants still discuss health largely in relation to an individualised medical model. These findings suggest that it is the social or economic focus of the written policy text that creates the contextualisation, rather than the beliefs or understandings of the actors in different policy settings.

In chapter 6, I described how social and economic policy actors used 'health' as shorthand for 'health policy', giving a new perspective on 'Health in All Policies' (from the vantage point of policy areas beyond 'health') as a potentially competitive imposition of a more powerful policy domain. Social and economic policy participants described more

"*evangelical*" approaches of population health teams, at times "*pissing people off*" and "*undermining*" population health aims, or alternatively of needing to "*battle, all the time*" to get NHS colleagues to consider wider determinants of health. In short, population health policy actors were criticised for crossing boundaries, while healthcare actors were criticised for attempting to maintain them. Other social and economic policy participants associated a particular evidence culture with health policy, which led to fears of rigorous challenge about health claims. Still other participants described health policy and NHS colleagues as having a higher status than themselves in the eyes of decision-makers. Therefore, social and economic policy actors sometimes seemed mistrustful of, and somewhat resentful towards, health policy actors, largely due to the perceived power and status of healthcare.

Partly for this reason, social and economic policy actors were enthusiastic supporters of 'wellbeing' as an alternative aim of policy. 'Wellbeing' was not associated with a powerful and competitive policy domain, and therefore carried none of the relational baggage of health policy. Further, wellbeing aligned better with the social model of health: social and economic policy actors were able to connect their own work with 'wellbeing' easier than with 'health', which had narrower, more medical connotations, and may be subject to contestation. Wellbeing's ambiguity made it easy for non-health teams to support; although participants from various policy settings also expressed some awareness of risks arising from this ambiguity.

Meanwhile, self-aware health policy participants described the "*mistrust*" of other policy teams, who they felt resented the ever-protected budget of "*fortress health*". Health policy participants engaged in 'Health in All Policies'-type (HiAP) approaches attempted to minimise distrust and suspicion from other policy departments by offering resources, and by compromising on collaborative goals. Yet this required a tightrope act: they sought to avoid "*pissing people off*" by emphasising the importance of health outcomes; but minimising the importance of health might also minimise their own relevance to discussions.

10.3 How are inequalities conceptualised by social, economic and health policy teams in these devolved settings?

A key interest of this thesis has been exploring prior suggestions from Asthana et al. (2013), Douglas (2015), Lynch (2017, 2020) and others that 'health' distracts from 'inequalities'. This compelled me to avoid being similarly distracted: I wanted to analyse

conceptualisations of 'inequalities' as well as conceptualisations of 'health'. Here, previous literature has largely focused on the connotations of terms such as 'inequalities', 'inequities', 'disparities' and 'variations' following 'health'; particularly how they might depoliticise or politicise such patterning (Braveman, 2006; Ward et al., 2013; Arcaya et al., 2015; Kriznik, 2015; Collyer & Smith, 2020). In this thesis, I mostly wanted to understand who was identified as suffering an inequality compared to who else. This interest was sparked by reading, in the GM text Transforming the Health of Our Population (2019, p28), "*our cancer survival rates of 69.9% compare well nationally*". I recognised this as subtly having an alternative, less-positive meaning for those of us who do not live in Greater Manchester. Therefore, what motivates policy text framings of health inequality? What are the policy impacts of choosing different comparison groups? And what are the implications for those who may be subtly omitted from such framings?

The key finding of chapter 7 was that policy texts in GM mostly characterised systematic variations of health as producing 'poor us' outcomes: GM residents suffered various health disadvantages in comparison to England. Several participants in GM suggested this was part of an organisational strategy to continually make the case for devolution powers and resources by emphasising the needs of Greater Manchester and its difference from England. With increasing confidence about the long-term viability of GMCA, and with local conversations now changing, framings of health inequality in later GM texts shifted to look more at disadvantages between parts of Greater Manchester: therefore, attention was turning to the 'poor among us', in addition to the 'poor us' comparison with England.

Notably, the 'poor us' characterisation was almost completely absent from Scottish policy texts, despite evidence that Scottish residents do have worse health on average than other British or Western European residents. Unfortunately, despite my questions about this absence, no Scottish policy participant was able to offer an explanation. In section 7.2.2, I discussed the political risks and benefits of 'poor us' and 'poor among us' framings, and the relatively high political salience of the 'drug deaths emergency'. Unfortunately, I also had limited data about the 'drug deaths emergency'. I believe this is partly because I too was misdirected by the framing effect of 'health inequalities': I did not contact the drugs policy participant suggested to me by a colleague, intuitively considering their work not sufficiently relevant to my interest in health inequalities. Therefore, further research could

modify or strengthen the analysis of this section by providing insightful data from relevant policymakers.

A further notable finding was the total absence of the 'social gradient in health' framing from any policy text in either corpus. In section 7.3, I analysed the implications of this finding. I found that the Scottish Government could plausibly claim to be addressing the gradient using an existing array of policy initiatives; but that the cognitive challenge presented by the framing, and the perceived weakness of additional moral force it added to existing health-disadvantage conceptualisations, provided little motivation to do so.

Finally in chapter 7, I analysed patterns of passivisation, adjectivisation and nominalisation in the policy texts, to show that the style of writing used across both corpuses portrayed disadvantage and deprivation as pre-existing states of no known origin. This depoliticises social and economic inequality and excludes the possibility of remedying it directly. Therefore, section 7.4 described how 'health inequality' often means a focus on those who are most 'health disadvantaged', while those who are most advantaged are spared scrutiny.

10.4 How is 'health inequality' conceptualised in these social, economic and health policy teams in these devolved settings?

As discussed in chapter 8, 'health inequality' was used in three distinct ways in these devolved policy settings: to mean widespread illness-related economic inactivity; to seek the improvement of healthcare for disadvantaged groups; and to describe the social injustice of systematic variations in population health more generally.

This first understanding of health inequality, found in economic policy settings, does not include considerations of social patterning, of injustice, or of prevention by upstream policy; instead it constitutes the problem as economic, and the solution as largely medical. This policy frame was a high political priority in both Greater Manchester and Scotland. In my analysis, this frame provided opportunities for collaboration between economic and health policy teams, but also presented risks, particularly while solutions were continually sought within healthcare rather than, for example, elsewhere in economic policy.

The second of the three health inequality policy frames resulted from the conflation of 'healthcare' and 'health', was institutionalised within two teams within the Scottish Government's DG Health, and was promoted by the First Minister of the time, Humza

Yousaf. I discussed this policy frame, and the continuing policy conflation of 'healthcare' with 'health', in section 8.3. In my analysis, health policy teams having responsibility for health inequality creates a situation where 'health inequality' inevitably struggles for political attention and resourcing.

In contrast to the first two version of health inequality, the third version of health inequality – the one promoted by an 'international consensus' of researchers - was struggling for coherence and attention in these policy settings. For example, the Scottish Government's Care and Wellbeing Portfolio not only omitted the word 'health' from its name, it also reframed its mission from 'reducing health inequalities' to 'reducing inequalities', specifically in an attempt to avoid the medicalisation of policy responses described by Lynch (2017, 2020). Although removing 'health' seemed to improve cross-departmental relations, it did not change the levers available to the DG Health-based group. Therefore, in both this approach to health inequalities, and for unrelated HiAP approaches, minimising 'health' seemed to improve cross-departmental relations, without necessarily improving policy decisions on social determinants of health inequalities, which remained beyond the scope of health policy actors.

These findings reflect the basic conceptual incongruence between policy structures for health and a social model of health. The policy actors with most interest in reducing systematic variations in population health have direct access only to healthcare levers; therefore, 'health inequalities' becomes reshaped either to mean healthcare inequalities, or to mean inequalities in determinants of health over which health policy actors have little-to-no control.

Then, I explored the supposed 'political suicide' of redistribution, as one senior health policymaker in my research followed health policymakers in various previous settings in using extreme terms like "*political suicide*", "*socialist revolution*" and "*Marxist command-economies*" to associate reducing economic inequality with radicalism or danger. This is directly relevant to Lynch's (2017, 2020) contention that 'health' solutions are sought because redistribution is 'taboo'. Yet, while redistribution as a solution to health inequality continues to evoke 'red scare' words, there presently appears to be an open policy window for redistribution as a solution to child poverty in Scotland.

Related to this, I addressed the possibility (suggested by many of my health policy participants) that policy frames other than 'health inequalities' might be more effective at

preventing systematic and unfair variations in health. Many of my participants offered alternative suggestions, which all excluded the word 'health'. This raises important questions about the viability of future agendas to reduce health inequality, and whether the best route to reducing health inequality may lie outside of health policy departments.

I further analysed these latter two findings in chapter 9, expanding on findings by Blackman et al. (2012) and Lynch (2016) to posit a key relationship between policy frames (such as 'child poverty') and political narratives concerning Scottish devolution and independence. In this analysis, I discussed the construction by political actors of a 'distinctly Scottish egalitarianism'. In this political context, a flagship egalitarian agenda to reduce child poverty appeared politically safer and practically more straightforward than one to reduce health inequalities. But in England, where 'Greater Manchester' itself remains in a process of construction, the collaborative approach required to reduce health inequality appears to align with Andy Burnham's narrative of political difference from Whitehall.

10.5 What are the implications of these findings for efforts to reduce systematic variations in population health in devolved settings?

This research largely supports existing research on, for example, the conflation of health with healthcare (Bambra et al., 2005) and the risks of health expansionism (also known as 'health imperialism') to Health in All Policy approaches (Cairney et al., 2021). This research supports the key implication of Lynch (2017) and others that 'health inequalities' has unintended framing effects which act to medicalise potential policy solutions to social inequality; and it extends the political economic analysis of Lynch (2020) by focusing on policy conceptualisations of the words 'health' and 'inequalities' both separately and together.

This has important implications for other policy and research domains using the word 'health', such as 'mental health' and 'public health'. As already mentioned in section 5.2.3, there is already a substantial critical literature alleging the 'mental health' paradigm of medicalising 'misery' (Pilgrim & Bentall, 1999); 'social problems' (Moncrieff, 2010); or even 'everyday life' (Fawcett et al., 2020). Therefore, my findings also have relevance to policy

approaches to population mental health, and prompt further questions about 'public health', 'population health' and other framings including 'health'. New research might usefully explore further areas where the inclusion of 'health' within a policy frame might have counter-productive impacts, and whether alternative policy frames may avoid such impacts.

Further, this thesis contributes two additional elements to political and ideational analyses of policy approaches to health inequality. Firstly, it connects framings of health inequality with literatures on devolution, political identity, and spatial-economic imaginaries by highlighting the use of health comparisons by sub-state polities to construct differentiated identities and claims for further powers. By understanding political representations of health comparisons in this way, health inequalities become further 'de-naturalised', and better understood for their broader political functions. This can only encourage a deeper critical engagement with policy framings, for both the 'reality' that they represent, and the function that their representation is intended to serve.

Secondly, this research finds two further 'health inequalities' policy frames - in addition to the 'International Consensus' frame described by Lynch (2020) - which compete with it for policy attention and resources, and presently seem to be achieving higher political prioritisation. This finding highlights how policy frames which fit with existing policy paradigms – of economic policy and healthcare policy – are much more likely to succeed than those which fundamentally misalign, such as the 'international consensus' frame. This should prompt further research and thinking about how to construct a policy frame or frames targeted at the injustice of systematic variations in population health which aligns with policy paradigms; while also considering whether new policy paradigms might plausibly be constructed to facilitate such ends.

I make one specific suggestion in this regard. The main findings of chapters 5 and 6 - that 'health' is often conceptualised biomedically and often used as shorthand to mean 'health policy' - are neatly counter-balanced by the findings of section 5.3.4 and 6.5: that wellbeing is understood to have a broader meaning than biomedical health; that it aligns with the social model of health as described by social and economic policy actors; and that it is not associated with any particular policy team, far less a powerful or resented one. 'Wellbeing' has conceptual challenges – including those described in section 6.5.4 - but it does not suffer from either of these two key conceptual challenges of 'health'.

In section 6.3.2, I described how healthcare actors ("*clinicians*" and "*the NHS*") were criticised for apparently resisting efforts to consider the wider determinants of health, while population health teams were criticised for being "*evangelical*" in crossing policy boundaries to promote 'Health in All Policies'. This conceptual confusion seems inevitably to lead to disappointment and frustration, as some health policy actors acting on healthcare inequalities fail to reduce overall health inequalities as billed; while others tread a tightrope between trying to influence colleagues to act on their behalf on social determinants of health, without provoking resentment or distrust.

Further, as described in section 8.3.1, policy approaches to health inequality – and indeed policy approaches to preventative public health – will always remain firmly secondary to healthcare while they are led from the same departments. The political imperative to focus on highly visible healthcare outcomes is always intense. The framing effect of 'health' in 'health inequality', I argued, implies that the hard-working staff and suffering patients of the NHS must suffer more, now, to pay for preventive action on future suffering, which may never be observable. This implied trade-off is both false, and unwinnable.

A clearer conceptual divide – perhaps between 'healthcare' and 'wellbeing' – would enable clinicians to focus on the clinical needs of patients, as they are most able to do, while also allowing population health teams to disassociate themselves from healthism and from the resented budgets and status of the NHS. It may also provide clearer terms for public and policy debates about funding reactive or preventive approaches to health.

The Care and Wellbeing Portfolio of the Scottish Government appear to have already alighted on the need for this conceptual divide, as seen in its name. Yet it remains within DG Health, with a Board dominated by DG Health and NHS actors, and so (as my interviewee said): "*we give more emphasis to the care element*".

Therefore, the central implication of this research is to encourage the division of 'health policy' into distinct *healthcare* and *wellbeing* strands, the former representing the medical model of treating illness and already well established in policy institutions; the latter representing the social model of ill-health prevention and requiring further development across settings. It is to this project that researchers, practitioners and policymakers may now helpfully turn: while healthcare actors reduce healthcare inequalities, how might the rest of us reconstitute public and population health structures and processes as *wellbeing* teams focused on the upstream prevention of systematic variations in population health?

In a chapter titled ‘Beyond ‘health’ – Why don’t we tackle the causes of health inequalities?’, Douglas (2015, p121) argued similarly to Lynch that “*we have focused on ‘health’ – usually understood to mean health care and behavioural interventions - rather than ‘inequality’*”. As economic thinkers continue to explore how to move ‘Beyond GDP’ (Stiglitz et al., 2018) in search of greater social wellbeing, the challenge for those of us interested in limiting the proliferation of preventable illness will be to explore, and to lead others, ‘Beyond ‘health’’.

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Appendix A – Consent Form and Information Sheet for interview participants

Participant Information Sheet

Name of department: School of Social Work & Social Policy
Title of the study: *How do social and economic policymakers approach health inequalities?*
(As part of the UKPRP SIPHER Consortium (Systems Science in Public Health and Health Economics Research))

Introduction
Doctoral researcher Ally (Alistair) Brown is conducting interviews for the SIPHER project, supervised by Professor Katherine (Kat) Smith and Dr Gillian Fergie. Contact details are on p3.

What is the purpose of this research?
SIPHER is a major investment by the UKPRP (UK Prevention Research Partnership), which brings together scientists across six universities, three government partners at local, regional and national level, and ten practice partner organisations. It is led by Prof Petra Meier and Dr Corinna Elsenbroich, both at the University of Glasgow, and Julian Cox, of Greater Manchester Combined Authority (GMCA). The long-term vision for SIPHER is to collaborate with policy partners to support a shift from health policy to healthy policy. This means working together to tackle health inequalities and improve the health of the public. More details about SIPHER's overall aims, the eight workstreams, SIPHER's policy partners and the research team can be found on the SIPHER website: www.sipher.ac.uk

Ally's research specifically relates to policy approaches to health inequalities. Ally has looked closely at recent Scottish Government policy strategy texts to see how they frame 'health' and how they frame 'inequalities'. He is interested in how and why this may vary across different policy departments, and particularly how non-health policy approaches may differ from health policy approaches. Ally intends to discuss these issues in the interviews.

Do you have to take part?
It is your decision to take part in the research or not (i.e. participation is voluntary). Further, if you do agree to participate, you can withdraw from the research at any point, without consequence or detriment. If you would like to withdraw, simply let Ally know. You do not have to provide reasons for your decision.

What will you do in the project?
You are being asked to take part in an interview as part of Ally's PhD at the University of Strathclyde, connected to SIPHER's Workstream 1 (Understanding Policy). The interview questions will focus on your policy knowledge and expertise. The interview requires no preparation and will involve a structured conversation led by Ally, who will ask you a series of questions. If you are willing to be interviewed, Ally will arrange a time and date that is convenient for you. The interview will take place online, using your preferred online

platform, such as Zoom, MS Teams or another. You can request an in-person interview if you would prefer. Interviews are likely to last about an hour.

Why have you been invited to take part?
You have been asked to participate due to your expertise in a policy area that Ally has been exploring, such as planning, housing, transport, or health, and/or due to your employer's involvement in SIPHER.

What are the potential risks to you in taking part?
There are unlikely to be any significant risks to taking part, especially as the transcripts will be anonymised. However, it is possible that some interviews will include information that is considered sensitive to policy partners or that individuals may make statements that inadvertently identify them. To minimise these risks, Ally will anonymise all data before use and is also happy to share transcripts with interviewees, if requested. In addition, SIPHER's policy partners will be able to view draft outputs before they are submitted to conferences, blogs or journals. The PhD thesis will be accessible once approved by examiners via the University of Strathclyde library, or directly from Ally on request.

What information is being collected in the project?
Ally would like to record interviews using either the recording function of Zoom or Teams, or an encrypted digital recorder, and will seek your consent for this. Both approaches mean the digital recordings are encrypted and only available to Ally. No personal information will be collected. Zoom video recordings will be immediately deleted. Ally may also take brief notes. If you agree to be interviewed but do not consent to it being audio recorded, then Ally will take notes of the full interview.

Who will have access to the information?

Only Ally will have access to any interview transcripts, recordings or notes. After anonymising all transcripts and notes, the anonymised transcripts and notes will constitute research data for Ally's PhD (connected to SIPHER Workstream 1). Anonymised transcripts will be accessible to Kat and Gillian if required. If you agree to have your interview recorded, it will be transcribed in full by an external, UK-based company (JHTS) with whom a confidentiality and non-disclosure agreement is in place. Extracts from the anonymised data may be used in project outputs (e.g. thesis, conference presentations, blogs, journal articles or book chapters).

Where will the information be stored and how long will it be kept for?

If using the recording function on Zoom or Teams, Ally will automatically receive an audio-video recording (separated into two files in Zoom), and a transcript (the original of which is securely stored on the University of Strathclyde's cloud – it is encrypted and only accessible to the person who undertook the recording, i.e. Ally). Zoom video files will be deleted as soon as they are received. Ally will immediately transfer the audio recording and transcript onto the University of Strathclyde's secure server, using a folder which will only be accessible to him. Once Ally has checked the transcripts for accuracy and anonymity, any audio recordings and automated transcripts will also be deleted.

If using another online platform, meeting in-person, or if you prefer Zoom's or Teams' recording function is not used, the interview will be recorded on an encrypted digital

recorder. The audio will then be uploaded to a secure University of Strathclyde server and deleted from the digital recorder. As soon as Ally has checked transcripts for accuracy and anonymity, any remaining audio recordings of the interview will be deleted.

In all cases Kat and Gillian will only be able to access anonymised transcripts of the interviews. These will be shared via Strathclyde's secure data-sharing platform. SIPHER has a Collaboration Agreement in place which commits all team members to not sharing any data beyond the SIPHER team members and Strathclyde is a signatory to the agreement. Anonymised transcripts will be stored securely on a University of Strathclyde server until the end of Ally's PhD, and then at the University of Glasgow until the end of SIPHER. Ally may keep the anonymised transcripts beyond this time if they are still useful for research, but they will still be stored on a secure server, and only Ally will have access. Ally will delete the anonymised transcripts permanently when they are no longer needed for further research.

Thank you for reading this information – please ask any questions if you are unsure about what is written here.

Please also read our Privacy Notice for Research Participants

What happens next?
If you would like to find out more about SIPHER or are interested in SIPHER's findings and outputs, you can visit the project website (www.sipher.ac.uk) or email Ally. If you are willing to participate, you will be asked to sign a consent form (as shown on the next page). If you do not wish to participate, then please let Ally know and, in that case, we thank you for your time and consideration.

Researcher contact details:
E-mail alistair.brown@strath.ac.uk or text 07768 411091

Supervisory team details:
Kat Smith: Katherine.Smith.100@strath.ac.uk
Gillian Fergie: Gillian.Fergie@glasgow.ac.uk
Postal address: School of Social Work & Social Policy, Lord Hope Building (6th Floor), University of Strathclyde, 141 St James Road, Glasgow G4 0LT.

This research was granted ethical approval by the University of Strathclyde Ethics Committee. If you have any questions/concerns, during or after the research, or wish to contact an independent person to whom any questions may be directed or further information may be sought from, please contact:

Secretary to the University Ethics Committee
Research & Knowledge Exchange Services
University of Strathclyde, Graham Hills Building
50 George Street
Glasgow G1 1QE

Telephone: 0141 548 3707
Email: ethics@strath.ac.uk

Consent Form

Name of department: School of Social Work & Social Policy
Title of the study: SIPHER (Systems Science in Public Health and Health Economics Research)

I confirm that I have read and understood the Participant Information Sheet for the above project and the researcher (Ally Brown) has answered any queries to my satisfaction.

Statements for which we are seeking consent	**Please tick confirm**
I confirm that I have read and understood the Privacy Notice for Participants in Research Projects and understand how my personal information will be used and what will happen to it (i.e. how it will be stored and for how long).	☐
I understand that my participation in interviews is voluntary and that I am free to withdraw from them, up to the point of completion, without having to give a reason and without any consequences.	☐
I understand that I can request the withdrawal from the study of information given and that whenever possible researchers will comply with my request. This includes the following personal data: ● Audio recordings of interviews that identify me; ● Information about me in transcripts.	☐
I understand that anonymised data (i.e. data that do not identify me personally) cannot be withdrawn once they have been included in the study.	☐
I understand that any information recorded in the research will be treated as confidential and no information that identifies me will be made publicly available.	☐
I consent to being a participant in the project.	☐
I consent to being audio and/or video recorded as part of the project. I understand that I can turn my video off at any point during an online video interview to withdraw consent for video recording.	☐

Please type your name in the box below and email this form back to Alistair.brown@strath.ac.uk

We will consider this as proof of consent but will also check verbally at the start of the interview.

Participant Name [type name]:	Date:

Appendix B – Example interview schedule

Interview Schedule – How do social and economic policymakers approach health inequalities?

Below is an interview schedule describing the introductory remarks and broad question set that I plan to use during interviews for this research.

Depending on answers given, and time constraints, I may not ask all of these questions, or I may ask them in a slightly different order. I may also ask respondents to elaborate on specific aspects of answers given. I am not able to predict those answers or follow-up questions in advance.

Prompts: I may show participants interesting sections from policy documents to help recollection.

Sample: GMCA and Scottish Government policymakers involved in constructing 'inclusive' social or economic policy agendas and health policymakers.

Introduction

- My name is Ally, I am doing a PhD as part of workstream 1 of SIPHER, based at the University of Strathclyde, and this interview forms part of my PhD research.
- I am recording this interview, I'll delete the audio as soon as I've checked it's been transcribed accurately, let me know if you've got any questions about that or if it's not OK.
- The aim of this research is to understand how policymakers conceptualise 'health' and 'inequalities', how that may vary in different teams, and how that may shape policy approaches to health inequalities generally.
- I expect the interview to take around an hour or so, but if you want to stop at any time, just say so, it's absolutely fine, you don't need a reason. Excuse me if I interrupt once or twice, that'll just be if I've got more questions I want to get to while we've got time.
- I'll then go through the transcription and anonymise it, so I'll remove any information that would give clues as to who you are, or specific people you talk about. So if I use any quotes from this interview in my thesis or in any publications or presentations, I won't use your name or job title and I won't use any specific information that somebody could use to identify you. So, everything you tell me today will be treated as confidential.
- Do you have any questions for me?
- Great, so, if you're happy to continue, we'll move on to the first part.

=== Proceed only if consent to continue is apparent ===

Non-Health Participants

1 General/Intro

1. Firstly, can you give me a wee intro about the day to day work you do for SG and how it might relate to SG's efforts to reduce inequalities?
    a. (Roles & responsibilities? How long at SG? What's your speciality, or do you consider yourself a generalist?)
    b. [keep eye on clock, can run on!]

2. And briefly about your background, what led you to where you are now?
    a. (Educational background? Other job experience? Other teams? Epistemology!)

2 Conceptualisation, Framing and Solutions Questions

GENERAL

OK, so, firstly I'm going to ask you a few general questions about the role of 'health' and of 'inequalities', and of 'health inequalities, in your work. Then there'll be a few questions about strategies you might've worked on, and finally a few questions about how things work at SG, how it's all organised and how people work together and so on.

1. So, firstly, is health part of the work you do? If so, how?
    a. (how do you approach health as a topic – do you have expertise within your team or would you seek help or advice from others? Who would you go to? How would you go about that?)

2. And then the same for wellbeing, is that part of your work?
    a. (what are the overlaps between health and wellbeing? What are the differences?)

3. And then, how does your work fit into the Wellbeing Economy agenda?

4. And then moving on to inequalities, there are lots of different kinds of inequalities of course -which types of inequalities do you feel are getting most attention at SG, and why?
    a. *[~Prompt: I'm thinking is it education or employment or health or place that's most important, or economic, or specific groups of people that need more help?~]*
    b. (Why are these inequalities most important? Moral, political, practical, EA, other?)

5. How would your team approach issues of equality or inequality – is that knowledge within your team or would you seek advice or help from others?
    a. Who would you go to? How would you go about that?
    b. Would you think differently if it was health inequality?

6. Speaking now about health inequalities specifically, how much of a priority would you say addressing health inequalities is to [your team]?
    a. (How can your team best contribute to reducing health inequalities? What do you lack? Are health inequalities rhetorically useful?)

7. How might health inequalities fit within 'the Wellbeing Economy' in your understanding?

8. How do you think about the interactions between health inequalities and other types of inequality?
    a. (How do health inequalities interact with housing inequalities? Are health inequalities more important than other inequalities? Why are [health] inequalities bad?)

9. In my research so far, I have found a preference in Scottish Government texts for framing health inequalities as disadvantages of "the most deprived areas", rather than for example, Scotland's poor health compared to the rest of Britain or Europe. Might there be reasons for the way these inequalities are framed?
    a. (Are some framings preferred for some audiences? Why? What are the benefits of certain framings?)

10. There's also not much sign in the texts I reviewed of the social gradient in health, which is a finding often emphasised by Michael Marmot and other health

inequalities researchers. Why might there not be any interest in a gradient perspective?

SPECIFIC *[only if direct/significant knowledge]*

So, moving on now, I have been looking at how thirteen SG policy texts approach health, inequalities, and health inequalities but are NOT health policy. If I can ask you to think to when you were working on the [TEXT] or [TEXT]

- What was your role in putting that together, or, how do you know about it?
- How does a document like that get drafted, do you know the process, roughly?
- What are the various aims of a document like that?
- How would a document like that approach a cross-cutting issue like inequalities?
- How might they have included health in the development of that text?

Then…

- [TEXT]
    - The concept of "Health" doesn't feature much at all in this written text, it is conceived as just a part of Human Capital. Can you tell me about this approach?
    - Is it superseded by 'wellbeing'?
- [TEXT]
    - The text frequently refers to quality of life, life chances and living standards. How do these relate to wellbeing?
    - Can you tell me about the Centre of Expertise in Equality and Human Rights that is proposed to advance economic policymaker understandings of equalities and human rights?

3 Policy Processes Questions

So, moving on now to talk about how things work behind the scenes,

1. In your understanding, who has responsibility for tackling health inequalities in Scotland?
    a. *[~~note: may name dept within SG, or NHS, or UK Gov, or individuals, or "everyone"…~~]*
    b. *[if various/"everyone", follow-up for 'main responsibility']*
    c. *[are they aware of Health Inequalities unit within Pop Health?]*

2. How do you think it works that [~previous answer~] have that responsibility?
    a. (What might they lack? Who else could take on responsibility?)

3. Can you tell me about the use of targets or indicators in [your department]?
    a. What are the key differences? Why use one or other?
    b. As far as you know, do other departments use targets or indicators in different ways?
    c. *[What I'm wondering is… do specific targets drag policy actions closer to the outcomes/towards linear (not systems) thinking?]*

4. What kind of relationship, if any, do you have with Public Health Scotland?
    a. (Do you lead, or do they lead? How do they differ from other teams in terms of collaboration? Do you appreciate their input? Are they easy to work with?)

5. And what kind of relationship do you have with the NHS?
    a. (Do you lead, or do they lead? How do they differ from other teams in terms of collaboration? Do you appreciate their input? Are they easy to work with?)

6. Have you heard of 'Health in All Policies'? What is your understanding of it? Are any similar approaches used in SG?
    a. *[~Prompt: HiAP is very popular at local levels in England / but other research has suggested non-health policymakers can be resistant to the*

idea/the prioritisation of 'health' above all else has been called 'health imperialism'~]

7. How did your work change during the pandemic?
    a. Might that have had any long-lasting effects? [*I'm getting at either: WFH effect on policy collaboration?; polarised further medical 'health' from non-medical 'wellbeing'?; increased salience or understanding of inequalities?*]

4 Wrap-up Questions

OK, just a couple of broad final questions now before we wrap-up, thanks very much for all your thoughts so far.

1. Is there anything you'd like to say that we haven't covered yet? Particularly about SG's approach to health inequalities.

2. Great, and, is there anything you'd like to say about this interview, anything I should have done differently?

3. And finally, is there anyone else in SG that you think might be interesting to talk to about all this, or interested to talk to me about it?

4. Anything else? Thank you so much.

Appendix C – Example Health Frames

Scottish Government – Mental Health Strategy (2017)

Causal Stories of HWB	Multiple causes of good and bad MH are identified. Poverty is described as "*the single biggest driver of poor MH*". Forms of trauma, including Adverse Childhood Experiences (ACEs), homelessness, experience of war, and displacement, are also highlighted as important drivers of MiH. Isolation, substance use, inequality, poor relationships, stigma and discrimination are all associated with poor MH. Various forms of treatment, help or support are good for MH, as is physical activity. Outcomes of poor MH include premature death, employment difficulties, smoking, poverty and costs to healthcare services. PH is closely linked to MH. Physical illness and disability are associated with poorer MH; physical activity and stopping smoking are beneficial to both.
Problems of HWB	Some groups are more likely to have mental health problems than others, including people who have experienced trauma, homelessness, or war, people with substance use problems, and people living in isolation. People with mental illness are more likely to die prematurely Mental and physical health do not have parity of esteem or treatment. Discrimination and stigma related to mental health remains a problem
Solutions for HWB	Solutions for MH are overwhelmingly based around improved support services. Early intervention is particularly important, so support needs to be accessible, and prevalent. This means joined-up MH support available in multiple public venues - in schools, police stations, prisons, GP surgeries - and aimed at high-risk groups, such as parents, children and young people. This will require substantially more investment, including new MH specialist staff in different setting and training of existing staff about MH issues and response. People with MH problems also need help to quit smoking, be physically active, and find work.

Actors for HWB	Joined-up and prevalent support services capable of early intervention requires multi-sectoral collaboration from the likes of NHS boards, councils, third sector workers, primary care practitioners, school counsellors, the Scottish Prison Service, Active Scotland, and SAMH. Children and young people are a particular focus, particularly those with care experience, young offenders, vulnerable children, disabled children, those with autism or learning difficulties. Veterans, refugees and asylum seekers, and armed forces veterans are also at higher risk of mental health problems.
Moral Language for HWB	*"Challenges with mental health have touched every life in Scotland"* *"It is unacceptable that people with severe and enduring mental illness may have their lives shortened by 15 to 20 years because of physical ill-health. This is a significant health inequality"* *"It is unacceptable that people with severe and enduring mental illness may have their lives shortened by 15 to 20 years because of physical ill-health. This is a significant health inequality"* *"It is crucial to consider the mental health needs of disabled children and young people"* *"Public health is failing this population"* Lots more examples.
Summary HWB Frame	There are many causes of poor mental health, including adversity or trauma, poverty, unemployment, isolation, disability, and discrimination. Support services should be embedded across public settings to improve accessibility and enable early intervention.

Scottish Government – Climate Change Strategy (2020)

Causal Stories of HWB	Good health is caused by access to woodlands and peatlands, comfortable and well-insulated homes, healthy diets, and bus or active travel. A just and green recovery will cause economic, social and environmental wellbeing so that everyone can live well.
Problems of HWB	Covid-19 has caused profound social, economic and health impacts, and led to thousands of people losing their jobs. Vacant and derelict land blights community health and wellbeing, and is especially prevalent in deprived areas.
Solutions for HWB	The creation of green jobs for the just transition will improve wellbeing. Improving the bus network, building active travel infrastructure and providing access to bikes and e-bikes will improve health and wellbeing by reducing emissions and increasing physical activity. Enhanced peatland protection, expanding new woodland, and a shared carbon registry will help promote nature, which benefits wellbeing. Investing in vacant and derelict land.
Actors for HWB	Scottish food producers and Food Standards Scotland can help Scots eat healthier diets. Scottish Forestry, and Forestry and Land Scotland, can enhance opportunities for people to access nature.
Moral Language for HWB	"*We know the huge opportunities that a transition to a fairer, more sustainable and greener economy can bring for Scotland, including in creating green jobs and wellbeing for everyone.*" "*This approach is at the heart of Scotland's ambitions to move to a wellbeing economy that prioritises society's wellbeing as the core aim of our economy*"
Summary HWB Frame	Our wellbeing can be enhanced by a just transition agenda that reduces climate emissions while tackling inequalities by creating green jobs.

AGMA - Places for Everyone (2021)

Causal Stories of HWB	Good health is caused by walking and cycling routes, as they both encourage active lifestyles and discourage motorised transport. Physical activity is good for mental and physical health. Motorised transport creates pollution, contributes to climate change, and causes road accidents. Good health is also caused by natural environments and green spaces, which enhance wellbeing and enable recreation. Good quality housing, and spaces for sports and child's play, also benefit health.
Problems of HWB	GM residents suffer many health and wellbeing problems due to air pollution. Low levels of physical activity also cause health problems in GM. GM residents have low life expectancies compared to the English average. Residents in more deprived northern areas of GM have poorer health than those in southern areas of GM.
Solutions for HWB	Improvements to the walking and cycling infrastructure, such as the Bee Network of paths, can increase physical activity and reduce pollution. Improvements to public transport infrastructure can also reduce pollution. The Clean Air Plan will reduce pollution in central areas. Parks, forests, rivers and canals (green and blue infrastructure) should be planned for and preserved to boost quality of life and facilitate physical activity.
Actors for HWB	AGMA is nine of the ten GM local authorities (Stockport withdrew from GM spatial plan). AGMA will work with the UK Government, Natural England, Highways England, Transport for Greater Manchester, and the NHS and local Clinical Commissioning Groups on enacting this plan.
Moral Language for HWB	"*GM has a wide range of attributes and enormous potential, but its long-term prospects will be contingent on delivering major improvements in public health. It cannot be considered a success unless existing health inequalities are addressed.*"
Summary HWB Frame	Health in GM can be improved by increasing walking or cycling, to both boost physical activity and reduce pollution. Attractive natural spaces, both green and blue, are also vital to wellbeing, and facilitate physical and social activity.

Appendix D – Example Inequality Frames

GMCA – Children and Young People's Plan (2019)

Causal Stories of Inequality	Lifelong disadvantage is caused by disadvantage in childhood, through diverging development pathways and educational attainment. Children with special educational needs (SEND), and those with care system experience, also face poorer outcomes both during and after school age.
Problems of Inequality	Children and young people in GM suffer many disadvantages compared to English averages: poorer communication, language and literacy in pre-school children; more children in poverty; poorer mental health, obesity, asthma, and life expectancy for GM children. Care-experienced children, SEND children, and children from disadvantaged backgrounds within GM, all face poorer outcomes.
Solutions for Inequality	Develop an EY Workforce Academy to improve workforce skills, establish integrated EY teams. Develop new pathways for families with complex needs. Embed a Curriculum for Life in schools so CYP prepared for life including relationships & sex, finances, politics and culture. Develop a SEND commissioning strategy for LAs, review SEND inclusion funding, develop a GM SEND Mediation Framework.
Actors of Inequality	Children with special educational needs and disabilities (SEND), looked after children, and care leavers, all need particular support. No further actors of inequality identified.
Moral Language of Inequality	GM should be "*a place where all children have the best start in life*". "*We will ensure that we support our children and young people, whatever their backgrounds and needs*"
Summary Inequality Frame	Children and young people in GM suffer many disadvantages in a national context, and disadvantaged, care-experienced and SEND children and young people are further disadvantaged within GM. Services can be refined in some technical and many aspirational ways, particularly for SEND.

Scottish Government - Vision for Trade (2021)

Causal Stories of Inequality	Trade has differential impacts globally, and within countries. Increased trade liberalisation creates both winners and losers. Trade can differentially impact employment, and therefore income, prices, and access to products and services. International trade can reduce poverty. Gender-focused trade policy can reduce gender-based employment inequalities. Differential impacts within and between countries can harm health outcomes. Brexit and Covid-19 had differential impacts.
Problems of Inequality	There are losers, as well as winners, from trade. Some people and communities will lose employment because of increased international competition. Women both shoulder the burden of unpaid care work, which trade may cause an increased need for, and rely more on public services, which trade may threaten. Higher prices due to elongated patents on drugs, for example, negatively impact lower-income people.
Solutions for Inequality	Trade policy should be negotiated with inclusive growth as one of its five core principles. SGs red lines for trade include building a fairer society, reducing inequality, and pursuing inclusive economic growth. SG will use trade to promote fair work and high labour standards, especially supporting "left-behind" areas. Tax gains from trade could be targeted to create jobs and invest in skills retraining Trade policy should be developed through a gender-focused lens.
Actors of Inequality	UK gov negotiates UK trade agreements. This text has 11 asks of them. Populations of interest include the winners and losers of international trade: the latter often means women, the young, low earners, and other marginalised groups.
Moral Language of Inequality	"*The Scottish Government recognises that trade policy is not neutral, depending on income, gender, ethnicity, position in the labour market, educational level and age, among other factors, and active steps need to be taken to understand its impacts and prevent or address these. Trade policy must be designed to take into consideration outcomes for different groups*"
Summary Inequality Frame	Trade creates winners and losers. There are differential impacts both between countries and within countries that must be managed and mitigated.

Scottish Government - Delivering Economic Prosperity: a National Strategy for Economic Transformation (NSET) (2022)

Causal Stories of Inequality	Poverty is caused by low pay, and causes lower productivity, unemployment, and economic harm. Lack of childcare, adequate transport, and disability, cause employment inequalities.
Problems of Inequality	Poverty and, in particular, child poverty, is a major problem in Scotland. Structural poverty and in-work poverty are also problematic. There is a 35.5 percentage point disability employment gap. Fewer women than expected start-up businesses. There are regional employment inequalities. A fifth of working-age Scotland is not working. A tenth of working-age Scotland have no or low qualifications. There is a 20 year gap in healthy life expectancy for those in the most deprived areas.
Solutions for Inequality	Fair work principles, including better wages, must provide a route out of poverty. The Young Person's Guarantee promises training, study or work to everyone 16-24. A similar guarantee for all ages will be targeted at those most disadvantaged in the labour market. Wraparound childcare for schoolchildren will enable parents to gain employment. Efforts to ensure everyone earns at least the Real Living Wage. The Scottish Child Payment has been doubled and will be extended to children U-16 in 2022.
Actors of Inequality	There are six priority family types at higher risk of poverty: lone parent families, the large majority of which are headed by women; families which include a disabled adult or child; larger families; minority ethnic families; families with a child under one year old; families where the mother is under 25 years of age. Help with careers is also needed by disabled people, women, and those with care experience or from ethnic minority groups. Local government, trade unions, businesses and entrepreneurs, and regional economic partnerships are key collaborators.
Moral Language of Inequality	*"In the next decade, we face a choice to either lead or to lag behind other successful economies all whilst we recover from Covid, deliver net zero, tackle structural inequalities and grow our economy. We choose to lead."*

	"[Covid-19] has both exacerbated existing inequalities and heightened awareness of the need to protect those at risk in society." *"Tackling child poverty is an economic as well as a moral imperative"*
Summary Inequality Frame	Poverty, and in particular child poverty, must be tackled with a strong economy that delivers fair work and better wages for all.

Appendix E – Example Lifestyle Drift Analysis

Scottish Government - Public Health Priorities for Scotland (2018)

HWB Problems	HWB Problems were identified across all Marmot Principles. However, almost all were within MP1 (Early Years), MP4 (Poverty), MP5 (Places) and MP6 (Behaviours). Very few were directly related to MP2 (Education), MP3 (Employment), or Cat7 (Health & Social Services). This reflects that of the six Public Health Priorities (PHPs), PHP1 was about Places; PHP2 was about the early years; PHP5 was about poverty and inequality, which was a cross-cutting theme; and PHP4 and PHP6 related to alcohol, drug, tobacco use; unhealthy diet & physical inactivity.
HWB Solutions	Again, HWB Solutions were identified across all Marmot Principles, but almost all were within MP1, MP4, MP5 and MP6. This reflected the focus of the PHPs.
Inequality Problems	Inequalities Problems were identified in all Marmot Principle categories. The most common problem related to MP4 (Poverty). Several problems were also identified as MP1 (Early Years) and MP5 (Places). This again reflects the structure of the PHPs. However, it was notable that, while two PHPs addressed the poor health outcomes of alcohol, drug, tobacco use; and unhealthy diet & physical inactivity (commonly depicted elsewhere as 'lifestyle behaviours'), there was very little mention of social patterning, and it was framed passively (as harm "affecting" those in poorer communities). Mental wellbeing, the subject of P3, was mostly represented in Category 8: Unequal Outcomes.
Inequality Solutions	Inequalities Solutions were identified in all Marmot Principle categories, however there were few. Almost half of all solutions were identified in MP4 (Poverty).
Lifestyle Drift?	HWB and Inequalities Problems and Solutions were identified across all Marmot Principles. However, there were clear tendencies towards MP1, MP4, MP5 and MP6, reflecting the six PHPs. Skills and employment were scarcely discussed in this text. A third of the PHPs - two of six - concern alcohol, drug and cigarette use (PHP4), physical inactivity and unhealthy diets (PHP6): these are the 'lifestyle' behaviours that are commonly depicted as being the responsibility of individuals to change. This may appear at first an excessive focus on lifestyle. However, no behavioural interventions are suggested. Instead, the regulation of price, availability and marketing is suggested, as is reformulation of unhealthy foods. Therefore, while this text does focus on the traditionally-conceived 'lifestyle behaviours', it

	does so from an upstream position, attributing responsibility to authorities rather than to individuals or communities. Both P4 and P6 maintain a passive framing of "*substance use*" that is partly driven by "d*ifficult economic and social conditions*" rather than agentic decision. Not only does the text avoid words such as 'lifestyle' or 'choice', it specifically rejects the terms 'addiction', 'dependency' and 'misuse', highlighting that the normal use of tobacco and alcohol is harmful. This locates the problem as the availability of tobacco and alcohol rather than as individual relations to them. This characterisation of tobacco and alcohol contrasts with a positive characterisation of the food industry as "*supporting transformational change*". This may reflect that food is necessary for life, problematic in many ways but not inherently problematic like alcohol/tobacco. It may also be tactful. In PHP4, the behaviour of substance use is vaguely said to "*var[y] across communities*", but the harm "*disproportionately affects those living in deprived communities*". Therefore, while outcomes are associated with deprivation, behaviour is not. Further, every PHP chapter features two pages of infographics showing statistics about the priority. Of the 27 statistics highlighted in P4 and P6, zero refer to a social patterning. This contrasts with almost half of the 57 statistics highlighted in other chapters referring to an inequality, usually of area deprivation. These seem like deliberate choices to frame outcomes, but not behaviours or lifestyles, with disadvantaged people. This locates the problem upstream. I should ask.

GMCA - Greater Manchester Housing Strategy (2019)

HWB Problems	HWB Problems are entirely categorised as MP5: Places and Communities.
HWB Solutions	Almost all HWB Solution statements are categorised as MP5: Places and Communities. Just one specific statement is categorised as MP6: Behaviours (see analysis below).
Inequality Problems	Around half of all Inequality Problems were categorised as MP5: Places and Communities. Several Inequalities Problems were identified relating to MP4: Poverty, and some to MP3: Employment.
Inequality Solutions	Inequality Solutions were almost entirely categorised as MP5: Places and Communities. A few Inequality Solutions related to MP3: Employment.
Lifestyle Drift?	Almost all Problems and Solutions, across HWB and Inequalities, were categorised within MP1-5. There was a consistent focus on solutions that are causes of the causes of health inequalities. There was one short comment coded as MP6: that GMCA will "*use the housing sector's workforce as key agents of behaviour change*". This was in the Health and Social Care section of the document, which also described a Housing & Health programme that involved working with the health and social care sector, investing in housing with help from Clinical Commissioning Groups, and a proposed Healthy Housing Service, a "reimagined version" of established care & repair service models. This implies using Housing Officers to deliver health behaviour change interventions at the individual level. This is a very interesting interpolation of an individualised understanding of health, within a section called Health and Social Care, in a document that is otherwise consistent in taking a contextualised, social determinants approach. This may be a momentary glimpse of lifestyle drift in a non-health text - must ask interviewees!

Scottish Government - National Transport Strategy 2 (2020)

HWB Problems	HWB Problems are overwhelmingly identified in MP5 (Places), due to this category including aspects of the built environment and planning, active travel, air pollution, climate change, social connectedness, and traffic accidents. A few HWB Problems are also present in MP4 (Poverty), MP6 (Behaviours).
HWB Solutions	HWB Solutions are almost entirely identified in MP5 (Places), because they refer to the policy areas described before. The only other HWB Solution is in Category 7, where "*more effective management of waiting lists*" is suggested due to the volume of traffic that is attributed to healthcare appointments.
Inequality Problems	Around a quarter of Inequalities Problems were categorised in MP5 (Places) or MP3 (Employment), the latter mostly comprising references to women, low-income and remote populations struggling to access employment due to inadequate transport. Inequality Problems were identified in all other categories. Young children suffer health disadvantages of pollution and traffic accidents; transport access to education can be inadequate; socio-economic inequalities in physical activity (including cycling and walking) are identified.
Inequality Solutions	Most Inequality Solutions are identified in MP5 (Places), mostly relating to embedding principles of equality in planning and decision-making. Some Inequality Solutions are identified in MP3, and very few others.
Lifestyle Drift?	There is no Lifestyle Drift in this text. Behaviours are identified as problematic for both health and inequalities. Behaviour change is repeatedly called for. For example, "*a key challenge will involve getting people to change their travel behaviour*" (p23) and "*we recognise the clear need for people to change their travel behaviour*" (p58). However, these calls are contextualised by structural determinants of behaviour, rather than portrayed as a free 'lifestyle' choice, or made the responsibility of individual-level services. The former quote is followed by an explanation that people's choices are "*complex and influenced by a number of factors*", including "*age, sex and income [...] where people live and/or work, geography, availability of transport, convenience and the built environment*". The latter quote is followed in the next paragraph by "*people are more likely to walk and cycle where safe and accessible active travel infrastructure is available*", and an explanation that the Sustainable Travel Hierarchy will ensure the transport system is designed for that.

	There are other notable sociological descriptions of behaviour. A long section describes the particular travel behaviours of women due to the typical gendered division of labour. Another part highlights the correlation between household income level and both access to bicycles, and likelihood of walking for fitness or fun. Another part cautions that private car use is often "*not a luxury but a necessity*" in rural areas. I'm intrigued why "*more effective management of waiting lists*" is suggested, due to the volume of traffic that is attributed to healthcare appointments, but e.g. "more flexible working" or "more remote working/education" are not. Why does this transport text make IMHO quite a big ask of the healthcare service but not of other essential social activity? Surely if it was written now, post-pandemic, it would account for such changes.

Appendix F – Example One-page Profile

GMHSCP - Taking Charge: The Next 5 Years (2019)

Document	**Taking Charge: The Next 5 Years. Our Prospectus. (GMHSCP, 2019)**
Context	Update after 3-4 years of initial 5-year health & social care plan ('*Taking Charge*', 2015) by new Greater Manchester Health & Social Care Partnership. GMHSCP was established after 2015 agreement with national government for devolved control of £6bn budget for health and social care in GM. GMHSCP involves all 10 local authorities of GMCA, plus various NHS organisations and groups, and works closely with GMCA. GMHSCP is essentially GMCA's arms-length health department.
Intention	"*To take stock, present what we have achieved and what we have learnt, and set out where we go next as a Partnership*"
Health Frame	Healthcare systems in GM can be improved in dozens of ways, including localising and joining-up health and social services, innovating interventions, and improving efficiencies. These are made possible by devolution.
Inequalities Frame	GM suffers health disadvantages compared to English averages. Healthcare variations within GM can be reduced by various methods of standardisation, monitoring, and sharing.
Are there signs of lifestyle drift?	Yes. There is prominent approval of the social model of the health on page 20, emphasised by two large pull-quotes. The importance of non-health policy is explained, there is an "*urgent need*" for prevention, and solutions beyond medicine are sought. However, the same page declares "*time to focus on persistent causes of poor health*", listing behavioural and biomedical risk factors. Deprivation is described as an additional factor, not a causal one. Throughout the text, HWB Problems and HWB Solutions are based on the biomedical model of health: diseases are solved by healthcare. There is very little mention of social inequalities. Reducing or easing deprivation is never suggested (i.e. of almost 300 coded 'solutions' for HWB or Inequalities, none were categorised as MP4: Ensure a Healthy Standard of Living For All).
How are variations in health conceptualised?	Of twenty conceptualisations identified, 13 are gaps between GM and the national average, while 4 are within-GM gaps. In four of the 13 cases, GM has an advantage over the national average: however this is framed positively as evidence of good performance, not as a health inequality. Nine of the twenty are variations in healthcare performance, and four are associated with health behaviours. Four of the remaining seven are 'health inequalities' generally.

Further Observations	Inequality Problems were mostly framed as disadvantages suffered by GM compared to English average, but efforts to improve overall-GM health were not framed as inequality-reducing, but as health-improving. Inequality Solutions mostly sought to reduce within-GM healthcare service variation. Therefore, the GM-disadvantage frame was used to justify overall-health-improving policies, which may widen within-GM inequalities. This is consistent with the first stated priority (of three) "*improving people's health*". Others are "*creating a [financially] sustainable H&C system*" and (notably) "*helping to achieve the region's economic potential*".

GMCA - Transport Strategy 2040 (2017 (updated 2021))

Document	**GM Transport Strategy 2040 (GMCA, 2017 (updated 2021))**
Context	Following devolution of transport policy to Greater Manchester, Transport for Greater Manchester (TfGM), GMCA and the ten local authorities approved this strategy document in 2017.
Intention	*"This document sets out Greater Manchester's Transport Strategy to 2040…This version of the Strategy was updated in 2021."*
Health Frame	Motor traffic harms public health through air pollution and accidents. Active travel improves health by minimising those harms, and increasing physical activity. Therefore, motor traffic should be discouraged and active travel encouraged.
Inequalities Frame	Within GM, social and economic participation is harder for those without access to cars, paths or good public transport. Pollution and path provision affect health unequally. Reducing pollution, improving path provision, and considering diverse users and needs in transport planning will redress these inequalities.
Are there signs of lifestyle drift?	No. Problems and Solutions across HWB and Inequalities were mostly categorised as issues of MP5: Places and Communities. In HWB, the desired move from car to active journeys was predominantly framed as requiring infrastructural solutions. Physical activity and speeding were framed only *in part* as behavioural problems that required promotional solutions. For example, "*improvements in infrastructure and services need to be* complemented by *behaviour change measures that encourage people to choose active travel*" (p121). Almost all Inequalities Problems and Solutions were categorised as MP3-5: employment, affordability, and places & communities.
How are variations in health conceptualised?	Two variations in health were conceptualised: a GM disadvantage compared to the UK average (people killed or seriously injured in a road traffic accident); an unspecified inequality of physical activity (e.g. some people are physically inactive, with unexplained patterning).
Further Observations	The above quote (p121) is particularly pertinent to universalist infrastructure interventions such as 'The Bee Network' of cycle paths, said to "*connect all areas of GM*". As Lam (2018) discusses, cycle paths aimed to 'all' or 'everyone' may merely help social groups already disposed to cycling without expanding access to others. This may increase overall cycling without reducing – or even widening- inequalities. This is where further targeted measures – such as behaviour change activities – may be beneficial. Many pages are given to describing the economic benefits to GM of both Northern Powerhouse Rail (NPR) and High Speed 2 (HS2) projects. They are described once as 'critical' to Greater Manchester's part in the national 'levelling up' agenda, creating hundreds of thousands of jobs, mostly across the north of England. Therefore,

	there is clearly huge potential for these projects to significantly reduce health inequalities between GM and the English average, which are repeatedly identified in *OPOP* and health documents as priorities. Nevertheless, I am yet to find a health frame including NPR or HS2, nor an NPR/HS2 frame including health or wellbeing.

Scottish Government - Covid Recovery Strategy (2021)

Document	**Covid Recovery Strategy – For a Fairer Future (2021)**
Context	Towards the end of the acute phase of the Covid pandemic, this strategy text dealt with calls to 'build back better' by summarising SG's social and economic policy agenda and placing it within the new Covid-world context. Prior to the pandemic, the Citizens' Assembly of Scotland had been asked to consider "What kind of Scotland are we seeking to build?". This text also claims to be based on their report, produced in January 2021.
Intention	*"Our vision for Covid Recovery [address the systemic inequalities made worse by Covid, make progress towards a wellbeing economy, accelerate inclusive person-centred public services] is bold and ambitious.* *Our three key outcomes [Financial security for low income households; Wellbeing of Children and Young People; Good, green jobs and fair work] are central to achieving this vision and are areas most likely to have the greatest impact on tackling the inequality and disadvantage highlighted by Covid.* *These outcomes will also benefit population health, by addressing some of the key upstream drivers of health inequalities."*
Health Frame	Improving the wellbeing of children and young people - which was harmed by the Covid-19 pandemic - is one of three key outcomes for Scotland's recovery.
Inequalities Frame	The Covid-19 pandemic made systemic inequalities worse, particularly for young people and women. We must use the urgency, creativity and flexibility shown then to provide good, fair jobs, financial security, and wellbeing for young people.
Are there signs of lifestyle drift?	Yes. 'Health' is mentioned often to indicate the Covid-19 virus, rather than the broader impacts of social restrictions, which are experienced as 'wellbeing'. It is also used in the Wellbeing of Children and Young People chapter, after paragraphs about education and employment, thus: "*The pandemic has* also *had an impact on health, both on physical activity levels and on increased purchases of food higher in fat, salt and sugar, and these are likely to have exacerbated health inequalities, including among children and young people*". It is interesting to say "the pandemic has *also* had an impact on health" – as if that is not its primary impact – and then to link that to physical activity and diet. These elements could easily have been described in relation to wellbeing without invoking health. It is also interesting to highlight these 'lifestyle' factors as "*likely to have*

	exacerbated health inequalities", when all the inequalities in the entire document are likely to have exacerbated health inequalities (as it does say, on p7 and p8 for example). The paragraph continues: *"We will focus on improving the health of our young people, aiming to halve childhood obesity by 2030 and significantly reduce diet related health inequalities, by taking forward the actions in our 2018 Diet and Healthy Weight Delivery Plan"* Here again 'health' is used in a wellbeing chapter to specifically refer to diet and healthy weight. Another paragraph in this chapter, describing pilot schemes to distribute free bikes to children who cannot afford one, concludes that this scheme "*can also improve health outcomes*", implying that the main benefit of the scheme is some other component of wellbeing: participation, mobility, fun? Health therefore implies something very specific in this chapter, perhaps akin to physical fitness, while wellbeing is broader, including education and job prospects and the non-health benefits of riding a bike. For the word 'health' to be so specifically used this way within a wellbeing chapter surely conveys assumptions about the meaning of the word. This also makes me wonder whether biomedical or behavioural conceptualisations of health may also be influenced by assumptions about health at different life stages. Further, one paragraph on the following page describes the action being taken: a 25% increase in budget for childhood obesity and adult weight management programmes, including pilots in three NHS board areas, and "*training for frontline staff… to have conversations about healthy weight and diet in a non-stigmatising way*". Here, then, healthy weight requires NHS-led management, including conversations with service staff. This conveys individualistic, biomedical, and rational actor-based assumptions.
How are variations in health conceptualised?	A few paragraphs describe a range of health inequalities. In one, the impact of Covid-19 on the employment and income of women, disabled people, minority ethnic communities, carers, lone parents and people in precarious employment is highlighted, and that this will have long-term health implications, including on health inequalities. Firm focus on the determinants. Another para describes NRS data on the "*stark reality of health inequalities*" between most and least deprived areas of Scotland, highlighting as outcomes: alcohol deaths, drug deaths, Covid-19 mortality, HLE, and suicide.

	Finally, a section of the Wellbeing of Children and Young People chapter describes increased purchases of unhealthy foods, and decreased physical activity, as contributing to health inequalities (including to children and young people). It is not clear which axes of health inequalities are implicated here. Therefore, differential impacts of the pandemic on social groups are highlighted; and existing socio-economic place-based inequalities are highlighted. There is no attempt to describe a gradient.
Further Observations	Health has a very biomedical meaning in this text – it means the acute impacts of Covid-19 infection, or of physical inactivity or poor diet – while wellbeing is much broader, encompassing education, employment opportunities, access to creative or communal experiences, family life, mental health, and health.
	Note that of the three outcomes and three visions, none mention health, one is 'Wellbeing of Children and Young People", and one is "Make progress towards a wellbeing economy".
	Within the broader conceptualisation of 'wellbeing', mental health solutions tend to default straight to support services. Therefore 'wellbeing' covers the social determinants of mental health (education, employment (income), relationships), and 'support services' are its healthcare.
	The main paragraph that describes health inequalities, referring specifically to a recent NRS report, is on a new chapter page titled "*Rebuilding Public Services – how we will deliver*". This seems to imply that socioeconomic health inequalities – drug deaths, alcohol deaths, suicide, Covid-19 mortality, and HLE – should be tackled by "rebuilt" public services. This is a downstream, reactive position. It should also be acknowledged that a more upstream conceptualisation is used elsewhere, e.g. on page 8 when it is said that aiming for the three outcomes "*will also benefit population health, by addressing some of the key upstream drivers of health inequalities.*"
	There are also explicit drivers towards individualised approaches. For example, the engagement activity informs Figure 2 on p9 which says (among other things): "*People told us they want a recovery that… starts from the individual*". Later, events with stakeholders produced themes including "*the need to talk about people and families, not systems…*". Therefore, participation and engagement processes seem to evoke individualistic desires. This is understandable for frontline service staff, and service users, whose work and system experience is interpersonal. This reminds me of Mackenzie et al. 2020 interviews

	with GPs in Glasgow about health inequalities: "*Thinking socio-politically is not at the forefront of [their] thinking; a phenomenon likely related to GPs experiencing health problems through individual presentations*." Unfortunately this is likely to act as a downstream drag away from systemic solutions.
	I noticed an imbalance in coding for MP5 (Places and Communities): only problematised three times (homelessness x2, libraries) but categorises as a solution thirteen times. The 'excess' solutions are public transport or mobility solutions, anchor institutions, and 20-minute neighbourhoods. I guess this reflects the general approach to consider inequalities between aggregated social groups (including by place), rather than between individuals (gradients). Place-based solutions are targeted at the social group resident in that place, rather than defined by some individual or intrinsic factor. May be something to ask interviewees about.