Public participation in tackling health inequalities: implications from recent qualitative research

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Recent qualitative research highlights important issues for successful public participation in action to reduce health inequalities. In the UK, the New Labour government has made a sustained commitment to tackling health inequalities and advocates the active engagement of local communities in this agenda. This offers a historically unprecedented opportunity, but there remains a paucity of research documenting effective interventions. Critically, if there is to be successful community participation in action tackling health inequalities we need to understand the subjective perceptions of lay community members regarding these issues. It is here that findings from recent qualitative research can provide important insights for developing best practice.

A review of ethnographic, interview, and survey data obliquely exploring what laypeople themselves think about health inequalities offered the tentative conclusion that ‘social inequality in health is not a topic which is very prominent in lay presentations, and paradoxically this is especially true among those who are most likely to be exposed to disadvantaging environments’ (p. 747). More recent studies in the UK and New Zealand have qualified this initial finding.

A large mixed-method study found that interviewees living in relatively disadvantaged areas questioned the existence of health inequalities despite the effects of inequity being evident elsewhere in their accounts. In part, this stemmed from a rejection of the stigma associated with living on the wrong side of the health divide when directly questioned about health inequalities. Likewise, it has been found that participants in interview and follow-up focus groups fixed upon agency and strength of character when talking about individual experience. Structurally oriented explanations appeared only when talking about the wider social and political context of health and were more prevalent among middle-class, especially public sector, professionals. Interview studies of African-Caribbean and Pakistani local community networks within a deprived multi-ethnic area found that material and symbolic social exclusion militated against participation in partnerships to tackle health inequalities. An interview study conducted in New Zealand, however, found that working-class participants often used structural explanations of health, and suggests this may in part be due to awareness of recent health care reforms prominent in contemporary mass media.

In sum, these qualitative studies show that laypeople have complex understandings of health inequalities but should not be assumed to hold the same beliefs as professionals wishing to work towards the reduction of these inequities. It is these members of disadvantaged communities who may be targeted by such efforts who are most likely to reject the potential stigma associated with being seen as a ‘victim’. Further, public discourse about health and health care shapes the context in which individual beliefs are formed.

The central implication of these findings is that successful participation may need to overcome adverse public perceptions, especially pronounced among disadvantaged groups, concerning the nature of health inequalities and efforts to reduce them. Effective participation will necessarily entail the sensitive design of projects to avoid the potential stigmatization of disadvantaged individuals or communities. Health promotion via the mass media has historically advocated individual responsibility for health. Promoting awareness and public discussion of inequalities and the social determinants of health in the local context, for example via media advocacy, may therefore be one important preparatory activity to lay the ground for successful public participation in the agenda for tackling inequalities.

References


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