Supplementary material

Contents

Table S1. Websites searched to identify sample

Dates of search: 8th-30th November 2018

URL	Description
www.gov.scot	Scottish Government
www.healthscotland.scot	NHS Health Scotland (lead agency in Scotland with responsibility for health improvement and health inequalities)
www.scot.nhs.uk	NHS Scotland
www.gov.uk	UK Government, including Public Health England (lead public health agency in England)
www.nhs.uk	NHS England
https://europa.eu/	European Union
https://ec.europa.eu	European Commission
https://www.who.int/	World Health Organisation
http://www.euro.who.int/en/home	World Health Organisation Regional Office for Europe

Figure S1a. Coding framework

		CATEGORY					
		Description	**Explanations**	**Relationships**	**Recommendations**	**Target/monitoring**	**Other not listed here**
EXPERIENCE	**Homelessness or unstable housing**						
	Imprisonment or offending						
	Substance use						
	Serious mental illness						
	Sex work						
	Other - generic						
	Other - specific						

Figure S1b. Coding scheme for issues of interest

Issue	Description	Does not include
Homelessness or unstable housing	• Use of terms "homelessness", "homeless", "unstable housing/unstably housed", "insecure(ly) housing/housed", "rough sleeping" and synonyms • Other descriptions of lifetime experience of having been roofless (without a shelter of any kind, e.g. sleeping rough), houseless (temporarily accommodated in institutions, shelters, or by friends/family), or living in insecure housing (e.g. insecure tenancies, potential to have to leave housing due to eviction or domestic violence) [based on ETHOS criteria]. Slums/informal settlements/squat are included under this code as they are generally insecure in nature.	General statements about housing where access to one's own house/housing security not at issue
Imprisonment or offending	• Use of terms "imprisonment", "prison", "prisoner", "offending", "offender", "involvement in criminal justice system" and synonyms • Other descriptions of lifetime experience of having been convicted of an offence and/or held in custody, whether on remand or sentenced. • References to crime and violent crime	References to domestic abuse where clearly focused on the victim
Substance use	• Use of terms "drug addiction", "drug problems", "substance use disorder", "drug user" and synonyms • Other descriptions of lifetime experience of use of substances illegal in the jurisdiction of the document.	
Serious mental illness	• Use of terms "serious mental illness", "severe mental illness", and synonyms • Other descriptions of lifetime experience of psychotic disorder (such as schizophrenia or bipolar disorder)	Mental (ill)health more generally – code under "Other –specific"
Sex work	• Use of terms "sex work(er)", "sex trade", "commercial sex", "prostitution" and synonyms	

	• Other descriptions of lifetime experience of having exchanged sexual acts for money, goods (including drugs), or services (including housing)	
Other - generic	• Statements referring to social inclusion, exclusion, cohesion • Statements about "vulnerable", "excluded", "hard to reach", or "disadvantaged" people or groups, without further detail as to which experiences are being referred to • Statements about people or groups who are described as being "at risk", without further detail as to how they are defined	Instances where clearly referring to socioeconomic disadvantage or area-based disadvantage Specific named forms of disadvantage e.g. in labour market
Other - specific	• Reference to another specific experience or population group, either: o typically considered as part of the 'inclusion health' agenda or commonly described as associated with social exclusion o mentioned in the context of inclusion, exclusion, disadvantage, or vulnerability Examples: • Ethnicity/migration/Indigenous status • Lone parents and carers • Care-experienced people • People with mental ill-health (other than SMI)	e.g. disability-free years e.g. disability benefits

Figure S1c. Coding scheme for categories of interest

Category	**Description**

Descriptions:	• Statements about the existence or nature of health inequalities according to these aspects of social experience • Statements about the prevalence of these aspects of social experience.
Explanations:	• Statements about why health inequalities of this kind exist, and their causes (proximal or distal) • Statements about social processes/distribution of social determinants within these groups which might affect health. • Includes case studies of individuals' lived experience as t
Intersections and relationships:	• Statements about the links between these experiences and/or with other forms of social or health inequality, such as socioeconomic position, ethnicity, age, gender etc – e.g. how they co-occur in the population or how they are causally related.
Recommendations	• Proposals for action to address these experiences and/or any associated health inequalities. May be explicit or implicit; latter may include case studies; statements of effectiveness of interventions. • Endorsement of existing actions/interventions to address these experiences and/or any associated health inequalities
Targets/monitoring:	• Proposals for the identification/ongoing monitoring of health inequalities associated with these experiences • Proposed normative values (absolute or relative) for specific health indicators
Priorities	• Statements of importance of experiences of interest to the health inequalities agenda, or their relative importance in relation to other forms of health inequality • May be explicit or implicit (e.g. choice of photos, highlight boxes etc).

Table S2. Overview of documents included in the sample.

	Equally Well (2008; 2010)	**Closing the Gap in a Generation (2008)**	**Solidarity in Health (2009)**	**Fair Society, Healthy Lives (The Marmot Review, 2010)**	**Review of Social Determinants of Health and the Health Divide in the WHO European Region (2014)**
Jurisdiction	Scotland	Global	European Union member states	England, though encompasses reserved policy areas affecting devolved UK nations	World Health Organisation European region
Background	Output of a Ministerial Task Force on Health Inequalities set up by incoming Scottish National Party minority Government in 2007. Published as a trio of social policy documents, alongside others on early years and poverty/income inequality).	Commissioned in 2005 by the WHO Director General, JW Lee.	Set up in 2008 following the EU Health Strategy (2007) and the EC's Communication on a Renewed Social Agenda (2008), which identified a need to carry out further work to reduce inequities in health.	Commissioned in 2008 under a Labour Government by the Secretary of State for Health, who had asked whether the results of Closing the Gap report could be applied to England.	Commissioned by the World Health Organisation Regional Office for Europe in order to inform the development of Health 2020, a European policy framework for health and wellbeing, and to apply and extend the evidence from Closing the Gap to the European context.
Authorship	Task Force membership included seven government ministers; Chief Medical Officer; and representatives from local authorities, academia, healthcare, third sector, and civil service. Published by the Scottish Government and endorsed by Convention of Scottish Local Authorities. Authorship not specifically described.	Chaired by Michael Marmot, assisted by 17 international commissioners with backgrounds in research, policy, and the third sector. Published by the World Health Organisation. Authorship not specifically described.	Report was jointly led by the Directorate-General for Employment Social Affairs and Equal Opportunities and the Directorate-General for Health and Consumers. Published as an official communication of the European Commission. Authorship not specifically described.	Chaired by Michael Marmot, assisted by ten Commissioners and nine task groups. Published independently by the Marmot review. Authorship not specifically described.	Carried out by "a consortium chaired by Michael Marmot and the Institute of Health Equity University College London and supported by a joint secretariat from the Institute and the WHO Regional Office for Europe". Marmot is named as lead author, with seven other contributing authors from the Institute of Health Equity.
Stated aims and objectives	Aims of original review: • "Agreeing priorities for cross-cutting government activity that will achieve measurable outcomes in reducing health inequalities. • Identifying practical measures to reduce the most significant and widening health inequalities. • Ensuring key sectors and organisations that are involved in delivering action on health inequalities work alongside the Task Force in order to build commitment and support." Objectives:	"To gather and review evidence on what needs to be done to reduce health inequalities within and between countries, and to report its recommendations for action to the Director-General of WHO."	The general objective was described as "to support and complement the efforts of Member States and stakeholders and mobilise EU policies towards reducing health inequalities". The specific objectives were to: • "Raise awareness, promote information, best-practice exchange and policy coordination and advocate the tackling of health inequalities as a policy priority;..	"…to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010…The Review had four tasks: 1. Identify, for the health inequalities challenge facing England, the evidence most relevant to underpinning future policy and action 2. Show how this evidence could be translated into practice	The report was commissioned "to address health inequities within and between countries across the 53 Member States of the European Region… The review's explicit purpose was to assemble new evidence that could be applied to the remarkable diversity of countries that make up the European Region, drawing on the findings and recommendations of the Closing the Gap".

	Equally Well (2008; 2010)	Closing the Gap in a Generation (2008)	Solidarity in Health (2009)	Fair Society, Healthy Lives (The Marmot Review, 2010)	Review of Social Determinants of Health and the Health Divide in the WHO European Region (2014)
	• "To reduce factors in the physical and social environments in Scotland that perpetuate health inequalities. • To build the resilience and capacity of individuals, families and communities to improve their health. • To enhance the contribution that public services make to reducing health inequalities."		• Improve data availability and the mechanisms to measure, monitor and report on inequalities in health across the EU and improve the knowledge base on the causes of health inequalities and the evidence base for action. • Develop the contribution of relevant EU policies towards reducing inequalities in health...."	3. Advise on possible objectives and measures… Publish a report of the Review's work that will contribute to the development of a post-2010 health inequalities strategy"	
Process	Engagement between Task Force and stakeholders including "members of the police, the business community, NHS Scotland, local authorities, and young people". Three specific consultations, targeting young people, third sector, and front-line staff and managers.	Following development of a conceptual framework, 9 'knowledge networks' collected evidence on specific topics, such as employment, social exclusion, and health systems. Also informed by engagement with regional networks; researchers; and 'country partners'.	A targeted written consultation of EU institutions, key groups convened by the Commission and wider stakeholders was undertaken, supplemented by expert input from research and monitoring projects funded or commissioned by EC institutions.	Nine task groups produced individual reports, which formed basis for evidence review and policy recommendations. Also informed by stakeholder engagement – scope and membership not described.	Thirteen task groups convened to review the evidence on the major social determinants of health, covering topics such as early years; employment and working conditions; social exclusion, disadvantage and vulnerability; and global influences.
Key recommendations	78 recommendations, under the headings of: • early years and young people • tackling poverty and increasing employment • physical environments and transport • alcohol, drugs and violence • health and wellbeing (primarily relating to healthcare provision) • delivering change (relating to plans for implementation and evaluation).	Three "overarching recommendations", accompanied by a total of 56 specific recommendations: • Improve daily living conditions • Tackle the inequitable distribution of power, money, and resources • Measure and understand the problem and assess the impact of action	Five "key issues to address", accompanied by a total of 20 "EU-level actions": • An equitable distribution of health as part of overall social and economic development • Improving the data and knowledge base • Building commitment across society • Meeting the needs of vulnerable groups • Developing the contribution of EU policies	Six policy objectives, with 18 specific recommendations: • Give every child the best start in life • Enable all children young people and adults to maximise their capabilities and have control • Create fair employment and good work for all • Ensure healthy standard of living for all • Create and develop healthy and sustainable places and communities • Strengthen the role and impact of ill health prevention	12 recommendations and 57 specific actions, in four themes: • The lifecourse (with particular emphasis on early years, as well as working ages and older ages) • Wider society (with particular reference to social cohesion, social protection, empowerment and resilience) • Macro-level context (with particular reference to the economic crisis and societal policies relevant to health) • Systems (with particular reference to 'whole-of-government' and 'whole-of-society' approaches.

Figure S2. Schematic diagram summarising how health inequalities associated with the issues of interest were described.

	Equally Well	Marmot Review	Solidarity in Health	Closing the Gap	Review for WHO-Europe
Homelessness	Poorer physical, mental, emotional health	Risk to health Identified as a group which is "particularly disadvantaged"	Greater burden of mortality and disease	Slums – higher rates of child mortality, TB, "life threatening" conditions	"Extreme negative effects on health" Increased rates of physical/mental morbidity, premature mortality High rates of TB
Offending and imprisonment	Mental health, substance use as particular problems, esp. among women High prevalence of learning ifficulties Poor physical health Impact on families				Growing inequalities in TB especially marked among those with history of incarceration TB in prison as contributor to overall high rates in former Soviet Union
Substance use	Rising inequalities in drug-related harms; drug-related deaths as driver of premature mortality among young Social/economic/family impact	Effects on foetal and early brain development; increasing number of babies born to mothers with opioid dependence		Important contributor to global burden of disease	
Sex work					
Serious mental illness				Important contributor to global burden of disease	
Other experience or generic references	Ethnicity – ethnic minorities have higher rates of cardiovascular disease, diabetes, but some have better mortality and self-rated health Disability, race, religion/belief, sexual orientation as axis of inequality LGBT - mental health problems, adverse health behaviours Learning disability - health risks and specific health problems e.g. obesity, respiratory disease People with mental health problems - health risks, specific conditions, premature mortality Looked after children and young people – substance use, suicide/self-harm, oral health Disadvantaged groups – "health particularly at risk"	Race/ethnicity, religion, language, sexual orientation, physical/mental health as domains of inequality Ethnicity - infant mortality, injuries, obesity, poorer general health Refugees/asylum seekers identified as groups which are "particularly disadvantaged" "Those in disadvantage" – excess mortality/morbidity from heart disease, cancers, drugs, alcohol, smoking, nutrition/obesity, accidents/violence, mental illness; differences in life expectancy and infant mortality	Roma – life expectancy gap Race and health inequalities across lifecourse Poor average health and greater mortality/disease burden among "vulnerable and socially excluded groups" e.g. migrant/ethnic minority status, disability, homelessness Persistent/growing health inequalities between most advantaged and most disadvantaged	Indigenous people – life expectancy gap Race/ethnicity – mortality rates, late diagnosis of cancer Internal migrants – experience "massive health burden" Disadvantaged groups – higher infant mortality, obesity	Roma – health/wellbeing, TB Ethnicity – malnutrition, life expectancy, maternal mortality, domestic violence Migrants – self-reported health, perinatal outcomes and maternal mortality, cardiovascular mortality, TB Most disadvantaged groups/communities experience much worse health (including TB) Social marginalisation along with poverty as underlying social determinant of TB

Figure S3. Schematic diagram summarising explanations for health inequalities associated with the issues of interest

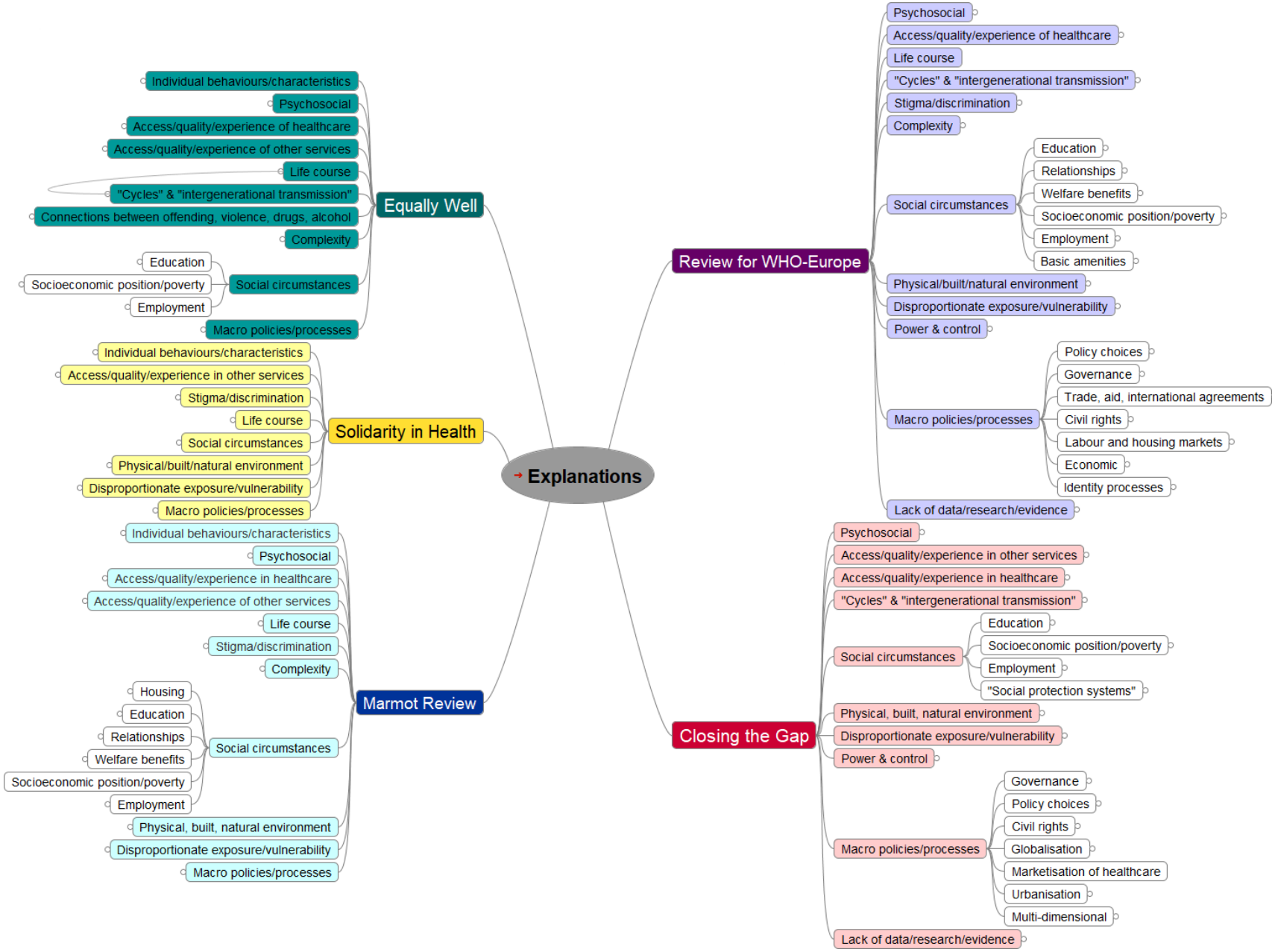

Figure S4. Schematic diagram summarising recommendations for tackling health inequalities associated with the issues of interest