Public Health in Practice 6 (2023) 100430

Contents lists available at ScienceDirect

Public Health in Practice

journal homepage: www.sciencedirect.com/journal/public-health-in-practice

Editorial

Equity-focused evidence synthesis - A need to optimise our approach

Despite decades of evidence on health inequalities, we still lack a detailed understanding of what works to address them. While the reasons for this are multi-factorial, the research community has historically focused too much on the average effects of interventions and services. By doing so, we fail to understand how interventions can disproportionately affect disadvantaged groups, such as those on low incomes, minority ethnic communities and inclusion health groups, and potentially widen inequalities through so-called intervention-generated inequalities.

Over the past decade there has been a welcome move to examine research findings through an equity lens, particularly as health policymakers value health equity in decision-making [1,2]. The emergence of equity-focused systematic reviews has attempted to synthesise evidence to understand the distribution of benefit across groups. These reviews have been an important addition to the literature base, despite being highly contingent on the primary studies themselves reporting data by disadvantaged groups.

The PROGRESS-Plus framework was developed to consider health equity within systematic reviews, and subsequently endorsed by the Cochrane collaboration. Drawing from the WHO Commission on Social Determinants of Health [3], PROGRESS-Plus includes: Place of residence, Race/ethnicity/culture/language, Occupation, Gender/sex, Religion, Education, Socioeconomic status, and Social capital. The PLUS is an all-encompassing term, referring to all other potential determinants, for example age, sexual orientation, and disability. Since its development, PROGRESS-Plus has been increasingly used within systematic reviews [4]. Over the last five years (August 2018 to August 2023) articles which mention PROGRESS-Plus in the title or abstract increased by over four-fold compared to the preceding five years; from 17 articles to 71.

Despite the success of PROGRESS-Plus, there are notable limitations to the framework which have been highlighted by a recent critical analysis [5]. First, the categories stratify the determinants of inequity into discrete groups. Although this simplifies the framework, it disregards complexity, including intersectionality and the interaction between multiple aspects of disadvantage. Subgroup analysis which stratifies by a single dimension encourages the assumption that addressing one of these disadvantages will improve outcomes, without considering the dynamic and interacting nature of disadvantage. For instance, people who are on a low income and from a minority ethnic group might experience a compounding effect of disadvantage; interventions needed to improve outcomes for this group may be considerably different. An equity-focused evidence synthesis framework provides an opportunity to highlight the need for this perspective in research [6].

Second, inclusion health groups (such as people experiencing homelessness, asylum seekers, or street-based sex workers) are not explicitly mentioned in the PROGRESS-Plus criteria, risking them being overlooked. For instance, "Place of residence" is the category which would perhaps intuitively include those experiencing homelessness or living in temporary accommodation. However, when expanded by Lu et al. (2018) in a review on diabetes inequalities, this category was interpreted as location as being remote, rural or inner city [7]. Inclusion health groups are particularly vulnerable to poor health outcomes - they often live with multidimensional factors which affect their risk factors, access to treatment, and ultimately higher mortality rates [8]. Without mentioning these groups explicitly, the specific health needs of these groups may be unintentionally overlooked in equity analyses, with evidence gaps remaining uncovered.

Thirdly, PROGRESS-Plus seems to inconsistently prioritise some groups over others. For example, whilst occupation has its own category, sex and gender are conflated into one category despite extensive literature supporting their existence as different concepts. These two groups have important social and biological factors which may contribute to health inequalities across the life course. Furthermore, the factors included into the 'Plus' component of the framework have much less emphasis and can easily be forgotten in simplified versions of the framework. For example, whilst sexual orientation is technically included in the "Plus'' component of the framework, it is not included on the main Cochrane website [3]. Similarly, race, ethnicity, culture and language are combined. This varied emphasis could contribute to the fact that some categories are rarely reported. For example, in a Cochrane review examining how researchers approach inequalities in systematic reviews, only 1% of studies examined inequalities by religion [6].

Finally, PROGRESS-Plus does not consider the difference between gap and targeted interventions. Health inequalities interventions examined in research studies generally either seek to reduce the gap between two groups, such as socio-economic or ethnic groups, or target specific disadvantaged groups, such as homeless populations. Both data are important and should be included in any equity-focused review of the literature.

To build on the advancements made by PROGRESS-Plus, a more detailed conceptual framework needs to be developed which effectively reflects the complexities of health inequalities and highlights the difference between interventions aimed at closing the gap and those that are targeted at disadvantaged groups. It needs to balance flexibility with standardisation to ensure no sub-groups are neglected and that the impact of multiple intersecting disadvantage is considered. With health inequalities still entrenched after the pandemic and an increasing use of equity-focused research to shape health policy, now is the time to get

https://doi.org/10.1016/j.puhip.2023.100430

Available online 14 September 2023

this right.

References

[1] J.P. Vogel, A.D. Oxman, C. Glenton, et al., Policymakers' and other stakeholders' perceptions of key considerations for health system decisions and the presentation of evidence to inform those considerations: an international survey, Health Res. Pol. Syst. 11 (2013) 19, https://doi.org/10.1186/1478-4505-11-19.

[2] M. McKee, D. Altmann, A. Costello, et al., Open science communication: the first year of the UK's independent scientific advisory group for emergencies, Health Pol. 126 (3) (2022 Mar) 234–244, https://doi.org/10.1016/j.healthpol.2022.01.006. Epub 2022 Jan 15. PMID: 35140018; PMCID: PMC8760632.

[3] The Cochrane Collaboration, PROGRESS-plus, 2023. https://methods.cochrane.org/equity/projects/evidence-equity/progress-plus. (Accessed 1 August 2023).

[4] J. O'Neill, H. Tabish, V. Welch, et al., Applying an Equity Lens to Interventions: Using PROGRESS Ensures Consideration of Socially Stratifying Factors to Illuminate Inequities in Health, vol. 67, 2014, pp. 56–64.

[5] T.P. Kunonga, B. Hanratty, P. Bower, et al., A systematic review finds a lack of consensus in methodological approaches in health inequality/inequity focused reviews, J. Clin. Epidemiol. 156 (2023) 76–84.

[6] V. Welch, O. Deqindar, G.E. Tanjong, et al., How effects on health equity are assessed in systematic reviews of interventions, Cochrane Database Syst. Rev. (1) (2022), MR000028.

[7] J.B. Lu, K.J. Danko, M.D. Elfasy, 'Do quality improvement initiatives for diabetes care address social inequities? Secondary analysis of systematic review': supplementary table 1, BMJ Open 8 (2018), e018826.

[8] R.W. Aldridge, A. Story, S.W. Hwang, et al., 'Morbidity and mortality in homeless individuals, prisoners, sex workers, and individuals with substance use disorders in high-income countries: a systematic review and meta-analysis' the, Lancet 391 (2018) 241–250.

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