research article

Framing the wider determinants of health and health inequalities: local stakeholder views in England

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Background: Despite decades of concern, health inequalities persist and collaborations to address them at a local level are yet to prove effective. One potential way of improving actions to address health inequalities is to pay greater attention to the way the problems and solutions are framed.

Aims and objectives: The aims of the study were to: 1) review existing advice and guidance on how to frame the wider determinants of health, health inequalities and how to address them in policy; 2) critically appraise this guidance with reference to a study of local action to address the wider determinants of health and health inequalities in England; and 3) offer insight into the future of framing these issues at the local level.

Methods: An exploratory qualitative study of local actors' activities and experiences that relate to framing health inequalities. Analysis is drawn from 14 in-depth, qualitative interviews with people working in health- and other-sector partnerships.

Findings: Local actors engaged in systemic framing of the wider determinants, health inequalities and what to do about them across localities, albeit in a non-routinised or uniform way. Evidence and data were a key part of telling the story. Owing in part to resource constraint, local practitioners tended to work with people who quickly 'got it' (the structural, systemic nature of health inequalities) and focused their efforts on working in these partnerships; this was a reflection of the relational process of 'co-framing'. Other tactics were used to try and persuade unconvinced colleagues or elected members. There were multiple challenges, however, to framing consistency, coherency and comprehensiveness of coverage, and using a systemic frame was no guarantee of cross-sectoral collaborative working.

Discussion and conclusion: Re-framing health inequalities is challenging and relational for local practitioners. Local tactics that include tailoring, co-framing and building strong local examples offer promise.

Key words health inequalities • wider determinants • framing • local government

Introduction and background

It is well established and evidenced that the conditions within which we live significantly influence our health (Marmot and Bell, 2010). These social, economic, cultural, environmental and commercial factors – the wider determinants of health (WDOH) – are unequally distributed and produce health inequalities across the UK population. These differences are avoidable and unjust and numerous attempts have been made to address internationally, nationally and locally (Marmot et al, 2020).

A popular, internationally endorsed response to the problem has been to encourage greater intersectoral collaboration between the health sector and other parts of the policy system. So called 'Health in All Policies' (HiAP) involve cross-sector working to promote other policy areas' role in health, the value of health and wellbeing, and their contribution to enhancing population health and reducing health inequalities (Ståhl et al, 2006).

Addressing the WDOH through intersectoral collaboration has, however, proved problematic with disappointingly minimal progress (Smith et al, 2009b; Bambra et al, 2010; Cairney et al, 2021). Overall, the ability of collaborations to deliver health and health equity is poorly evidenced. Where robust studies exist, modest positive outcomes are reported (Smith et al, 2009b; Hayes et al, 2012; Ndumbe-Eyoh and Moffatt, 2013; Baum et al, 2019; Alderwick et al, 2021). An on-going challenge to the ambition of more joined-up policy and action is the inherently messy nature of policymaking and its political nature (Baker et al, 2018). Unpredictable and inescapable, the durations of political cycles, rhetorical constructions (for example, the 'deservingness and undeservingness' of disadvantaged populations), ideological positioning (for example, libertarian vs. redistributive) and political instability all impact on meaningful collaboration (Ollila, 2011; Carey, Mcloughlin and Crammond, 2015; Khayatzadeh-Mahani et al, 2018). Specifically in relation to HiAP, Cairney et al summarise that a gap exists between the desire to implement healthier public policy and a political failure to own and protect health improvement (Cairney et al, 2021).

Despite this troubling backdrop, there is continued endorsement of cross-sectoral collaboration to meet health equity goals. In Godziewski's terms there is a 'discursive multistakeholderism' (Godziewski, 2020). Evidence on how cross-sectoral collaborations function identifies factors such as the context of initiatives (social, political, economic, organisational), the process of partnership working, the presence or absence of supporting structures for collaboration and implementation factors as important (Shankardass et al, 2015; Clavier, 2016; Delany et al, 2016; Baum et al, 2019). A recent evidence synthesis represented these elements as a dynamic system that generated, reinforced or undermined the internal and external legitimacy and credibility of collaborations (Such et al, 2022). Central to this dynamic system of creating or damaging collaborative power were relational factors – the ways in which collaborative partners as institutions and individuals interacted with one another – in generating trust. There were strong connections between relational trust and capacity-building activities, realised opportunities for relationship building between sectors and meaningful engagement with affected communities. In addition, collaborative trust was built by creating and using a common language and shared understanding between partners (Such et al, 2022).

Studies have indicated, however, that sharing a common language and developing mutual understanding between sectors, disciplines and fields of policy and practice

is not straightforward (Orton et al, 2011). Collaborators may find it challenging to establish common ground (Delany et al, 2016) and find it difficult to tackle organisational culture to improve joined-up working (Carey and Crammond, 2015b). 'Rallying calls' are required to promote HiAP action including the use of 'provocative metaphors' such as 'social exclusion' and 'inclusion' (Carey and Crammond, 2015b). Strong leadership (including enthusiastic and consistent leadership from politicians) is needed to create an 'authorising environment' for HiAP that could create organisational and policy cultural change (Baum et al, 2019). Delaney et al revealed that avoiding the use of sector-specific language and exploring particular terms such as health and equity with partners were enablers to creating shared understanding (Delany et al, 2016).

There remains, however, limited evidence about if and how actors in the policy mix create a shared understanding and language of the WDOH and collaborative working to enhance health equity. The purpose of this paper is to explore this further: how the WDOH are framed and acted upon by people working within the public health system at a local level in England. It serves as a contribution to understanding if and how we can progress the goal of systems-level action on health inequalities and what are some of the processes of and challenges to this ambition. It is explored through the lens of 'framing', a communications approach that intends to influence how people think, feel and act.

What is framing? Theory and application

Framing is variously defined across fields. Policy studies/political science, for example, identifies framing as a strategic process of 'meaning making' that shapes understandings of issues and solutions through de/emphases on different elements (Rein and Schön, 1996; Koon et al, 2016; Moerschel et al, 2022). In social psychology, frames are cognitive and communicative models that guide audiences towards a particular interpretation of a message. They enable people to make the necessary mental shortcuts to make sense of complex or complicated information quickly and efficiently. In summary, they are messages about messages (Goffman, 1974; Gilliam and Bales, 2001). These representations of issues, schemes of interpretation (Goffman, 1974) or popular reasonings are then called upon in decision-making processes. It is argued, therefore, that how an issue is framed is 'crucial to public reasoning' (Gilliam and Bales, 2001:4) and, by extension, action. It is important to note that framings relate to both problem definition ('agenda setting'; Kingdon, 1997) and causal interpretation as well as solutions- or action-focused rationales/justifications. They are fundamental to the political actors' toolbox in that they promote particular 'ways of seeing and doing' and can silence alternative framings (Kingdon, 1997). Of course, formal party-political actors are just one (albeit powerful) voice in the framing landscape. Issues undertake constant framing by a range of actors (for example, media, citizens, advocates, activists) representing a range of perspectives, and dominance is contested and changes over time (Steensland, 2008).

There are many examples of dominant issue frames across public policy, and there is extensive commentary on how frames or narratives have been challenged and have shifted or remained 'sticky' over time. Immigration in the US and welfare in the UK have, for example, been dominated by enduring 'deservingness' frames (Yoo, 2008; Garthwaite, 2011). A single dominant frame is less clear on the WDOH and health

inequalities. Indeed, a scoping review by Koon and colleagues identified that health policy framings were characterised by multiple frames in a highly-contested political space (Koon et al, 2016). The range of WDOH and health inequalities framings is, however, characterised by the series of dominant public perceptions. Understandings of health, for example, are largely based on individualised notions of lifestyle and personal choice, and means of achieving health in the UK often focus on the NHS and making individual, health-promoting choices such as taking more exercise or eating a healthier diet (FrameWorks Institute, 2022). In a study explicitly focused on people's understandings of health inequalities, Smith and Anderson also identified that people experiencing socioeconomic hardship often had a good understanding of the health harm of poor living conditions yet were often reluctant to explicitly acknowledge health inequalities (Smith and Anderson, 2018).

Among policymakers, Baker et al identified that health inequalities issue frames were characterised by an emphasis on the health behaviours of the disadvantaged (Baker et al, 2018). Smith et al record a striking similarity across Britain's devolved governments in this dominant framing, with a tendency to identify health inequalities as a problem of and for the poor (Smith et al, 2009a). In a later paper, Smith notes that 'ideational filters' in government resulted in the successful inclusion of lifestyle-behavioural ideas in policy, but the failure of material-structural ideas beyond rhetoric (Smith, 2013). This slippage from the rhetoric of health inequalities as a material-structural issue to one of lifestyle is characteristic of the public health system in England, a so-called 'lifestyle drift' in policy (Orton et al, 2011). Its dominance limits the room available for alternative, more structurally-oriented frames of understanding to emerge and gain purchase in policy.

In recognition of this, the purpose of this paper is threefold: first, to explore how, to date, the problem of framing health inequalities, the WDOH and HiAP has been addressed in advice and guidance in the UK. Second, to explore if/how this guidance relates to the experience of people working in cross-sectoral partnerships to address inequalities in their local areas. Finally, the implications of the findings for the future of local-level framing for action on the WDOH are presented.

Contemporary evidence-informed advice and guidance on framing the wider determinants, health inequalities and policy responses in the UK

Wider determinants of health

The UK health charity, the Health Foundation, undertook a comprehensive programme of work with the US-based FrameWorks Institute to spell out the dominant extant frames of the WDOH and how these can be reframed to promote action on health inequalities (Levay et al, 2018; L'Hôte et al, 2018; Elwell-Sutton et al, 2019; FrameWorks Institute, 2022). Through large-scale development and testing, the Health Foundation argue for a *systemic framing* of health that pushes back on dominant *individualised frames*. Such systemic framing locates the root of the causes of health in society's structures and environments. Through this lens, obesity prevention, for example, is not a question of individual choice and behaviour change but a consequence of an obesogenic environment that this is amenable to change through policy intervention (Khayatzadeh-Mahani et al, 2018).

The Health Foundation/FrameWorks Institute recommend three main steps on framing the WDOH (FrameWorks Institute, 2022). Their recommended steps include:

1. Showing why the WDOH matter. This recommendation highlights the need to frame the issue as a 'matter of life and death'; that people in the poorest parts of the UK are dying years earlier than people in wealthier areas.
2. Harnessing the power of explanation. This is about 'going deep' in explanations to show how health is shaped by the wider determinants and why experiences are unequal. Offering a narrative that uses 'building blocks' of how health is affected by, for example, poor housing or a lack of paid employment is advocated.
3. Showing change is possible. This is 'solutions-focused'; centring on problems being fixable, using concrete examples on what types of solutions are needed to improve outcomes. These focus on fixing systems, not people. It identifies policies such as Minimum Living Wage policies (that is, policies outside a traditional 'health' remit) as examples of possible solutions. The guidance does not, however, explicitly identify that health and non-health colleagues have to work together to promote these policy changes. Rather the guidelines focus on using a single policy example to illustrate the difference policy can make to the WDOH.

An attendant toolkit offers a summarised guide to local policy and practice actors on why, how, where, when and with whom to use these narrative constructions. It is intended that the use of these framings consistently can normalise a more systemic perspective and a more structurally-oriented response. It is implied that these strategies are dependent on widespread adoption, popularisation and repetition in order to gain prominence.

Health inequalities and Health in All Policies

Framing health inequalities and HiAP as topics for policy and local conversation is supported by a range tools. While space does not allow for a comprehensive review of all such materials, two key resources provide helpful insight: the Public Health England *Health inequalities: starting the conversation. A toolkit to support local conversations aimed at understanding and reducing health inequalities* (PHE, 2014), and the Local Government Association's *Health in All Policies: A manual for local government* (LGA, 2016).

The PHE publication (PHE, 2014) identifies seven principles to support effective dialogue on health inequalities:

1. Ensuring transparency of purpose, objectives and intended outcomes in public dialogue about the issue. Clarity that dialogue is seeking to improve quality of life, health and wellbeing of local people.
2. Using language and narrative which resonates with people. Dialogue is focused on people's lived experiences.
3. Supporting safe, active, equal and informed discussion among all participants. Plain English and allowing participants to get to know one another is important for inclusivity and trust. Seldom-heard groups should be appropriately represented.
4. Involving stakeholders. This should be balanced with the involvement of publics.

5. Incorporating an asset-based approach in the dialogue. This is about avoiding 'deficit' framings and promoting the key assets of a community. This is expected to promote a more positive and holistic approach to action.
6. Continuing the conversation. This highlights the need to be transparent about how dialogue will be used in decision making and if/how it will be sustained.
7. Reviewing and improving the process. This is a reflection stage that feeds back learning into subsequent dialogues.

The LGA take a further step into the policy implications of wider determinants and health inequalities framings by identifying how to 'talk' about HiAP[1] (LGA, 2016). They identify three core steps:

1) Triggering an environmental frame in the first instance by identifying that the environments in which people are born, live, study, work, play and grow old shape health outcomes.
2) Stating values. This is about connecting people in dialogue to broad and commonly held values such as fairness, efficiency, opportunity and equality. This is considered a good starting point to talk about HiAP
3) Stating the solution clearly and giving it as much as or more attention than the problem.

Connected to these key sources of framing guidance is the King's Fund (2013) report for local authority leaders on nine key areas of action that have high potential to improve the public's health: 1) early years/the best start in life; 2) healthy schools and pupils; 3) helping people find good jobs and stay in work; 4) active and safe travel; 5) warmer and safer homes; 6) access to green and open spaces, and the role of leisure services; 7) strong communities, wellbeing and resilience; 8) public protection and regulatory services (including takeaway/fast food, air pollution, and fire safety); and 9) health and spatial planning (King's Fund, 2013). All of these focus on the WDOH and require collaborative, cross-sectoral action.

There are notable consistencies across these guidance documents. First, the shift to systemic or environmental framing is repeated across the guidance. Second, using resonant language and examples that speak to people's experiences cuts across recommendations. An action-orientation is also repeated with both the Health Foundation/FrameWorks and the LGA focusing heavily on solutions arising from framings.

Although not consistently explicit across the guidance, the notion of 'co-framing' or the co-creation of framings with affected parties is also relevant. There is an implicit suggestion that co-framing enhances the resonance of messages and the likelihood of coordinated action on the wider determinants. This relates back to the literature on HiAP on the importance of collaborators developing a shared language and understanding of the problem and its solutions. First suggested in relation to framing obesity, co-framing blends the interests of policy and practice sectors such as health with those of others (for example, agriculture, transport, education, planning), encouraging these sectors to work together to address the wider determinants of health and health inequalities (Khayatzadeh-Mahani et al, 2018). The emergence of 'co-framing' across sectors and citizens and its implicit place in some of the guidance warrants further attention. It is also notable that

PHE guidance seems to position dialogue as an event or a series of events, whereas the LGA and Health Foundation/FrameWorks guidance is proposed as a continuous process.

Taking into account the literature on HiAP, cross-sectoral collaboration and the guidance on framing the WDOH, health inequalities and HiAP, we are presented with a series of questions on how this knowledge relates to practice:

1. If/how people working within cross-sectoral partnerships for health equity frame the WDOH, health inequalities and HiAP-style responses.
2. If/how framings are used strategically or tactically with different people and partners.
3. If/how WDOH framings translate into systemic responses (for example, HiAP) and what are the opportunities and challenges experienced.

These questions are considered in the following analysis.

Methods

Study design

The study was designed as exploratory, qualitative research using in-depth, semi-structured interviews with local practitioners. Two regions of England were chosen to take part in the research: Yorkshire and the Humber and the West Midlands. These were chosen for both pragmatic and purposive reasons. First, the lead researcher was based in the Yorkshire Humber region and had existing connections to the West Midlands statutory sector. This enabled access to local practitioners. Second, both areas experience significant health inequalities, both relative to other areas of the UK and within their region. For example, in Yorkshire Humber, life expectancy is estimated at 78.3 years (2018–2020) which is 1.3 years less than life expectancy for the same period in the South East (80.6 years) (Office for National Statistics, 2021). In addition, life expectancy for women living in the Rotherham local authority area in 2020 was 79.8 years whereas in North Yorkshire it was 84.1 years (Office of Health Improvement and Disparities, 2021).

The onset of COVID-19 and a series of lockdowns across the UK reduced the size and scope of the original study, which was designed to included participatory mapping of HiAP across local authority and third-sector partners. During this time local authority public health departments (which were an important means of accessing participants within and outside the local public health system) were assigned to emergency response duties and face-to-face interaction was restricted. Before COVID, the lead researcher engaged in face-to-face familiarisation and discussion events with three local authorities (2019–early 2020). These centred on local health inequalities and how these were being addressed as well as the structures and practices of local governance. Two representatives of one local authority public health department also participated in a two-hour session of HiAP policy mapping and discussion in late 2019. These inputs informed interview topic guide design. The necessary change in the design of the project represents a limitation; richer insight (particularly context) was likely if the planned mix of qualitative methods had been fully applied.

Sample

The sample population was broad: to be included in the study, people had to self-identify as working in the general field of social inequalities with a health and wellbeing focus, health inequalities specifically or the wider determinants of health in their local areas. People could be working in local or regional statutory or third sector organisations. This was informed by the rationale that a broad range of local and regional agencies delivering policy and services addressed the wider determinants of health and inequalities. A purposive sample of key informants was drawn across a range of geographical areas within the regions. Diverse characteristics including local/regional, urban/rural, divergent socioeconomic and ethnic profiles, and contrasting party political local leadership were represented. All participants were working in active collaborations at the time of interview. The profile of interviewees is in Table 1.

Six different local authority (LA) areas were represented among the nine LA interviewees and two different English regions in the regional-level interviews. One interviewee was a senior public health leader, two were consultants in public health, two worked for a local charity network, and nine worked in more practice-facing roles (for example, health promotion, employment and health initiatives) that were cross-sectoral, either in a public health department in local government or in a regional agency.

Recruitment

Potential participants were approached through a variety of local and regional networks including programme-specific initiatives (for example, a local employment partnership board), research-practitioner collaborations (for example, National Institute for Health and Care Research (NIHR) Collaboration for Leadership in Applied Health Research and Care (CLAHRC) Yorkshire and Humber), through direct approaches to local authorities, online (http://hiay.org/) and through established local or regional fora (for example, communities of interest or practice). Snowballing was also used to recruit new participants.

Potential participants were given the opportunity to express an interest and were contacted by email with an information sheet and consent form. Consent forms were completed before the start of interviews; all participants were given opportunities to ask questions and provide informed consent.

Data collection

Semi-structured interviews using a topic guide were conducted either face-to-face (pre-pandemic) or online (during lockdown restrictions). All were audio-recorded (with permission) and transcribed verbatim. Interviews were structured around largely open-ended questions to allow participants to expand on their thoughts and answers

Table 1: Sample characteristics

Sample characteristics (n=14)	n
Worked in local authority	9
Worked in regional public health function with a cross-sectoral remit	3
Worked in third sector	2

and to speak freely about their experiences and examples in context. Interviews lasted, on average, 58 minutes and were conducted between December 2019 and September 2020. The limitations of time, resource and the impact of the pandemic on the research programme meant that data adequacy, rather than saturation, was reached. This means that the richness and complexity of data, alongside the extent to which the data addressed the area of research interest, was deemed suitable and appropriate (Braun and Clarke, 2021). It is likely that further themes relevant to framing would have emerged with a larger, more diverse sample. This is a further limitation of the study, although the focus of the analysis is applied and exploratory and 'dwells with uncertainty'; a necessary element of qualitative data interpretation (Braun and Clarke, 2021).

Analysis

Notes from the participatory events were used as context for the interview data. Transcripts were entered into the qualitative data software package NVivo 11 which was used for data management and coding. Extracts of interviews were coded with descriptive labels and then 'clustered' under higher order themes. A blend of deductive and inductive reasoning was used to develop themes and analysis; known, preexisting dominant frames were thematised alongside emergent themes from the interviews. Emergent themes provided much explanatory insight; they expanded on how framings were used in practice, in what context, with whom and why and what enhanced or limited their impact on action.

Ethics

Ethical approval for the study was granted by the University of Sheffield's School of Health and Related Research Ethics Committee, reference number 030027. Data are available at the University of Sheffield's Digital Research Database (ORDA) under a Creative Commons BY 4.0 licence. Link: 10.15131/shef.data.22732700.

Findings

Framing at the local level – how might it work in practice?

Interviews with people working in local systems facing population inequality challenges revealed a range of issues relevant to framing the WDOH and collaborations to address them at the local level. These were broadly: 1) How the WDOH and health inequalities were framed; 2) The tactics and strategies local actors employed when framing the WDOH and health inequalities; 3) The challenges of and to framing the WDOH and health inequalities.

'Doing' framing

How participants talked about WDOH and health inequalities

Interviewees described talking to colleagues outside of public health in a way that largely reflected systemic framings of the WDOH. While this mirrored the available advice and guidance, there were few examples of how this had been achieved in

a systematic way that was routine across an organisation, department or team. For example, interviewees talked about how living conditions and employment affected health and described engagement in committees, commissions (for example, Fairness Commissions), informal discussions, strategy creation and action planning with non-health colleagues, using population health data and wider determinant framings to present their case. For example, respondents talked about having conversations about inequalities as "unjust" / "the injustice of it all", about "doing the best for the population" / "making people's lives better", and using data and evidence to tell the story (LA1Pa, R1Pa, LA5Pb). Data and evidence featured heavily in how health inequalities issues were presented to colleagues outside of public health. A public health practitioner working with a planning department described using local health profiles and PHE 'Fingertips' data to identify the health and inequalities context of planning applications (LA5Pa). This approach of blending arguments of justice for the population with data and evidence represented a framing of the problem similar to the processes described in current framing guidance. It particularly relates to the early phases of stating what the problem is and linking it to the issue of injustice (for example, the statement that people are dying earlier than they should in Frameworks Institute / Health Foundation guidance). Using data and evidence to illustrate the WDOH is also supported in contemporary guidance but with a note of caution; data, it is argued, should be used sparingly to demonstrate a clear point and should not be used to 'speak for itself' (FrameWorks Institute, 2022). One participant recognised this challenge, noting how data and evidence was just one part of framing the problem, noting:

> I've always used this sort of quadrant approach where you've got your strategic leadership and advocacy, your networking and partnerships, your resources, tools, the evidence, the data… health inequalities and these abstract concepts – you need to create a sensible narrative. (R1Pa)

This reflection on creating a narrative that includes data and evidence but does not hinge upon it represents the perspective advocated in current guidelines.

Challenges with using existing language and different starting points

Some noted that communicating the WDOH and health inequalities was sometimes difficult. A public health practitioner, for example, said that, "sometimes I can't even explain what health inequalities are" (LA5Pb). Others referred to large volumes of existing information from which to draw framings, some of which was felt impenetrable to a person working outside the field of health inequalities. For example, a participant referred to the WHO definition of HiAP as: "The best [definition] I've seen is the WHO manual, but it's ginormous, and it'll never have any traction in my world 'cos I'm the only person in my organisation that'll actually read that document" (LA6Pa). These comments reflected an implicit need to find better ways of framing these interconnected concepts in a more routine and simplified fashion (FrameWorks Institute, 2022).

Participants also highlighted that people had different starting points when discussions concerned local wider determinants, health inequalities and actions to address them. There were signs that the scale of the challenge at the local level was considerable with a general low level of literacy of the issue across practice, policy

and political partners, except in a few, specific examples (for example, regeneration (LAP1a)). In response, local officials and practitioners chose their areas of cross-sectoral activity carefully (usually those people already engaged in the issue of inequalities) to avoid wasted effort and to optimise opportunities for change. There was evidence that getting colleagues to think about health and health inequalities was challenging:

> I think in terms of like the local authority, in other directorates and systems and possibly the elected members, I don't feel that health is probably not the most common thing that comes to the top of their priority list…. Some bits of the council kind of really get it and embrace it. And then I think some others don't. Like 'What's it got to do with me?' (LA1Pb)

Confident discursive multistakeholderism

It was evident that interviewees often talked about how health and non-health partners needed to work together to address many health inequalities challenges. This discursive multistakeholderism (Godziewski, 2020) was evident in sometimes taken-for-granted language; one respondent noted how the partnerships element of the local strategic plan was "obvious" (LA2Pb) and required no explanation. Respondents talked about routinely working together with other teams (for example, housing, planning, transport, environmental health), reflecting many of the King's Fund nine areas of local authority influence on health inequalities (King's Fund, 2013). Some roles were explicitly designed to "embed public health" across council policy areas (LA5Pb). One respondent identified that working in a wider determinants team in a council *without* partners was "totally ineffective" (LA5Pb).

The narrative of working together to solve health inequalities departs from FrameWorks/Health Foundation guidance which recommends framing the solutions in more straightforward single policy fashion. The LGA guidelines, however, identify the solution of HiAP as a logical next step in the narrative as many WDOH sit outside the traditional domain and power structures of the health sector (for example, setting the minimum wage, housing, education). They suggest that public health practitioners need to work to influence the decision making of others. This was reflected in the comments of a public health practitioner: "It is our job is to influence our colleagues, to influence our colleagues in planning or in the environmental health team, for example, as opposed to doing that work" (LA5b).

Tentative collaborative approaches

Discursive clarity about working collaboratively was not always matched with a confidence on how best to go about it. Working with collaborators was often a cautious, tentative and hit-and-miss process of establishing a negotiated shared understanding. The following example demonstrates how this was developed in one context. It flags some of the sensitivities and complexities, including values, that were points of negotiation between partners:

> [First, we] step back; 'What are we really about?' you know. And anybody in the rooms I sit in who says that they're not about 'Try and do the best for the population here' then we're not in the same place, are we? And then

you just build gentle stepping stones towards how your particular agendas or policy areas help towards some of that. But I think you have to give it the time to go right back. And be quite giving of yourself and your own values. People won't share where they're coming from unless we're quite open, value driven. (LA1Pa)

This quote highlights how the collectively held principle of working together could prove challenging to action; requiring an alignment of values that were not easily judged or immediately evident. In this respect, guidelines propose creating narratives that relate to commonly-held values such as fairness, efficiency, opportunity and equality (LGA, 2016), although, as we have already determined, some collaborators found communicating concepts such as (in)equality challenging.

'Getting it' and the tactics and relationships needed for HiAP

'Getting' the WDOH, health inequalities and what to do about them

There were positive signs that when systemic framings of the WDOH were shared, multiple, non-health colleagues 'got it'. This meant colleagues understood and appreciated what a wider determinants perspective looked like, what it was trying to do and how collaboration was a means of achieving goals. The language of working with people who 'got it' was strong: "The guy who was heading up planning who was really great, totally gets it… the housing colleague, she just gets it" (LA2Pb); whereas others talked about 'cultures' of collaboration: "It feels like we've got a culture of officers that genuinely want to work with us…. They see the value in what we can bring to the table, you know, a different perspective… we're on each other's radars" (LA2Pa).

Sometimes, finding people who 'got it' was a long process and a key part in developing wider relationships:

It was difficult, it's not easy. It's just plugging away at it, really. What I found in [place] – one particular person that works in planning – she really got it, what we were talking about, and so she's been our advocate, really, in planning and helping get everybody on board and it sort of developed through that relationship and that sort of got us into making that relationship wider. (LA5Pa)

This reflection indicates that deliberately working with key advocates or leaders who 'get it' could be a route into more widespread understanding of and action on the WDOH. It is possible that there may be a need for a critical mass of people across levels 'getting it' to enact more widespread change, as suggested by Carey and Crammond in the context of joined-up government (Carey and Crammond, 2015b).

'Winning hearts and minds' and co-framing

Participants expanded on the sorts of tactics they used in their attempts to get people 'on board' or to "make sure people are on the same wavelength" (R1Pb). Interviews reported conscious (active, deliberate) and/or implicit framing of WDOH was a core

part of their attempts to "win hearts and minds" (LA2Pb), and that this had to be "persistent and consistent" (LA5Pa). This was tactical, not least because, in the case of local councillors, "at the end of the day they have to vote for our policies – it's their decision. So, we've got to present information in a way that we know they'll understand and they'll realise why we want to do that for [the town]" (LA5Pa).

Those with a public health background spoke consistently about the need to ensure framing recognised the understandings and fields of others. This included acknowledging that work to address wider determinants had a long history in other professions. For some, this meant sometimes avoiding framing problems as health issues:

> With regeneration, the jobs message is getting through which does support the wider determinants of health. So, it's maybe not dressing it up as a health message – it's maybe dressing it up as a – you know, economic regeneration, or air quality [issue]. So not going in with a health message, it's going in with an air quality message which we know we can link into active travel which can link into people increasing physical activity and tackling obesity. (LA1Pb)

This reflects the concept of 'co-framing' across sectors (Khayatzadeh-Mahani et al, 2016).

Beyond polite co-framing: more forceful tactics

The theme of finding things in common, including values and end-goals were used alongside other more 'brute force' tactics like dogged persistence (for example, repeating the message relentlessly, standing your ground, attempting persuasion, "chipping away at it", "bringing things up in a meeting when it's awkward" [LA5Pb]). These methods could be hit-and-miss ("[I] try somebody else if that person doesn't work", LA2Pb) but was often carefully and tactically used with a "win-win" or a "give and take" (LA3Pa) focus. In one participant's terms: "People will do things for you if you ask them in a nice way and if you offer something in return" (LA3Pa).

At the core, then, of tactical framing was the intentional creation of collaborative relationships between people working across sectors. Sharing values, goals, motivations and a common approach to dealing with issues were the building blocks of them. As one public health professional put it, this meant "not being little public health dictators" (LA1Pa). They expanded on this by saying:

> It's about opening up what others see as the opportunities through their lens for delivery on [health inequalities]. As opposed to constructing it from a public health [perspective]. And I think we [public health] have to be a little bit less arrogant sometimes.… Some people have been round this territory a lot longer than we have and they've been doing stuff longer than we have. And they've got a lot of lessons to teach us. (LA1Pa)

The risk of the charge of 'health imperialism' (Cairney et al, 2021) was reflected in comments where health imperatives had "gone too far" in collaborations and led to speculations such as "[Colleagues] were like, 'Are you gonna tell people next that you can't eat a chocolate bar in public because you're gonna get obesity?'" (LA3Pa).

The tactic of letting others take the lead or public health humility, was not without risk, however. Some participants spoke about "ways in" to dialogue across non-health sectors, as, in part, one of "we haven't got the answer" (LA1Pb). Public health officials talked about letting others lead and about influencing others to act but not "doing" actions, reflecting the LGA's guidance on 'practising humility' (LGA, 2016: 25). However, the FrameWorks Institute findings indicated that efficacy was raised and fatalism reduced when narratives about how it was possible to act on the wider determinants were presented clearly (FrameWorks Institute, 2022). 'Not having all the answers' could add uncertainty and reduce that sense of confidence and efficacy required to enact change.

Tailoring narratives and examples to the local level

Reflecting the evidence that examples are important to mobilise systemic framings (PHE, 2014; FrameWorks Institute, 2022), the study revealed the importance of tailoring narratives using local examples. Some tailorings were considered straightforward, for example, planning for healthier environments and active travel. Others were emergent, more fragmented and harder to mobilise, such as developing narrative examples on 'inclusive economies', climate change, gambling, food poverty and food insecurity. This challenge was exacerbated when levers, mechanisms and resources for change were not seen to be accessible within local power structures (and the extent to which change could be evidenced). For example, work between public health and trading standards was identified as an empowered partnership that could address the health implications of alcohol licencing and illicit trading in tobacco (LA3Pa). In contrast, mobilising change to address the climate emergency though a public health or cross-sectoral partnership was only just "starting to make some inroads" (LA2Pa).

The strategy of situating the wider determinants in 'place'

One framing strategy that some local actors adopted was to situate the wider determinants within 'place-based' talk. This was a narrative device that emphasised the local characteristics of problems and how solutions were located in the 'place' of the town, city or county in question. Place-based narratives demonstrated that actors were knowledgeable about the locality and the people in it, and provided a focus for examples of the wider determinants and action on them in context. This was intended to enhance engagement. Some professionals were reported to demonstrate this proficiently. For example, in reference to a public health leader working to address health inequalities with elected members, one respondent commented:

> She's been around a lot, she knows [place]. Knowing street names, knowing names of stuff and having that personal relationship I think can help smooth the decision-making process. Just recognising it's not just data and stats, it's kind of stories with statistics, with evidence, but the storytelling, I think, is quite critical working with elected members. (LA1Pb)

Existing guidance, while highlighting the value of using 'deep dive' or detailed illustrative examples of the WDOH in framing, does not comment on this point

about the authenticity and local knowledge of the communicator. In this example, the tailoring of narratives to the specificities of place, based on local knowledge, appeared to be an important component of bringing political decision makers into the WDOH/HiAP fold.

The challenges of and to framing the WDOH for collaboration

Cross-sectoral collaborative challenges

As noted earlier, cross-sectoral collaboration is notoriously difficult to put into practice and the link to health equity outcomes is weak, at best (Smith et al, 2009b; Bambra et al, 2010; Holt et al, 2018; Godziewski, 2020; Cairney et al, 2021; Such et al, 2022). This was reflected in the responses of some respondents who expressed frustration that, despite using WDOH and health inequalities framings, the push to partnership working was not being matched by leadership and adequate resources. This was referred to as a "letting the wildflowers grow" approach to collaboration, continuing:

> This should really be driven from the centre and not just by saying 'Work in partnership. Get on with it. There's no other support or funding or anything else that comes with it'. And then, being critical of what's happening around the UK, in terms of partnership working if there's no real support behind it. (R1Pc)

The challenge of how to work with people who did not 'get it'

Individual challenges with framing the WDOH and health inequalities for collaborative action mostly related to the problem of how to work with people who did not 'get it' or would not to engage with a systemic frame. This could be especially challenging in the case of local politicians:

> One challenge has been sometimes how to get information over in a way that's understandable to them, so that when we're talking about policies, they have got an understanding of why we want to do it…. [Councillors are] still human beings with their own thoughts and their own prejudices and their own values and their own area of people that they want to keep on side. (LA5Pa)

This reflects a broader observation in the data that there were competing narratives or alternative framings, notably individualised framings such as the 'lifestyle choice' narrative, that impeded the mobilisation of more systemic framings. Some pushed back on this popular framing:

> Up until recently I'd say [people in the council think of] health improvement in the context of lifestyle behaviours and not the structural impact that actually has adverse or positive impacts on health. So, I think for some time we've had to get that message across to say 'It's beyond lifestyle behaviours and it's beyond an individual's control'. So, it's not down to an individual making. (LA2Pb)

There was some evidence that public health officials working in the health inequalities field felt that a misunderstanding or failure to engage with WDOH impacted on the

outcomes achieved. In one example, a systemic framing of child obesity led to an isolated 'daily mile' initiative in schools, rather than a focus on broader, upstream determinants. This felt disappointing and a point of failure for the public health practitioner:

> We banged on about it and then we just got that action, it was like 'Oh, okay, we've missed the point here'… obviously we didn't tell a good enough story… you were trying to do this population bigger, grander stuff and then it just was like, 'Oh, just do the daily mile'. (LA1Pb)

Conversely, interviewees reported that if political leaders were 'on-side' and connected to a systemic frame then this could be agenda- and policy-shaping:

> If we're struggling, if we've got issues or challenges that we need [the Health and Wellbeing portfolio holder] to help break down a little door for us or something, he's really supportive that way. So that when you're doing policies or trying to get something in policy, you've got more people on side because you've got that backing. (LA5Pa)

Organisational challenges: 'silos', capacity and ad-hoc practices

Several organisational challenges to mobilising collaborative working practices were reported, reflecting the literature. 'Traditional' or siloed institutional structures and practices were identified as a hindrance: "You're often up against traditional institutional biases. The sort of history and a mentality of an organisation. So often it can take a while to break those down and to find common ground" (R2P1).

Participants also reported how wider determinants work that required partnership was capacity-dependent and was often 'out-competed' by other, seemingly more urgent and immediate issues:

> Some colleagues with road safety and some of the major project stuff, I just didn't get anything back from them. Sometimes it's because they're so pressured and they've got to do their day job, it's not because they don't care or anything. (LA2Pb)
> Colleagues working in housing enforcement…. They're professionals, they've got a public health remit in a sense. But they've got no time… although the will's there, the resources and the time aren't there. (LA5Pb)

One further organisational challenge to consistent framing-to-action in local areas was a historically rooted opportunistic and ad-hoc approach to addressing the WDOH through collaboration. For example, participants commented that:

> I don't think it's systematic. I think, at this stage of the game, it's opportunistic. [It's] where we've got strong partnership arrangements, where we've got good connections, where we've got some expertise. (LA1Pa)

These characteristics of addressing the wider determinants in a non-routinised or strategic way was an on-going challenge to consistent framing and the coordinated

action across sectors that was needed. It was possible that ad-hoc working could, in fact, undermine how messages 'cut through' or were taken seriously by decision makers.

Sustaining continuous and consistent framing

There were also on-going challenges to sustaining a continuous and consistent framing; in public health terms, there were issues of both fidelity (the extent to which framings adhered to the guidance developed) and dosage (how much and how often the framings were repeated). Exposing potential and actual collaborators to a consistent and frequently repeated framing was challenging and, as we have seen, reportedly sometimes focused on those who 'got it'. It was also problematic in, what was, contested terrain:

> Every year I go and deliver training to our planning committee, so we'll talk through various topics. I've talked through about takeaways, I've explained the health impact assessment process, talked about the relationship between planning and public health… some of them'll grasp it and go with it, but there's others that I think like a bit of an argument, really. Like to challenge it. That can be quite tricky. You've just got to be consistent and persistent and keep using your skills to try and bring them round. (LA5Pa)

How often and how much partners, collaborators, colleagues or local politicians had to be exposed to systemic framing was unclear. Participants rarely discussed the amount of exposure people needed to discussions about the WDOH to 'bring them round'. Conversely, it was contested that repeating the narrative was always necessary:

> There's a strong narrative around public health. I don't feel the need to keep re-selling. I don't have to keep going to the tables of regen[eration] or whatever and say 'If we improve health outcomes we'll end up with a more economically productive city'. They get it. They know it. I don't need to keep reinforcing it. (LA1Pa)

Reference was also made to seemingly influential wide-scale mobilisation of 'signature issues' such as poverty by powerful local leaders (for example, a council leader or elected mayor) and how this was expected to act as a guiding light to action. This reflects the findings of others on how 'rallying calls' can be used by leaders to elicit action (Carey and Crammond, 2015a). Others identified small examples such as co-written strategies or the acceptance of health impact assessments in policy processes as evidence of effective framing-to-action. These intermediate steps or 'small victories' in pathways to broad acceptance of wider determinants framings and action offered some optimism that broader mobilisation was possible.

Discussion and conclusion

Framing the WDOH, health inequalities and what we do about them in a systemic frame and in a systematic way is a promising means of progressing better delivery on health inequalities in the UK. Extant guidance, built from robust research, suggests

it offers clearer, more consistent and universal understanding of the problem and the solutions (PHE, 2014; FrameWorks Institute, 2022). To address the research questions from this small, exploratory study:

1. If/how did people working within cross-sectoral partnerships with a health equity interest frame the WDOH, health inequalities and HiAP-style responses?

The findings presented here identify that systemic framing was used by people working in partnerships to address health inequalities. This was not characterised by organised, systematic and routine ways of presenting the WDOH, health inequalities or HiAP frame but there were many similarities between the guidance and participants' narratives. In particular, interviewees adopted a WDOH framing when talking about what the problem was (that health inequalities arose out of social-structural inequalities rather than lifestyle choices) and appealed to commonly held values about justice and fairness to communicate a moral imperative to address them. Participants appeared to lean on data and evidence to communicate the problem. Guidance suggests these should be used explicitly to demonstrate a key element of the problem (for example, inequalities in life expectancy). There appeared a risk that data and evidence could be over-emphasised, overused or not clearly explained, potentially confusing the audience. This risk relates to the observation that evidence is only one source of knowledge that can lead to collaboration in policy and practice; emotions and beliefs, for example, are shortcuts to decision making (Cairney et al, 2016) and local public health practitioners are advised to blend, for example, value-based narratives with well-explained local data and evidence. This was demonstrated in some participants' admiration of others' place-based knowledge and how they applied that to their narratives and negotiations. This relates to the need identified in the HiAP literature for advocates to demonstrate authenticity and inclusiveness to generate trust (Delany–Crowe et al, 2019; Such et al, 2022), and highlights how systemic framings need to be tailored to the local context. Future research could usefully explore how tailorings are developed and their effectiveness in mobilising action on the WDOH. Case study research would be especially useful.

2. If/how were framings used strategically or tactically with different people and partners?

Systemic framings were used as a tool to build relationships between internal and partnership colleagues and, sometimes, local politicians. The focus on building relationships in the interviews points towards the insight that framings were important in local action but perhaps less important than the relationships they developed. This reflects evidence on the relationality of HiAP (Holt et al, 2018). Multiple relational factors such as opportunities to engage with colleagues and working with different disciplines have been shown to contribute substantially to the success (or otherwise) of HiAP (Such et al, 2022).

Interviewees referred to this as the process of "getting it"; developing a shared understanding between colleagues about what the problem was and what they wanted to do about it. This could be a delicate process and participants indicated a preference, given resource constraints, for working with those who quickly or already "got it". This presents a known challenge to HiAP and other cross-sectoral initiatives. Working

in partnership to address challenging inequalities issues is evidently time-consuming and resource-intensive, and even apparently well-resourced HiAP initiatives have been limited in their impact by resource constraint (Delany et al, 2016; van Eyk et al, 2017). Lack of resources and capacity were sources of frustration in the current study.

Nevertheless, interviewees reported being persistent with their communication of the WDOH. Finding ways to more actively mobilise existing guidance, for example, through actors such as the LGA and Health Foundation in the UK, may help reduce the burden of framing among local actors. The future of framing at the local level also needs to address if and how local actors can promote the goal of 'getting it' among people who seem to be unreceptive to the message. Future research should also ask questions of what 'getting it' means in practice.

3. If/how were WDOH framings translated into systemic responses (for example, HiAP) and what were the opportunities and challenges experienced?

It was largely unclear if systemic framings translated into systemic responses in this small-scale study, although many respondents identified that such framings connected closely with active or prospective cross-sectoral collaborations. Partnerships and collaborations (a HiAP-style response) was often a taken-for-granted discursive element of framing the WDOH, a factor that the most recent FrameWorks Institute guidance does not cover. This discursive multistakeholderism has, however, been noted by others (Ollila, 2011; Godziewski, 2020) and is, therefore, likely an important element of future thinking about framing the WDOH and health inequalities. Among the current group of local actors, it appeared to be an extension of the WDOH and health inequalities framing and is probably one that, therefore, requires considering. It is unknown if these framings are helpful or unhelpful in furthering the cause for action. Future research should ask this question.

Opportunities for mobilising systemic framings included the many and varied examples of the WDOH, health inequalities and cross-sectoral working at the local level provided here. Interviewees reported working across multiple sectors with a range of colleagues. The number and range of working areas indicates that illustrating the WDOH through examples is accessible to local government. This helps fulfil the need identified in the guidelines to illustrate both the problem and solution through providing meaningful examples. Again, however, it is likely that support is needed to achieve this, given the reports some participants gave of how WDOH issues could get translated into lifestyle interventions, despite efforts to frame the problem in a systemic way. Addressing this issue in practice and through research, particularly with local politicians, would be a fruitful line of future enquiry.

Note

[1] The LGA acknowledge that the guide draws heavily from United States Public Health Institute, the California Department of Public Health and American Public Health Association (2013), Health in All Policies: a Guide for State and Local Governments.

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Conflict of interest
The author declares that there is no conflict of interest.

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