'Where's the Evidence? The contribution of lay knowledge to reducing health inequalities'

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Overview:
This lecture presented the case for lay knowledge and theories to be taken more seriously. Professor Popay argued that lay knowledge is sophisticated, helps to answer questions about meaning and experience, and should be treated as an 'equal but different' voice in informing decision-making about policy and practice.

Key Ideas:
- What is lay knowledge?
- How can it inform action to reduce health inequality?
- Concepts of meaning and causality.

Summary:
Focusing largely on experience in England, Professor Popay's lecture covered three main questions:
1. What is lay knowledge?
2. How can it inform action to reduce health inequalities?
3. Why isn't it taken more seriously?

1. What is lay knowledge?
Professor Popay characterised this as a robust approach to understanding, explaining and assigning meaning to everyday life. It usually has a narrative base, formed around talk and stories and is subjective in nature. Whereas science seeks to answer questions about causality, lay knowledge seeks to address meaning (e.g. why me?, why now?). Its use is often viewed as a remnant of a bygone, less scientific age. However, there is a growing recognition that lay knowledge can ascribe sophisticated meaning to events.

2. How can lay knowledge inform action to reduce health inequalities?
Three main ways were suggested:
- Improving the quality of care at both individual and collective levels.
- Providing a better understanding of behaviour by locating it in the context of everyday life.
- Addressing the wider determinants of health inequality by providing significant explanations for inequity.

Evidence and examples were highlighted for each area, and the case made that collaborative decision-making (e.g. doctors taking account of lay knowledge in their practice) leads to better outcomes.

Focusing on the issue of inequalities in health, Professor Popay described her research into lay explanations of health inequality. People living in more affluent areas and those living in poorer areas were presented with profiles of the health of their areas. The more affluent communities accepted the statistical descriptions of health inequalities readily and looked for explanations, usually located in lifestyles. A common response among respondents from poorer areas was firstly to reject the statistical picture and the labelling which tended to accompany it, and then to provide vivid accounts of the lived experience of inequality. In doing so, their narratives encompassed both personal and structural factors, and emphasised indirect mechanisms, such as stress. Strength of character was emphasised as the most important protective factor in dealing with the circumstances in which these individuals and communities were living. In concluding this section of the lecture, Professor Popay summarised by suggesting that lay theories of health inequality are a way of assigning meaning to the experience of being at the bottom end of the health statistics, through reconstructing moral worth, re-asserting individual control ('strength of character') and reconciling this internal control with the well understood context of structural constraints.

3. Why is lay knowledge not taken more seriously (in England)?

Professor Popay argued that a number of barriers are getting in the way of taking lay knowledge more seriously in England. Barriers were described in terms both of those relating to public sector organisations/professions and those in communities themselves.

Within public sector organisations and professions, the factor which receives most attention is lack of appropriate skills and competencies for community engagement – even though, it was argued, this is the least important. A second factor relates to professional and organisational cultures, particularly around risk aversion, which colours the quality of support and resources available to communities (e.g. inappropriately high levels of accountability for relatively low levels of support). A third factor concerns problems linked to the wider civic system. So, for example, while initiatives are set up with the genuine intention of providing long term engagement and support, six months later there is often an organisational need for 'quick wins', which disrupts the contract with the community and destroys resources necessary for longer term success such as trust and engagement. Professor Popay highlighted the related point that community engagement is too often seen as a delivery mechanism for organisational agendas rather than a valued resource in its own right.

Professor Popay went on to discuss the frequent assumption that poor people need to learn how to participate and that professionals are able to teach them how to do this; a situation which is abetted by control over resources. This has the tendency to reinforce power imbalances, dependency and inequality.

Turning to communities, one barrier to participation is often assumed to be a lack of capacity to do so. However, the primary difficulty is not a lack of capacity but the dominance of circumstances which do not encourage capacity to be unleashed. People living in poor circumstances say they will become involved if there are important and relevant issues to act upon, and if collective action is likely to be effective. However, it is not difficult to arrive at the conclusion that many people, acting upon the evidence of experience do not believe that collective action will be effective.

It is possible to identify three groups in relation to engagement:

- The engagers: the smallest group, those whose lives have been transformed by the experience of engagement.
- The disillusioned: a larger group for whom the experience of engagement was significantly damaging. (Linked to this, Professor Popay discussed the need to beware of the iatrogenic consequences of engagement.)
- The reluctant: the largest group who do not become involved because they have seen no evidence that this way of working can change things.

In this categorisation, most people will be 'disillusioned' or 'reluctant'. The task is not primarily to build their capacity to engage but to release it by addressing the barriers which lead to disillusionment and reluctance.

Conclusion

- Lay knowledge is not a silver bullet to understanding and tackling health inequalities, but it will enhance decisions and result in improved policy and services responses.
- Engagement strategies which are poorly conceived and undertaken are likely to have a damaging effect.
- The challenge is to release people's capacity to engage by addressing the issues that lead to reluctance and disillusionment.
- The process needs to be long-term, and to allow lay people to re-establish their social worth.

Finally, Professor Popay argued that the primary questions are not about how money is to be spent but are about involving people in enduring processes focusing on how life is to be lived. The struggle is over meaning rather than resources.