Eliciting public values on health inequalities: missing evidence for policy windows?

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Title: Eliciting public values on health inequalities: missing evidence for *policy windows*?

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Abstract

Background: There is a widening health divide in the UK despite health inequalities being a long-standing subject of policy and research. New types of evidence are needed.

Key points for discussion: Knowledge of public values for non-health policies and their associated (non-)health outcomes is currently missing from decision-making processes. Eliciting public values using stated preference techniques can provide insights on what the general public would be willing to give-up for different distributions of (non-)health outcomes and the policies that can achieve them. To understand the role this evidence could have in decision-making processes, Kingdon's multiple streams analysis (MSA) is used as a policy lens to explore *how* evidence of public values could affect policy processes for ways to tackle health inequalities.

Conclusions and implications: This paper outlines how evidence of public values could be elicited through the use of stated preference techniques and suggests this could facilitate the creation of *policy windows* for tackling health inequalities. Additionally, Kingdon's MSA helps make explicit six cross-cutting issues when generating this new form of evidence. This suggests the need to explore reasons for public values and how decision-makers would use such

evidence. With an awareness of these issues, evidence on public values has the potential to support *upstream* policies to tackle health inequalities.

Keywords: public values; health inequalities; policy windows

Word count: 5,192 words

Key Messages:

- UK health inequalities are widening despite being a long-standing subject of policy and research
- We are missing evidence of public values for non-health policies and their (non-)health outcomes
- Kingdon's MSA is used to consider the role this evidence could have in decision-making processes
- This evidence could facilitate the creation of policy windows for tackling health inequalities

Background

In the UK, there is a health divide. Individuals who are worse-off in terms of socioeconomic position have shorter lives in poorer health than those who are better-off (Marmot, 2010). Worryingly, despite the long-standing attention of researchers and policy makers health gaps have widened in recent years (Marmot et al., 2020a; Scottish Government, 2020; Smith et al., 2015) and have been exacerbated by the COVID-19 pandemic (Bambra et al., 2020; Marmot et al., 2020b). Health policies alone cannot redress this situation because health is determined by social, economic and environmental factors (Dahlgren and Whitehead, 2007; WHO, 2008). Rather than focusing *downstream* on modifying individuals' health behaviours, action is required on *upstream* underlying causes of poor health (Douglas, 2016; Marmot, 2010). This requires that health outcomes are considered by non-health sectors such as social security, housing and education and has led to calls for *healthy public policy* or *health in all policies* (Solar et al., 2009; WHO, 2014, 2012). However, such an approach is challenging as it necessitates intersectoral approaches to policy making and because acting on structural determinants of health is more likely to require *policy windows* through which to implement specific policy solutions for tackling health inequalities (Cairney and St Denny, 2020; Kingdon, 2011). In this paper, it is argued that one type of evidence, currently missing from decision-making processes is knowledge of public values for non-health policies and their associated (non-)health outcomes. Such evidence could potentially facilitate the creation of *policy windows* for tackling health inequalities.

The paper is in two sections. The first section introduces public values and outlines reasons for eliciting them for tackling health inequalities. The second section uses Kingdon's multiple

streams analysis (MSA) as a policy lens to explore *how* evidence of public values could affect policy processes for ways to tackle health inequalities.

Public Values

What are public values?

The term public values requires some unpacking. First, there is no one *public*. Many different *public(s)* can be assembled with people asked to occupy different roles depending on the situation (Baker et al., 2021; Barnett, 2008; Escobar, 2017; Stewart, 2016). Different subsets, or communities, of people can be constructed who share a common characteristic around, for example, place and/or interest (Brunton, 2017; Popay, 2006). People could also be asked to adopt different perspectives, for example, individual, self-interested; societal, other-focused; or, socially inclusive, personal and other-focused (Dolan et al., 2003; Tsuchiya and Watson, 2017). As public values for health inequalities could be elicited in relation to a variety of possible research questions this paper does not provide a prescriptive definition of *public(s)*. However, one clarification is the focus is not on patients or health service users, two commonly used subsets of the public (Fredriksson and Tritter, 2017), as the area of interest includes but extends *beyond* the health sector.

Value(s) can also take different forms. Baker et al. (2021) differentiate between two forms of value: ethical/philosophical values and economic values. For the former, values are high-level principles or moral standards, such as equity, efficiency, human dignity or security that can be used to justify a choice or decision. For example, different equity principles may be invoked to justify different approaches to allocating a fixed health budget: maximising health outcomes

(utilitarianism) or equalising health outcomes for all (egalitarianism). It is common to use qualitative methods to elicit these values. For the latter, value is commonly expressed through sacrifice: what is the *most* you would be willing to give-up in order to achieve a particular change in the world. The maximum trade-off represents the *value* placed on that change and provides a measurable indication of strength of preference. Values are typically elicited through stated preference techniques that incorporate trade-offs. These techniques are used when we wish to know the *value* placed on non-market goods, services or programmes. While both types of values are important, particularly in regard to resource allocation decisions, this paper focuses on economic values.

Different types of public values can be elicited. The focus of this paper is on public values for non-health policies *and* their associated (non-)health outcomes as this evidence is currently missing from decision-making processes. Eliciting these public values using stated preference techniques requires knowledge of a policy's impact. It is well established that generating such evidence for *upstream* socio-economic policies that impact on health inequalities is more difficult than for policies further *downstream* (the 'inverse evidence law') (Bambra et al., 2010; Ogilvie, 2005; Petticrew, 2004). However, recent innovative modelling work has provided a better sense of the potential impact of *upstream* policies, such as regulatory or tax options, on non-health, population health and health inequality outcomes (see the Scottish Public Health Observatory's 'Triple I' Project (McAuley et al., 2016; Richardson et al., 2020). These new insights, in combination with suggestive evidence from systematic literature reviews (for example, Bambra et al. (2010); Thomson et al. (2018); Hillier-Brown et al. (2019)) and expert discussion, can enable the elicitation of public values for non-health policies *and* their associated (non-)health outcomes. For example, stated preference studies could focus on valuing: policies that impact on (non-)health outcomes across different determinants of health

(i.e. income, education or environment); policies within one determinant only (i.e. income); and/or policies that are considered upstream only or that range from upstream to those further downstream. Additionally, public values could be explored in relation to how different configurations of the same policy, for example, universal basic income (Richardson et al., 2020), impacts on (non-)health outcomes.

How to elicit public values?

Public values can be elicited in different ways using different stated preference techniques. The purpose of this paper is not to provide an in-depth discussion of how to elicit public values (for this see, for example, Ryan et al. (2001) and Bateman et al. (2002)). However, brief consideration of two different techniques - Contingent Valuation (CV) and Discrete Choice Experiments (DCEs) - and the different perspectives from which public values can be elicited illustrates important considerations.

CV questions ask respondents to indicate the value they ascribe to a particular good by stating the *maximum* they would be willing to pay for it. Grounded in welfare economics, CV studies are commonly used to inform regulatory and investment decisions in non-health divisions of government as well as in health (economics) research when no market values exist (HM Treasury, 2020; Ryan et al., 2001). CV questions could ask participants how much they are willing to pay via extra taxation for a range of non-health policies across different determinants of health with (non-)health outcomes. In DCEs respondents evaluate discrete alternatives described by attributes of policies; for example, policy type, non-health outcome impact, population health impact, health inequalities impact and cost. These attributes vary according to a plausible set of levels, for example, for the attribute 'health inequalities impact', levels

could relate to reductions, increases and no change in health inequalities. Each technique has specific strengths. For example, as DCEs focus on the valuation of attributes they have greater analytic flexibility, in terms of more easily being able to delineate the relative importance of specific attributes (of policies) as well as providing a relative overall value of discrete scenarios. While CV questions more readily mimic the types of decision made in real-life policy making as the focus is on valuing the policy as a whole.

Public values can also be elicited from different perspectives. This is important as members of society may express different values depending on whether they are acting as individuals (personal/self-interested) or as citizens (societal/other-focused) (Dolan et al., 2003; Tsuchiya and Watson, 2017). The former perspective is concerned with individual benefits and the latter with societal benefits. As public values convey different information depending on the perspective participants are asked to adopt the choice of perspective has to relate to the research question under consideration.

Why should public values be elicited for tackling health inequalities?

There are two broad categories of reasons for eliciting public values for policies that impact on health inequalities - intrinsic and instrumental rationales. Intrinsic rationales relate to democratic arguments for accounting for public values in the allocation of public resources: taxes fund public policies and the general public are affected, positively and negatively, by resource allocation decisions (Baker et al., 2021; Tenbensel, 2010). This assumes that how resources are currently allocated should be indicative of the public value placed on different prospects, and the importance of different kinds of benefits to different beneficiaries. More

instrumentally, the elicitation of public values can generate new forms of evidence to inform resource allocation decisions.

No studies have elicited public values for non-health policies and their associated (non-)health outcomes. Stated preference research exists on the public's aversion to inequalities in health between socioeconomic groups (McNamara et al., 2020) and there are valuation studies of public health interventions such as water fluoridation and salt reduction (Kristiansen et al., 2006; Shackley and Dixon, 2000). There is also a large stated preference literature on non-health policies with non-health outcomes, for example, in environmental and transport sectors (Bahamonde-Birke et al., 2015; Carson and Hanemann, 2005) and there are public attitude/opinion surveys on redistributive non-health policies (for example, Reid et al. (2019)). However, crucially, this research does not ask the public to make trade-offs between different non-health policies where the (non-)health outcomes are made explicit nor to express what, if anything, they would be willing to give-up for different distributions of (non-)health outcomes and the policies that can achieve them. Such an approach can enable the elicitation of the relative importance of different *types* of non-health policies and/or the *outcomes* of these policies and the examination of whether public values change depending on how the effects of policies are framed.

While it is now possible to generate this new type of evidence and there are different rationales for doing so it is also important to consider the role this evidence could have in decision-making processes. The next section uses Kingdon's multiple streams analysis (MSA) as a policy lens to explore *how* evidence of public values could affect policy processes for ways to tackle health inequalities.

Multiple Streams Analysis (MSA) and health inequalities in the UK

Within health research there has been a tendency to subscribe to the rational, linear model of policy making - a problem is identified, research responds by producing a solution, this is adopted by politicians and the corresponding policy change is made. However this view of policy making is widely discredited (Exworthy, 2008; Smith, 2013). In reality policy change is a much more complex process. While there are different theories of policy making (Smith and Katikireddi, 2013), one of the most widely applied policy theories (Jones et al., 2016), which explains how and why issues get on the policy agenda is Kingdon's (2011) MSA.

In its original application, MSA details how policy change occurs *only* when there is a coupling of multiple streams – *Problem*, *Policy* and *Politics* – to create a *policy window*. *Problems* are issues which are deemed by decision makers to require attention. The *Policy* stream is concerned with finding some agreement on which solutions to implement. *Politics* relates to the receptivity of elected decision makers to particular solutions. Skilled and knowledgeable individuals, called *policy entrepreneurs*, work to aid the coupling of these streams and to exploit *policy windows* (for a more complete summary of MSA and the subcomponents underpinning the three streams see, for example, Cairney (2012), Jones et al. (2016) and Zahariadis (2007)).

This model has been applied in a variety of ways to examine health inequalities in the UK. For example, it was used to help explain the contrasting journeys of ideas from research into policy (Smith, 2007), to explore tensions between local and national policymaking (Blackman et al., 2012; Exworthy et al., 2002; Exworthy and Powell, 2004) and to understand the progress of national policy towards tackling health inequalities (Cairney and St Denny, 2020; Exworthy et

al., 2003). The last application is particularly important for the work proposed here as it highlights the difference between a *single policy window* and *multiple policy windows*. As tackling health inequalities requires the adoption of a large number of different and defined policy solutions at different times, multiple policy windows are considered necessary to deliver change (Cairney and St Denny, 2020). Yet despite this range of applications MSA has not been used with, or considered alongside, public values for non-health policies and their associated (non-)health outcomes. The reasons for this are unclear but could relate to different disciplinary perspectives and/or that, as outlined, new evidence on the technical feasibility of *upstream* ways to impact on (non-)health outcomes has only recently become available. In what follows, *how* evidence of public values could affect policy processes to facilitate the creation of *policy windows* for ways to tackle health inequalities is explored followed by discussion of cross-cutting issues that must be considered in generating this new form of evidence.

The Problem Stream

While health inequalities are on the health agenda (Marmot, 2010), non-health sectors may either not recognise health inequalities as a problem or as a problem relevant to their sector. Knowledge of public values for different policy outcomes could aid the recognition of health inequalities as a problem in non-health sectors. The design and implementation of policies always involves choices; different policies exist which can impact on different beneficiaries in different ways. For example, social security and taxation policies can have different impacts on income, population health and health inequalities (Richardson et al., 2020). Public values can provide an indication of the relative importance of different (non-)health outcomes from non-health sector policies. Such insights could potentially help policy entrepreneurs push certain policies up or down the agenda and enable them to pursue different intersectoral policy

making strategies, such as health, win-win, cooperation or damage limitation strategies, for tackling health inequalities (see Ollila (2011) for a discussion of these strategies).

The Policy Stream

While there is broad agreement on the *causes* of health inequalities (Marmot, 2010; WHO, 2008), amongst health inequalities researchers there is less agreement on specific policy *solutions* based on available evidence (Smith and Kandlik Eltanani, 2015). While new evidence on the technical feasibility of ways to impact on health inequalities (McAuley et al., 2016; Richardson et al., 2020) can provide valuable insights, such evidence alone cannot answer questions about prioritisation. Policies can impact on (non-)health outcomes in different ways and over different timescales, have distinct cost implications, align with diverse ideological beliefs and may be based in sectors where health is not the primary outcome. Through the elicitation of public values insights can be gained on what policies the general public believe should be prioritised and what they would be willing to give-up for different distributions of (non-)health outcomes and the policies that can achieve them. This can inform our understanding of what the public would accept which may help such policies gain traction within policy communities and make it onto a short list of proposals that are developed in preparation of specific policy windows opening.

The Politics Stream

Knowledge of public values can help decision makers to understand the national mood on solutions to health inequalities. While exploration of lay perceptions of the causes of health inequalities is well established (Smith and Anderson, 2018), similar work on potential solutions

is more limited (McHugh et al., 2019) and, crucially, evidence on public values for non-health policies in terms of their (non-)health outcomes does not exist. Grounding actions in the values of those affected by policy decisions could provide the mandate, acknowledged as missing and needed, for introducing more *upstream* policies to tackle health inequalities (Mackenbach, 2011; Whitehead and Popay, 2010). Likewise overcoming silos to act on social determinants of health (Carey and Crammond, 2015) can require an intersectoral approach to policy making which is also a well-known and politically-contentious issue, particularly as it can imply resource shifts across sectors. A receptive public could also help establish the political will necessary to facilitate cooperation across sectors for the implementation of *upstream* policies (WHO, 2014).

Cross-Cutting Issues for Generating Evidence on Public Values

While evidence of public values could help facilitate the opening of policy windows, Kingdon's (2011) MSA helps make explicit six potential cross-cutting issues when generating this new form of evidence. First, the public may value *downstream*, as opposed to *upstream*, policies which could result in the closure of policy windows for specific *upstream* policies. Given a prevailing view among the UK policy community is that the public lack appetite for more egalitarian policies (Smith, 2013) and there is evidence of individuals internalising neoliberal discourses (Peacock et al., 2014) such an outcome may occur. Second, due to the likelihood of plural views (McHugh et al., 2019) it is unlikely a clear mandate for specific policies will emerge. This then raises the question of what to do when people disagree? Third, the public may support less cost-effective policies which means, in the context of scarce resources, some health inequality reduction will be forgone. Fourth, at times, (desired) policy change for taking action on determinants of health can occur without public awareness of

policy options (Embrett and Randall, 2014). Therefore, it is possible that the need for new evidence on public values to tackle health inequalities is overstated. Fifth, there is evidence that intersectoral approaches to policy making can result in non-health decision makers framing health as a *means* to achieve non-health sector objectives (Holt et al., 2016). Typically, this leads to a focus on more *downstream* policies, such as healthy eating, as opposed to more *upstream*, structural policies. Lastly, it is not clear whether evidence of public values on (non-)health outcomes will hold weight with decision-makers in non-health sectors.

These are valid and important issues and highlight the need to explore the reasons for public values and how decision-makers would use such evidence. For this, undertaking qualitative work alongside, and/or independently of, work on public values is essential. Aggregative elicitation approaches are silent when it comes to rationales for public values. Qualitatively exploring why *downstream*, individualised policies and/or less cost-effective policies are favoured (if this is the case) would help to understand the reasons for such findings as well as why one *upstream* policy is preferred over another. Frameworks also exist for combining aggregative elicitation approaches with deliberative approaches, such as citizen's juries, to explore reasons, beliefs and principles underlying public values and provide ways to analyse and present plurality when people disagree (Baker et al., 2021). Understanding reasons for public values can aid the revision and adaption, or 'softening' (Kingdon, 2011), of policies to a form more likely to gain traction within policy communities. Exploring how (non-)health decision makers would use evidence of public values would also improve our understanding of how this evidence, in practice, affects policy processes and intersectoral policy making strategies. Additionally, it would help to identify the messages that work best for different audiences and the best communication strategies to achieve policy change. Finally, evidence of public values alone is unlikely to be sufficient, or always necessary, for policy change.

However, such evidence has the potential to improve the chances of *upstream* policies making it onto the policy agenda to counteract the well-known *lifestyle drift* in policy making (Smith, 2013; Whitehead and Popay, 2010) as public support and acceptance is often considered necessary for radical policy change (Mackenbach, 2011).

Conclusion

COVID-19 has exposed and exacerbated existing health inequalities in the UK (Bambra et al., 2020; Marmot et al., 2020b). This has stimulated debate about whether policies in response to the pandemic should aim to "Build Back Better" or 'Build Back Fairer' (Marmot et al., 2020b, p4). In this context there is an opportunity for radical policy change and an even stronger case for implementing policies for tackling health inequalities. In a democracy, a necessary part of this debate ought to be ascertaining what type of society the public want to live in. A key part of this is understanding what policies the public believe should be introduced. For this, the public should be provided with the best available insights into the impact of different policies to inform their choices and enable the systematic and methodical elicitation of public values. This paper highlights how evidence of public values for non-health policies and their associated (non-)health outcomes could be elicited through the use of stated preference techniques and suggests this could facilitate the creation of *policy windows* for tackling health inequalities. Additionally, Kingdon's MSA helps make explicit six cross-cutting issues when generating this new form of evidence. This suggests the need to explore reasons for public values and how decision-makers would use such evidence. With an awareness of these issues, evidence on public values has the potential to support *upstream* policies to tackle health inequalities.

Research Ethics Statement

The author of this paper has declared that research ethics approval was not required since the paper does not present or draw directly on data/findings from empirical research.

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NM conceived the idea for the paper, wrote the first and subsequent drafts and made all edits/revisions to the paper.

Conflicts of Interest

The Author declares that there is no conflict of interest.

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