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# Including ‘inclusion health’? A discourse analysis of health inequalities policy reviews

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## ABSTRACT

The ‘inclusion health’ agenda aims to draw attention to health disadvantages accompanying experiences putatively characterised by social exclusion, such as homelessness, problem substance use, or imprisonment. However, its increasing prominence has surfaced conceptual uncertainties and potential tensions with other understandings of health inequalities.

We undertook a discourse analysis of how recent health inequalities policy documents describe, explain, and make recommendations relating to inclusion health. Using the UK as a case study, and with reference to public health accounts of multi-level governance theory, we selected five recent health inequalities policy reviews covering Scotland, UK, European Union, and the World Health Organisation.

All documents referred to some inclusion health concerns, though their relative emphasis differed between documents. Terms like inclusion, exclusion, and vulnerability were commonly used, but ill-defined and often ambiguous. Explanatory discourses were diverse, with a particular focus on intergenerational cycles and disproportionate exposure to risk, with a varying emphasis on individual versus structural factors. Few documents provided coherent explanatory accounts for the relationship between the issues of interest to inclusion health, their associations with poor health, and other axes of inequality.

Our results suggest that health inequalities policymaking in a multi-level context may benefit from comprehensive conceptual frameworks which encompass diverse forms of social stratification, advantage, and disadvantage, and acknowledge potential tensions and trade-offs between different understandings. This may necessitate further theoretical and empirical work for inclusion health on its definitions, bounds, and how its scope of interest interacts with other forms of social and health inequality.

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## Introduction

The question of how to define, measure, and redress health inequalities is not straightforward and inevitably involves decisions and value judgements (Graham, 2009; Wistow et al., 2015). Policy discourses on health inequalities do not always reflect the available evidence; are utilised for different political purposes; and are often internally inconsistent between statements of the problem and recommendations for action (K. E. Smith et al., 2009; Graham, 2009; Lynch, 2017). Understanding such discourses is therefore important, since they simultaneously reflect and influence how the problem is conceptualised, how it should be tackled, and how success is defined.

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 Supplemental data for this article can be accessed [here](#)

Health inequalities are shaped by inter-dependent policy processes operating at sub-state, central state, and supra-state levels and include a multiplicity of actors from individuals and local communities to commercial, governmental, and civil society organisations: an example of multi-level governance in action, as described by other public health accounts (Katikireddi et al., 2016; Wilson, 2004). More than perhaps any other public health challenge, health inequalities require cross-cutting collaboration and co-ordination across levels and actors, but – in contrast to other topics (such as tobacco control or infectious disease) (Asare et al., 2009; Studlar & Cairney, 2019; Wilson, 2004) – suffer from a lack of common understanding of the problem or agreed roles and responsibilities (Harrington et al., 2009).

Recently, there has been increasing interest in policy, practice, and academic circles in ‘inclusion health’ (Marmot, 2018; Montague, 2018). There is at present no accepted definition or conceptual framework for inclusion health, though the most-widely cited paper on the topic defines it as ‘a research, service, and policy agenda that aims to prevent and redress health and social inequities among people in extremely poor health due to poverty, marginalisation, and multimorbidity’ (Aldridge et al., 2018). That is, it refers to efforts to improve the health of people experiencing social exclusion. Despite a long history of policy and academic interest in inclusion and exclusion in the UK and elsewhere, there is no consensus definition of these terms (Labonte, 2004; Levitas, 2006). Reflecting this, inclusion health discourses to date have encompassed a disparate range of experiences (including homelessness, imprisonment, substance use, sex work, serious mental illness, migration, and refugee/asylum seeker status) and identities (such as Indigenous, Gypsy/Traveller, or LGBT+ – lesbian, gay, bisexual, transgender, and other sexualities and gender identities).

Inclusion health may represent another conceptual iteration of the health inequalities problem, as well as a resurrection of the concept of ‘inclusion’ in policy discourses, after periods in and out of fashion (Levitas, 2006; Welshman, 2013). While it has arguably been successful in mobilising and unifying a community of practitioners, researchers, and advocates (Academy of Medical Royal Colleges, 2017; Allied Health Solutions, 2016; Luchenski et al., 2018), a greater emphasis on inclusion health within health inequalities policy is not without risks. Focusing on specific experiences like homelessness and substance use may cause health inequalities to be seen as a problem of an identifiable, disadvantaged minority, rather than a pervasive societal phenomenon: this risks stigmatising individuals and obscuring underlying structural drivers (Katikireddi & Valles, 2014).

The recent rise of inclusion health up the policy and service agenda is also potentially at odds with dominant understandings of health inequalities in terms of a socioeconomic gradient, since it draws attention to extreme health disadvantages experienced by a relatively small number of people: a tension akin to Rose’s ‘sick individuals’ versus ‘sick populations’ (K. E. Smith et al., 2009; Fisher et al., 2016; Graham, 2004; Rose, 1985; Vallgård, 2008).

There exist varying discourses within inclusion health about the role of socioeconomic position. Though the definition above explicitly identifies poverty as a causal factor, it has also been argued that the health inequalities with which inclusion health is concerned are at least partly independent of, or poorly captured by, conventional measures of socioeconomic position (Aldridge et al., 2018; Lewer et al., 2019). These understandings are not necessarily mutually exclusive: for instance, if social exclusion is conceptualised as a manifestation of extreme poverty, as per Marmot’s description of ‘deprivation upon stilts’ (Marmot, 2018). Alternative models might position socioeconomic disadvantage as a mediator between experiences of social exclusion and ill-health, an approach which has been influential in research on ethnic inequalities in health (Nazroo, 2003).

Though previous work has examined the construction of health inequalities in policy documents, it has largely focused on health inequalities defined solely by socioeconomic position (in the UK and Europe) or race/ethnicity/Indigenous status (in the United States and Australia/New Zealand) (K. E. Smith et al., 2009; Hill, 2015; Mackenbach & Bakker, 2003; Whitehead, 1998). However, there have been few attempts to study whether and how other forms of inequality feature in policy documents relating to health inequalities, or how relationships between different forms of inequality are understood.

Since the increasing prominence of inclusion health has surfaced conceptual uncertainties and potential tensions with other understandings of inequality, it is timely to examine whether and how this agenda has featured in health inequalities policy to date. We undertook a document analysis of flagship health inequalities policy reviews with the intention of identifying discourses deployed in: (1) *describing* health inequalities associated with the inclusion health agenda, (2) *explaining* them, and (3) *making recommendations* for action.

## Methods

We undertook a document analysis given the importance of written text to the formulation, communication, and implementation of policy (Prior, 2003). The UK is a suitable case study for this purpose given its established policy tradition and international influence in the field of health inequalities (Bartley & Blane, 2015; Mackenbach & Bakker, 2003). Our primary analytical approach was critical discourse analysis (CDA), which seeks to address social issues (in this case health inequalities) through critical readings of the relationship between language, social practices, and power relations (Fairclough, 2001).

### Selection of texts

Our focus was policy reviews produced or commissioned by governments or intergovernmental organisations to summarise existing evidence on health inequalities and make recommendations for policy. Freeman (2006) has described these publications as the ‘principal vehicle’ of the politics of health inequality, embodying and perpetuating dominant discourses of health inequalities.

In identifying the sample, we were informed by public health accounts of multi-level governance and therefore sought to reflect the different levels influencing UK health inequalities policy:

- a devolved administration, in this case the Scottish Government: powers for health and some related policy areas (such as housing, justice, and education);
- the UK Government: in addition to responsibility for England, retains power across the UK for reserved matters relevant to health inequalities such as employment, trade, and most social security policy;
- the European Union (EU), of which the UK was still a member at the time this project was initiated: supports member state activity and co-operation in several relevant policy areas and can adopt legislation in relation to public health and social policy in member states
- the World Health Organisation (WHO): global co-ordinating and influencing role, but does not mandate individual governments.

After searching government and public health agency websites (using terms listed in Table S2, supplementary material), we used existing research literature relating to UK health inequalities policy and discussion among the project team to identify ‘paradigmatic cases’ from each level of governance (Pavlich, 2010). These were defined as the most recent flagship policy review with an explicit focus on health inequalities, as indicated by either the title or subtitle. To be considered for inclusion, documents had to be published since 1998 and include both a statement of the problem and recommendations for action. Similar approaches to purposive sampling have been used in other research examining the policy construction of health inequalities (K. E. Smith et al., 2009; Fisher et al., 2016; Graham, 2004). This restriction enabled us to undertake close reading and in-depth analysis of each document, whilst still being able to identify the prevailing policy discourses in each jurisdiction.

The final sample consisted of the following documents:

- Scotland – Equally Well: Report of the Ministerial Task Force on Health Inequalities (2008), and subsequent review (2010)– referred to hereafter as ‘Equally Well 2008’ and ‘Equally Well 2010’

- UK – Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post-2010 (2010) – referred to hereafter as ‘the Marmot Review’
- EU – Solidarity in Health: Reducing Health Inequalities in the EU (2009) – main Communication and the section on ‘Statement of problem’ in the Impact Assessment – referred to hereafter as ‘Solidarity in Health’
- WHO –
  - European region: Review of social determinants of health and the health divide in the WHO-European region (2014) – referred to hereafter as ‘Review for WHO-Europe’
  - Global: Closing the Gap in a Generation: Commission on the Social Determinants of Health (2008) – referred to hereafter as ‘Closing the Gap’

Only one of our sample was published within the previous five years: this may reflect diminished policy attention to health inequalities, a lesser role in policymaking for such reviews, or the mainstreaming of inequality concerns into wider policymaking. However, in the absence of more recent documents, these reviews remain influential and are the most pragmatic source of data.

## Analysis

Our choice of CDA meant that in reading the texts, we focused on latent as well as manifest meanings, tensions in the construction of health inequalities, and relations of power within the documents (Fairclough, 2001). CDA informed our understanding the construction of health inequalities as a social practice, in which these documents participate through their creation and reproduction of different discourses about what health inequalities are, what causes them, and what should be done in response: in turn, these discourses exert power by determining policy options, research agendas, and broader societal perceptions of justice and injustice.

Since discourse analysis is a theoretical framework rather than a specific technique and is frequently used in combination with other approaches (Fairclough, 2001; Potter & Wetherell, 1987), we applied CDA using the framework method, in order to enable constant comparison; iteration during analysis; and transparency of interpretation (Spencer & Ritchie, 2002).

During familiarisation, an initial coding framework based on our research questions was iterated to develop a final version agreed by all authors (supplementary material). We operationalised topics of interest as those identified as the focus of existing inclusion health activity to date (Academy of Medical Royal Colleges, 2017; Department of Health, 2010; e.g. Luchenski et al., 2018), as well as additional experiences or identities identified during familiarisation. The first author then used the framework to guide line-by-line coding of source documents in NVivo 11. Results of coding were charted using the framework matrix function, accompanied by a second review of the source documents for completeness. Mind-maps were used to support discussion and collaborative interpretation within the study team, which drew on our understanding of the context and level of governance in which each document was situated (as described in Table S2, supplementary material). Illustrative quotations are included under ‘Results’, with underlining to highlight specific discursive devices or effects.

## Results

Table S2 in supplementary material summarises the included documents. Two were official governmental or intergovernmental publications (Equally Well and Solidarity in Health), while the remaining three were independently published, commissioned reviews (Closing the Gap, the Marmot Review, and Review for WHO-Europe).

### ***How did the inclusion health agenda, and the experiences within its remit, feature in the documents' descriptions of health inequalities?***

This section first describes how inclusion, exclusion, and related terms were described or defined within the documents, before moving on to examine how documents described health inequalities associated with these experiences.

### ***How were inclusion, exclusion, and related terms defined in the documents?***

Socioeconomic position dominated constructions of health inequality in most documents. No document made explicit reference to the inclusion health agenda, though all referred to some of the experiences typically considered within its remit (summarised in Figure S2 in the supplementary material).

Generic statements about people or groups as 'excluded', 'vulnerable', 'disadvantaged', or 'hard to reach' were common throughout the documents. These terms were rarely defined further; often used interchangeably; and frequently ambiguous in scope. A variety of specific examples were cited, including people experiencing homelessness, people with disabilities, some ethnic minority groups, migrants, unemployed people or people in precarious work, lone parents, and 'multiply deprived' families and communities. More implicit definitions appeared to be variously based on socioeconomic position, labour market participation, household type, health status, population norms, a lack of basic rights or services, a need for specific services, or combinations of these. Multiple possible readings of these terms were often evident within a single document.

Similarly, definitions of 'inclusion' and 'exclusion' varied. For instance, the Marmot Review used these terms in both in a narrow financial sense and a broader multi-dimensional sense relative to some normative group:

National target for social inclusion: It is proposed that there be a national target that progressively increases the proportion of households that have an income, after tax and benefits, that is sufficient for healthy living. (Marmot Review, p166)

It [social exclusion] is the multiple disadvantages experienced by particular groups and individuals existing outside the 'mainstream' of society. (Marmot Review, p137)

In contrast to the rest of the sample, the most recent document, Review for WHO-Europe, was unique in explicitly distancing itself from the perceived shortcomings of these 'labels':

From the perspective of the social determinants of health, it is important to understand exclusion, vulnerability and resilience as dynamic multidimensional processes operating through relationships of power. Previously, exclusion has too often been approached by focusing on the attributes of specific excluded groups. (Review for WHO-Europe, p xxix)

This definition of social exclusion as a continuum created by processes, rather than a binary state based on normative thresholds, allowed the Review to integrate exclusion into dominant conceptualisations of health inequalities as a social gradient, by arguing that the latter was the result of both 'socioeconomic processes (such as social stratification) and those that are exclusionary (unequal access to resources, capabilities, and rights)' (p8). However, it also sought to preserve continuity with social exclusion discourses which emphasise its distinctiveness from socioeconomic position by arguing that the social gradient in health was not linear for the 'most disadvantaged social groups and communities'.

### ***How were health inequalities associated with the experiences typically featuring in the inclusion health agenda described?***

Descriptions were generally dominated by medical and epidemiological discourses, with health a quantitative construct defined by the presence or absence of disease or other negative outcomes;

as illustrated by the quotations below. Broader understandings – based on wellbeing, quality of life, and self-reported measures – were less evident.

Vulnerable groups suffer a particularly greater burden of mortality and disease . . .

(Solidarity in Health, Impact Assessment p10)

Asthma and TB [tuberculosis] are common among homeless people, and a drug-resistant form of TB has emerged among homeless and other marginalized populations across Europe.

(Review for WHO-Europe p100)

Specific conditions were often associated with specific population groups: for instance, infections or mental ill-health among people with experience of imprisonment or homelessness. In relation to the health of people involved in offending or substance use, discourses of societal burden and harms to others – particularly children – were prominent, as in this example from *Equally Well*:

The health and wellbeing of offenders impacts not only on their individual life circumstances, but also on the wider health of families. The intergenerational impact of offending is clear. Approximately 15,500 children in Scotland lose a parent to prison per year. This impacts on the health, social and educational prospects of these children.

(*Equally Well* 2010, unnumbered page)

### ***What explanations were proposed for health inequalities relevant to the inclusion health agenda?***

This section briefly describes some of the overarching themes identified within explanatory discourses in terms of the presence or absence of explicit explanatory accounts; interactions between exclusion/inclusion and socioeconomic position; and references to intersections. It then moves on to examine in more detail discourses of lifecourse and intergenerational effects, and individual versus structural causes. The results of this section are summarised in schematic form in Figure S3 (supplementary material).

Though implicit claims were common, few documents provided coherent explanatory accounts for the relationship between the issues of interest to inclusion health, health inequalities, and broader social processes. One exception was *Review for WHO-Europe* which explained social exclusion as dynamic (dip in and out of vulnerable contexts’); continuous rather than binary (‘continuums of inclusion and exclusion and vulnerability’); context-specific (‘exclusionary processes and vulnerabilities vary among groups and societies over time’); and rooted in structural inequalities (‘historical and social processes operating through relationships of power’). The emphasis given to this conceptual and explanatory model is consistent with the document’s later argument that ‘conceptual failure’ contributes to a lack of policy progress on health inequalities.

Most documents alluded to potential interactions of socioeconomic position with other aspects of social identity and experience, in particular gender, ethnicity, migration, and disability. The *Review for WHO-Europe* went further in attempting to integrate socioeconomic understandings of health inequalities with those based on social exclusion, identifying a bidirectional relationship in which ‘poverty may result from, and contribute to, the processes of social exclusion’. The term ‘intersect’ was often used as a verb in this context, though it was not clear if these references were directly informed by intersectionality as a theoretical framework (Gkiouleka et al., 2018):

Other inequalities intersect in important and complex ways with socioeconomic position in shaping people’s health status.

(Marmot Review, p88-89)

Social inequity manifests across various intersecting social categories such as class, education, gender, age, ethnicity, disability, and geography.

(*Closing the Gap*, p18)

### ***Intergenerational and lifecourse explanations***

One explanatory discourse evident in most documents but particularly prominent within Equally Well, was intergenerational transmission or ‘cycles’ of exclusion and disadvantage. For instance, a case study in Equally Well invoked generational unemployment (‘an extended family none of whom have ever worked’); non-nuclear family structures (‘three “uncles” have convictions for serious violence’); parenting behaviours (‘outwith parental control’); and personal responsibility (‘his family resist offers of help’; p31) in describing a young man’s path to violent offending. However, the same document also referred to structural explanations, identifying ‘poverty, poor educational attainment, and lack of opportunities for young people’ as ‘the fundamental causes’ of violence, drug and alcohol misuse, and health inequalities more broadly (p33).

These were part of a broader set of discourses about lifecourse influences on health, especially prominent in the Marmot Review, which alluded to the importance of the early years; to the accumulation of disadvantages; and to potential differing impacts of inequality and exclusion at different stages of life.

### ***Individual and structural discourses***

More generally, the relative prominence of individual and structural discourses varied between documents and between explanatory factors. For instance, explanations focusing on healthcare access or quality generally gave prominence to systemic causes – such as marketisation and conditionality – though in some cases responsibility was attributed more to individuals, with the Marmot Review referring to barriers created by patients’ ‘capability’ and ‘chaotic lives’. In contrast, although stigma and discrimination were widely cited as causes of poor health, only Review for WHO-Europe provided a structural account of these processes, describing how anti-migrant sentiment could be shaped by institutional and policy environments. This document and Closing the Gap were unique among the documents in explaining some processes of social exclusion as deliberate political choices:

Active processes [of exclusion, disadvantage and vulnerability] are the direct and intended result of policy or discriminatory action including, for example, withholding political, economic, and social rights from migrant groups ...

(Review for WHO-Europe, p102)

Important features of the Nordic experience include commitment to universalist policies based on equality of rights to benefits and services, full employment, gender equity, and low levels of social exclusion.

(Closing the Gap, p33)

### ***What recommendations were made?***

Recommendations relating to the scope of inclusion health are summarised in Figure S4 (supplementary material). This section explores several dominant discursive themes relating to healthcare systems; intersectoral working; early intervention; and public involvement, before concluding with some reflections on each document’s concordance between explanations and recommendations.

### ***Healthcare systems***

In keeping with the dominance of biomedical and epidemiological discourses among descriptions, many of the recommendations relevant to inclusion health concerns were focused on healthcare. However, several documents did make recommendations with a broader role for health systems: for instance, Equally Well described how health services could challenge discrimination and act as an exemplar by employing ‘*vulnerable groups*’, while the Marmot Review recommended using the health service’s purchasing power to promote social inclusion locally.

## **Beyond healthcare systems**

Among recommendations beyond the healthcare system, intersectoral working was commonly mentioned. Examples included general references to ‘whole of society’ approaches, as well as specific case studies involving the sharing of funding, workforce, premises, or governance and processes. As the quotation below illustrates, most references to activities associated with intersectoral working were generic rather than concrete and actionable:

The Social Inclusion Initiative is the Government of South Australia’s response to addressing social exclusion through: facilitating joined-up implementation of programmes across government departments, sectors, and communities; sponsoring/employing innovative approaches; developing partnerships and relationships with stakeholders; and focusing on outcomes.

(Closing the Gap, p161)

Early intervention was another prominent discourse, especially in relation to the early years and families but also evident more broadly, particularly in Equally Well. Such discourses are consistent with the intergenerational focus of the documents’ explanations, though again there was a lack of specific examples and interventions:

To address health inequalities it is likely that public sector resources will have to focus on early interventions and prevention, and as part of that develop a more anticipatory and proactive approach to working with disadvantaged groups.

(Convention of Scottish Local Authorities, quoted in Equally Well 2008, p17)

Within recommendations relating to services and policy, discourses of public involvement were often present. While this was sometimes described as a means for improving the effectiveness or experience of services or policies, it was often justified in terms of benefits for individuals:

Promotion of the active engagement of service users can serve as a springboard for enhancing the lives of users who might be marginalised or stigmatised, enabling them to exercise greater degrees of control and responsibility.

(Marmot Review, p159)

A range of terms were used in this regard, including ‘engagement’, ‘consultation’, and ‘ownership’. Though each of these terms imply different levels of participation and power-sharing (Wait & Nolte, 2006), they were often used interchangeably within a given document, indicating a lack of clarity about the goals and processes involved. Only Closing the Gap and Review for WHO-Europe provided detailed descriptions of how greater involvement could be achieved, referring to the role of civil society and in general terms to new approaches to governance and decision-making.

A clear distinction was seen between documents invoking discourses of involvement to those of empowerment. Equally Well referred to ‘engagement’, ‘ownership’ and the need to ‘activate Scotland’s most vulnerable communities’, implying the existence of deficits of responsibility or motivation. On the other hand, in keeping with its explanatory model, Review for WHO-Europe emphasised the need to ‘empower disadvantaged groups relative to the societal systems with which they have contact’, seeing empowerment – and exclusion – as fundamentally relational and created by societal processes and institutions.

## **Consistency between explanations and recommendations**

Documents varied in their internal consistency between the explanations they proposed for health inequalities and the recommendations they made for action. Greater consistency was seen in those documents (Review for WHO-Europe and, to a lesser extent, Closing the Gap) which attempted to directly engage with the theoretical issues surrounding inclusion and vulnerability and which most clearly articulated with their relationship with broader societal processes and inequalities. One example of this is Review for WHO-Europe’s emphasis on empowerment, described above; another

is its recommendations on reducing exposure to exclusionary processes, by tackling incarceration rates, homelessness, and the rights of migrants.

In contrast, despite invoking ‘fundamental causes’ and socioeconomic inequality in its explanations, and a rhetorical commitment to prevention, Equally Well’s recommendations primarily focused on mitigation through service delivery, joint working, and individual-level prevention, rather than concrete policy changes in devolved areas such as housing or criminal justice which might serve to ‘undo’ or ‘resist’ the health inequalities with which inclusion health is concerned (Geronimus, 2000). (Geronimus, 2000) Similarly, while the Marmot Review’s overall recommendations addressed education, work, income, and place-making, many of those relating to inclusion health concerns focused on behavioural change, healthcare access, and targeted interventions.

## Discussion

The inclusion health agenda calls attention to populations experiencing extreme health disadvantage which are not always represented in conventional understandings of health inequalities. Though the inclusion health agenda brings potential risks and tensions, the dominance of socioeconomic position within health inequalities policy to date is also problematic, as approaches focusing exclusively on this dimension of social experience may fail to reflect the other forms of social position, power, and resources which determine individual and community health (Gkiouleka et al., 2018). As Hill has argued, diverse axes of health inequality share common drivers, and a broader understanding that goes beyond purely socioeconomic dimensions is essential for an effective response (Hill, 2015).

Our analysis shows that the inclusion health perspective is reflected to some extent in flagship policy reviews. Most reviews referred to some experiences associated with the inclusion health agenda, and associated health inequalities, though few proposed coherent explanatory accounts and explanatory discourses in each report were not always consistently reflected in their recommendations. We found that this area of health inequalities policy is conceptually under-developed, with terms such as inclusion, exclusion, vulnerability, and disadvantage used ambiguously and interchangeably. This may reflect constructive ambiguity, a discursive device permitting policy-makers flexibility in what ‘counts’ as action on health inequalities, especially when appetite for structural change is lacking (Carlisle, 2001). Others have argued that the term ‘vulnerable’ is used as a rhetorical device to avoid naming structural processes which put particular groups at risk; to limit the influence of such groups in policy (Stevens, 2019); and to justify responses of social control; conditionality; and responsabilisation (Brown & Wincup, 2019). This was arguably evident in the emphasis placed in some documents (particularly Equally Well) on ‘vulnerable’ families and targeted early years interventions. However, it is likely that this lack of clarity also reflects conceptual uncertainty within academic and practitioner discourses on inclusion health, particularly on the relationship between the issues of interest and other axes of inequality.

In explaining and making recommendations relating to inclusion health concerns, documents often simultaneously invoked individualistic, medicalised discourses and structural ones. For instance, health inequalities were often characterised in relation to specific diseases affecting specific populations, such as tuberculosis among people experiencing homelessness: while this may reflect the extant published research, none of the documents acknowledged potential biases within this evidence base as to which topics are studied among different populations, a phenomenon well-recognised in relation to ethnicity (Bhopal, 1997; G. D. Smith et al., 2000). The dominant role of healthcare in most documents’ recommendations is perhaps unsurprising given the well-documented medicalisation of policy responses to health inequalities (Clifford et al., 2019; Embrett & Randall, 2014; Fisher et al., 2016). Whilst healthcare – and a focus on specific conditions – can have a role to play, the dominance of individualistic and biomedical approaches can distract from potentially more impactful interventions seeking to address the societal conditions which give rise to health inequalities (Douglas, 2015)

The emphasis in most reviews on the early years and lifecourse influences on health often had parallels with what Levitas has identified as ‘moral underclass discourses’, which attribute inequalities to behavioural or cultural norms, parenting practices, and family structures among social groups constructed as peripheral (Levitas, 2006). Moreover, social models of explanation often focused on harms to others, particularly in the case of substance use: the people who use drugs, their social experience, and their ‘risk environment’ were largely absent (Rhodes, 2009). Those documents with more explicit explanatory frameworks tended to place greater emphasis on structural and societal factors than those without, and to have greater consistency between explanations and recommendations, though both individualistic and structural discourses co-existed in all documents.

Throughout the recommendations, discourses of early intervention and intersectoral working were prominent. This may reflect their status as ‘high valence’ ideas: abstract concepts which seem intuitively appealing and hard to dispute, but challenging to define and implement in practice (Boswell et al., 2019; Cox & Béland, 2013). Research in other areas of health policy have shown that early intervention is frequently constructed as inherently positive, precluding a more nuanced discussion of potential risks or opportunity costs (Clarke, 2007; Dixon-Woods et al., 2001): criticisms which could also apply to the texts in our analysis. Similarly, achieving genuine intersectoral working on health inequalities has been found to be consistently difficult, given diffusion of responsibility; lack of accountability; and differing motivations and approaches across different actors (Exworthy, 2008). This may be especially pertinent in relation to the issues examined here – for instance, there may be conflict between public health and criminal justice perspectives on individual versus population risks and rights in relation to the use of compulsion or restriction of freedoms – yet this was rarely acknowledged. This suggests that inclusion health has been incorporated into policy in a way that replicates existing shibboleths of health inequalities discourse, whose implicit assumptions and shortcomings may hinder shared understandings and action in the wider policy system.

To this end, our results suggest a need for policy reviews and guidance on health inequalities to be underpinned by comprehensive conceptual frameworks which go beyond single axes of inequality (such as socioeconomic status or race/ethnicity) to encompass diverse forms of social stratification, advantage, and disadvantage, and their intersections. Such frameworks can form the basis for a shared understanding necessary for action on health inequalities as a multi-level and multi-sectoral policy problem, and for making explicit the inherent tensions and trade-offs between different conceptualisations. For the inclusion health field, this may necessitate further theoretical and empirical work on its definitions, bounds, and how its scope of interest interacts with other forms of social and health inequality. In particular, the inclusion health agenda may benefit from moving away from its current emphasis on specific groups (defined by experience, identity, or illness) towards underlying processes (such as discrimination, criminalisation, political disenfranchisement, and intersection with other societal power structures), to provide greater conceptual clarity and consistency and avoid reinforcing the stigma it seeks to tackle.

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None

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