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## **First do no harm: Developing interventions that combat addiction without increasing inequalities**

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### **Abstract**

Interventions to combat addiction and related problems, like other public health interventions, have the capacity to increase health inequalities. To combat this, intervention developers should always undertake an analysis of the equity implications of interventions, set interventions in terms of a systems approach that takes account of reciprocal influences between 'upstream' and 'downstream' approaches, and act as advocates for strategies that address the social causes of inequalities.

**Key words:** health inequalities; complex systems; evaluation; intervention; policy; public health

**Declaration of interests:** None.

## **First do no harm: Developing interventions that combat addiction without increasing inequalities**

Across England, the life expectancy at birth gap between the 10% most deprived neighbourhoods and the 10% most affluent stands at around nine years for boys and seven years for girls [1]. These inequalities in health are ubiquitous across all high income countries - in the USA, for example, the life expectancy at birth gap between its most and least affluent counties is now over 20 years [2]. Health inequalities exist across almost all causes of morbidity and mortality ranging from obesity and cardiovascular disease to mental health and most cancers [1]. There is also a clear social patterning of addictions with harmful alcohol and tobacco consumption, problematic gambling, and drug use higher in lower socio-economic groups and in less affluent neighbourhoods [3]. For example, in the USA, smoking rates are almost double amongst adults living below the poverty line (26%) compared to those living above the poverty line (14%) and across Europe, binge drinking rates are considerably higher amongst those with the lowest educational level compared to those with the highest education [4] [5].

Addressing these socio-spatial inequalities in health and addictions has been one of the central aims of public health policy, practice and research - to a greater or lesser extent depending on the political mood [1]. The causes of these health inequalities are now fairly well understood. In the 40 years since the publication of the (in)famous Black report in the UK in 1980 (which was the first major piece of policy research internationally to set out the extent of health inequalities in a high income country) [6], there has been extensive research examining the determinants of these inequalities. A general consensus is now beginning to emerge that they are a product of the complex interaction of material, psychosocial, behavioural, and cultural factors experienced both individually and collectively and additionally structured by macro-level political and economic arrangements [1]. However, it is only recently that our sophisticated understanding of causality has actually been used to develop policies and interventions to explicitly address health inequalities. [1][6].

Although the evidence base on how to effectively tackle health inequalities is small and emergent [7], one area of research that is gaining increasing attention is that of intervention generated inequalities (so-called IGIs) [8]. Perhaps the most famous example of this is the Inverse Care Law - whereby the provision of health care services (including secondary prevention) is greater in areas with lower health need - thereby exacerbating existing inequalities in health [9]. This is increasingly the case as more health services across Europe are subject to marketisation and privatisation [10]. Additionally, there is suggestive evidence that IGIs might be a problem in the primary prevention strategies utilised in public health [8]. From a health equity perspective, this is important as interventions - however well intended - which inadvertently increase inequalities could be considered as 'harmful', even if they are beneficial to overall population health or reduce addictions within the general population. In the case of behavioural interventions this may be a result of their reliance on voluntary engagement with the programs [8] or because they do not address the wider social and economic factors that also shape socio-economic and spatial health inequalities [1][11]. For example, although the evidence base is still small, international systematic review evidence suggests that media based mass health promotion campaigns might increase inequalities (particularly in smoking and obesity) [12][13]. In contrast, primary prevention strategies that address the social - rather than just the behavioural - determinants of health and addictions and which use regulatory (e.g. age restrictions, standardised packaging; fast food marketing restrictions) or fiscal approaches (e.g. tobacco pricing; food subsidy programmes) may have more positive effects amongst lower socio-economic groups – thereby helping to reduce health inequalities [8][12][13].

The lessons from IGIs for public health and addiction policies are three-fold:

- Firstly, interventions that improve population health overall might not always be effective in terms of reducing health inequalities - so future initiatives should be equity checked and evaluated before full implementation. However, there is an accompanying issue about

whether policies that improve the absolute health of the most disadvantaged while also improving the health of the rest of the population should be criticised as IGIs – are they harmful? This raises important normative questions about whether the role of public health policy is to improve the status of those at the very bottom of society or whether it is about promoting more generalised equality [14]. Policy makers and practitioners of course need to balance reach and effectiveness alongside equity.

- Secondly, public health and addiction researchers and practitioners need to combine upstream and downstream approaches [6][7][11][12]. Indeed, addiction policy provides some examples of successfully intervening at multiple levels, with, many national tobacco control strategies successfully combining smoking bans with individual level smoking cessation interventions [11]. The *proportionate universalism* approach advocated in the seminal Marmot review of health inequalities in England (2010) is one potential way to address these issues – whereby interventions, such as smoking cessation schemes, have been shown to be effective when provided universally ‘but with a scale and intensity that is proportionate to the level of disadvantage’ [15, p.15]. This requires an understanding of complexity and the relational nature of the individual and contextual causes of health inequalities [11].
- Thirdly, researchers, practitioners and policymakers need to act as advocates for strategies that address both the behavioural and social causes of health inequalities [15] - especially in a time of austerity across Europe with associated reductions in public health services Where these are implemented, we need to work with policymakers to assess their effects on *both* population and equity outcomes, using a variety of methods to enhance the health inequalities evidence base [16].

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