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Commentary

The Knowledge Needed to Deliver Social Justice and Health Equity

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The 2009 Commission on the Social Determinants of Health chaired by Michael Marmot (CSDH) defined health equity as 'the absence of systematic differences in health, both between and within countries that are ***judged to be avoidable by reasonable action***'. Achieving greater health equity was the explicit goal of the global strategy Health for All launched in 1978 by the World health Assembly at Alma Ata. Yet almost a quarter of a century later, and despite many more fine words, gross inequalities in health and illness and in their social determinants are evident within and between nation states. And some of these inequalities are getting larger. The dynamics of globalisation, the current global recession and the almost ubiquitous neo-liberal responses to this, can only exacerbate these inequalities.

The CSDH concluded that the global toll of premature death and unnecessary pain and suffering is caused by ***social injustice.*** The message from the nine knowledge networks[1] established to review evidence to support the commission is equally bold: the most effective way to achieve health equity is for governments to pursue greater social justice; good government means supporting a vibrant civil society sector; and international agencies must support governments and civil society to address equity.

But where does research fit into all this and in particular qualitative research? The Marmot Commission made three strategic recommendations: improve people's daily living conditions; tackle the inequitable distribution of power, money, and resources; and measure and understand the problem and assess the impact of action. This last is a call for a radically different agenda for health research. In the past twenty years the global dominance of biomedical research (highly effective in its time) has been displaced by a new 'public health research' paradigm. But, not with-standing the achievements, from a health equity perspective this second global wave of health research is crippled by the seemingly irresistible 'lifestyle drift'[i] that focuses researchers, policy makers and practitioners alike on individual behaviours.

In this context the Commission's Knowledge Networks have argued that we may be on the cusp of a third wave of global health research that will create a new 'knowledge space' comprising of several elements[ii]. First, the ***problem space*** needs to be reframed. The same resources and energy that have been invested in 'mapping the genome' need to be directed at mapping the 'socio-

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[1] These Knowledge Networks focused on: Early Child development; Employment conditions; Gender; Globalisation; Health Systems; Priority public health conditions; Social Exclusion; Urban systems: and Measurement and evidence. Their reports are available from: www.who.int/social_determinants/knowledge_networks/final_reports/

nome'. While there is a lot of aetiological research on health inequalities very little of it explores the pathways linking upstream political, economic, social and cultural determinants to health equity. Priority questions include: what is the health equity cost of the global financial crisis and what pathways lead to these costs; what pathways link free trade initiatives to positive and/or negative health equity outcomes; and what precise pathways link the experience of disadvantaged neighbourhoods, low and unstable incomes to health equity outcomes?

Similarly, research in the 'solution space' needs to be refocused away from context-less life-style interventions to assess the appropriateness, equity impact and economics of action to address the wider determinants locally, nationally and globally. For example, given widespread attempts to roll back the state's involvement in health and welfare, research needs to assess the relative costs and benefits of different approaches to providing health care, education and social protection. This highlights the need for methodological innovation in research aimed at supporting action for health equity. We do not have the methods needed to evaluate the equity and other impacts of publically funded universal services (including the impact on social cohesion) or to unpick the processes driving these outcomes. Nor do we have methods to enable us to compare population level outcomes of universalism with the outcomes of the selective means tested and/or privatised alternatives currently finding favour around the world.

Research for greater health equity also needs to be more democratic research. The 'public' should have the right to be involved in all elements of the research process. This is particularly the case for groups who are the targets of research and whose voices are rarely if ever heard and for civil society advocacy groups. But this requires scientists of all types to recognise the value of 'lay knowledge' what the historian E. P. Thomson called the 'wisdom of experience'. A key characteristics of the Marmot Commission's knowledge networks was that they were ***communities of 'knowledge' practice*** connecting more than 350 people globally – researchers, policy makers, professional practitioners and civil society organisations - sharing a commitment to co-produce solutions to the social injustices generating health inequities. Their approach to knowledge was eclectic and inclusive – involving a wide range of disciplinary perspectives and scientific paradigms and including findings from quantitative and qualitative enquiry and the experiential wisdom of 'lay' people and civil society groups.

The global research community has a moral and professional responsibility to contribute evidence on the processes that drive health inequity and the solutions that can combat it. This requires us to combine diverse 'knowledges' – from research and other sources - in egalitarian and inclusive relationships. The specific challenge for qualitative research is simple: do its practitioners have the commitment and imagination to develop new more 'synthetic' knowledge spaces in what is already a very positivist quantitative landscape.

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[i] Popay, J. Whitehead, M. Hunter, D. (2010) Injustice is killing people on a large scale – but what is to be done about it? **Journal of Public Health**, 32(2):148-149; doi:10.1093/pubmed/fdq029

[ii] O¨ stlin P, Schrecker T, Sadana R, Bonnefoy J, Gilson L, et al. (2011) Priorities for Research on Equity and Health: Towards an Equity-Focused Health Research Agenda. PLoS Med 8(11): http://dx.doi.org/10.1371%2Fjournal.pmed.1001115