



# Beyond the Public Health/Political Science Stalemate in Health Inequalities: Can Deliberative Forums Help?

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## 1 INTRODUCTION: MINI-PUBLICS AND DELIBERATIVE FORA AS A SOLUTION TO THE STALEMATE?

As this book explores, we have recently witnessed multiple efforts to counter some of the shortcomings of the evidence-based policy ideal, many of which include strategies for democratising the production and utilisation of evidence. A 2020 special issue of *Evidence & Policy* suggests such strategies are much needed, given the ‘uneasy tension’ that exists between EBP and public participation (Stewart et al., 2020). Deliberative forums involving a small number of lay citizens (‘mini publics’) appear

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to be one of the most popular innovations for engaging publics in policy discussions (Jacquet & van der Does, 2020). This chapter explores one specific type of mini-public known as ‘citizens’ juries’ (see Box 1).

**Box 1: What Are Citizens’ Juries?**

Citizens’ juries are a method of deliberation, originally developed by the Jefferson Center in the USA. They involve a group of 12–24 individuals, selected to represent the demographics of the area or population of interest, being brought together to deliberate on a policy issue (generally clearly framed as a question), over the period of between two and seven days. ‘Jury’ reflects the design inspiration, taken from juries used within legal court cases: the ‘jurors’ are 12–24 demographically diverse participants, while the ‘witnesses’ are individuals invited to ‘give evidence’ to the citizens’ jury based on their expertise (e.g. in available evidence, personal or professional experiences, or a combination). The topics on which citizens’ juries deliberate tend to be complex policy issues (Wakeford, 2002), often involving normative/ethical dimensions. Over the period in which the jury meets, facilitators schedule structured encounters, which routinely involve the delivery of pre-conceived activities designed to help participants consider evidence and debate potentially desirable policy approaches (hence, these are spaces in which publics, evidence, and policy are all considered). Juries are intended to facilitate public engagement in democratic processes and so, ideally, ought to also involve commitments from decision-makers to engage with the results (Carney & Harris, 2013). There are multiple examples in which this has been the case, including several in Australia over the past decade (Victorian Local Government Association, Undated). However, in many cases, citizens’ juries are used for research purposes, albeit with some effort to bring findings to the attention of policy audiences (Street et al., 2014).

This chapter begins by outlining the case for citizens’ juries (and similar mini-publics) as a means of overcoming the ‘uneasy tension’ that Stewart et al. (2020) describe between efforts to promote evidence-informed policymaking and efforts to support democratically engaged policymaking. Next, it introduces the topic of health inequalities in the UK as a case study, explaining how efforts to achieve policy ambitions to reduce health differences between social groups achieved only limited success, despite a strong commitment to evidence-based policymaking from 1997 onwards. It notes that many of the key actors (in research and policy) have attributed this to a presumed lack of public support for research-informed

policy proposals to address health inequalities via redistributive, macro-level policies. It then challenges this presumption via a range of evidence, including qualitative studies, a national representative survey and a series of three citizens' juries, reflecting on the potential for citizens' juries to help overcome the apparent tensions that exist between evidence, policy and publics when it comes to tackling health inequalities in the UK. In the concluding discussion, this chapter returns to the broader literature on mini-publics to argue that deliberative spaces do appear to offer constructive discursive spaces in which it is possible to overcome potential tensions between evidence, policy and publics. However, it also argues there are reasons to be cautious about the potential role of deliberative forums, given the limited political engagement to date, concerns about potential tensions between representative and deliberative democracy, the high resources required, and challenges around ethically representing minority groups.

## 2 THE CASE FOR MINI-PUBLICS IN PUBLIC HEALTH POLICY

A 2014 systematic review of the use of citizens' juries in health policy research identified 37 studies that, between them, reported results from 66 juries (Street et al., 2014). One particularly high profile example has been in Ireland, where a citizens' assembly (similar to citizens' juries but slightly larger in format) informed a referendum on the topic, which subsequently led to a change in the law (Carolan, 2020). Yet, despite being widely used in health policy, there are only a small number of examples of published accounts of citizens' juries engaging in discussions about public (population) health, such as health inequalities, obesity, smoking or alcohol, with a view to influencing national health policy. This is despite the fact that a high-level review of the evidence on the social determinants of health specifically identified citizens' juries as a promising mechanism for those seeking to address the social determinants of health (Marmot, 2013).

Where deliberative methods have been used to explore citizen perspectives on tackling health differences, it has most often been at local, community level (Subica & Brown, 2020), which tends to restrict the potential policy options that can be discussed to those which are controlled by local decision-makers. However, there have been some interesting deliberative experiments on the topic of tackling obesity in

Australia (Anaf et al., 2018; Moretto et al., 2014; Street et al., 2017). For example, one of these citizens' juries 'unanimously called for government regulation to ensure that transnational fast food corporations pay taxes on profits in the country of income' (Anaf et al., 2018). A two-thirds majority of jury members 'also recommended government regulation to reduce fast food advertising, and improve standards of consumer information including a star-ratings system' (Anaf et al., 2018). In a separate citizens' jury, in South Australia, jury members agreed that obesity prevention requires multifaceted government intervention and made recommendations around health promotion and education, regulation of food marketing, taxation/subsidies and called for a parliamentary enquiry (Street et al., 2017). These two examples suggest, as did the Irish abortion example, that public views can sometimes be more sympathetic to the need for policy change than policymakers may presume.

### 3 THE CASE STUDY: TACKLING HEALTH INEQUALITIES IN SCOTLAND AND ENGLAND

This chapter builds on the conclusions of an earlier study that the lead author undertook of the relationship between evidence and policy relating to health inequalities in Scotland and England (Smith, 2013). The study, based on documentary analysis and a series of interviews with researchers and policymakers, found that a key issue was that most researchers and policy actors believed there was a lack of public support for the kinds of more egalitarian, macro-level policy changes research suggested was required to substantially reduce health inequalities. For example:

Policy advisor (interviewed 2011): *“Even if all the evidence said we must do this, but then again if there’s a whole opinion, national public opinion saying, well actually, no, we disagree with this approach, as an MP you would have to, obviously you have to weigh that in.”*

Senior academic (interviewed 2005): *“We’re not willing to live in societies where there’s equality in other domains, other than health. [...] In virtually every other domain of life, we don’t want equality; we actually worship inequality.”*

Overall, only 8 out of the 112 interviewees I interviewed in two linked studies (my PhD research 2004–2007 and a post-doctoral study that ran

2011–2012) claimed there was any public appetite for more egalitarian policies in the UK and no one claimed there was much media or political interest in such policies. This, then, was a powerful belief which worked to undermine and ‘filter out’ the research-informed ideas that pointed to the need for more egalitarian policy responses to inequalities in wealth, housing, education, etc. In effect, ‘the public’ were repeatedly implicated across interviews as political actors resistant to the kinds of policy proposals supported by the health inequalities research community. Yet, it was unclear how interviewees had reached this conclusion. When asked about the basis of these claims, interviewees’ accounts were often vague but commonly referred to media coverage, voting in general elections and general social attitudes surveys/polls. There were no references to empirical evidence relating to public understandings of health inequalities or specific views about responses to health inequalities. This is perhaps unsurprising given there has actually been very little research to explore public understandings of health inequalities and even less about public views on potential policy responses to health inequalities. Reflecting all this, suggests that the way in which interviewees referred to public preferences and beliefs is akin to Walker et al.’s (2010, p. 932) account of ‘the public’ as ‘imaginaries’ who were invoked in policy discussions, given agency and sometimes employed for strategic reasons (often in accounting for the failure of policy action to reflect prominent research-informed ideas, even though these ideas often featured in policy documents).

#### 4 EMPIRICAL EVIDENCE DEMONSTRATING GREATER THAN PERCEIVED ALIGNMENT BETWEEN PUBLIC VIEWS OF, AND RESEARCH ON, HEALTH INEQUALITIES

Informed by the above work, the lead author began asking questions about research on precisely this topic: what do members of the public in the UK think about health inequalities and potential policy responses, how has this been explored to date and are there any gaps in our knowledge. After considering multiple different options, it was decided to use a threefold approach involving: (i) a review of existing academic literature on this topic; (ii) a new national survey (which would follow up and expand some earlier survey work so allow some exploration of changes over time); and (iii) a series of deliberative citizens’ juries in three UK cities that had been widely studied in the health inequalities literature

(Glasgow, Manchester and Liverpool). The following sections provide a brief overview of the results of these three ways of trying to study what members of the public think about health inequalities and potential policy responses.

#### *4.1 What Does Existing Qualitative Research Tell Us About Public Understandings of Health Inequalities and Potential Policy Responses to These Inequalities in the UK?*

As a first step, the project tried to identify all published academic literature exploring public understandings of health inequalities and of potential policy responses (see Smith & Anderson, 2018). Despite a comprehensive search strategy, we identified only 17 relevant studies, most of which were qualitative, which we brought together as a meta-ethnography (informed by Noblit & Hare's [1988] approach to synthesising qualitative research). The findings of this synthesis (Smith & Anderson, 2018) suggest that people have sophisticated understandings of the underlying causes of socioeconomic health inequalities that closely mirror popular, research-informed theories about health inequalities (Bartley, 2004; Marmot, 2010). As Bolam et al. (2006) conclude, people's accounts tend to highlight the importance of both material-structural factors and social constructions of individual and collective experiences (i.e. of the deeply intertwined nature of materialist and psychosocial explanations of health inequalities). In particular, the emphasis that people place on experiences of employment, poor quality jobs and worklessness as health determinants, reflects extensive epidemiological evidence (Bambra, 2011). Indeed, while the complex and dynamic relationships linking people's experiences of socioeconomic deprivation to poor health make singular policy solutions unlikely, the findings add weight to calls for macro-level policy responses to health inequalities and suggest supportive employment policies are one of the most promising areas to focus on.

Likewise, the importance participants attached to experiencing fear, stress and social isolation, and their concern (and sometimes anger) at feeling judged or disrespected, all reflect research evidence concerning psychosocial pathways and relative social status and equality (Marmot, 2015). A recently published ethnographic and interview-based study of lay perspectives on health inequalities in north east England (not included in our meta-ethnography as it was published subsequently to our searches) also emphasised the importance of psychosocial pathways,

identifying ‘fatalism’ (linked to low sense of control) as a key psychosocial pathway linking disadvantage to poor health (Garthwaite & Bamba, 2017). This dimension of the findings underlines the importance of the ways in which public servants (from teachers to Job Centre staff and social workers) interact with the communities they serve. Indeed, in several cases, single experiences of disrespect, coercion or discrimination appeared to have had long-term consequences for participants. This suggests that the increased conditionality of welfare support (combined with cuts in public spending), in which those seeking benefits are required to provide an array of information to demonstrate their commitment to finding work (or to support their claim to be unable to work) is impacting negatively on health in Britain’s poorer communities, further exacerbating health inequalities.

Finally, participants consistently described proximal, behavioural contributors to poor health, such as high alcohol consumption, drug use, unhealthy diets and smoking, as ‘coping’ mechanisms or forms of escapism (i.e. as understandable responses to the multiple other factors impacting on wellbeing). This reinforces research claims that policy interventions aimed only at this level are unlikely to be effective in reducing health inequalities (Scott et al., 2013; Whitehead, 2007).

In sum, the lay explanations for the drivers of health inequalities in the UK appear to be sophisticated, multidimensional and in line with academic accounts (Marmot, 2010; Smith et al., 2016). Yet, seemingly paradoxically, the findings also suggest that people experiencing socio-economic deprivation are often unwilling to acknowledge the logical consequence of the impacts of the pathways linking structural disadvantage to poor health, i.e. the existence of health inequalities. We argue in the published paper (Smith & Anderson, 2018), following several authors of included studies, that this reflects an attempt to resist some of the stigma and shame associated with poverty (Walker et al., 2013), poor health (Scambler, 2008) and place (Wacquant et al., 2014) and to, instead, exert a sense of individual agency in the face of adversity. As Elliot and colleagues note, this presents a dilemma for researchers since, ‘acknowledging the impact of deprivation, disadvantage and exclusion is potentially to reinforce an identity that people may be trying to resist’ (Elliot et al., 2016, p. 229).

This paper made three suggestions as to how researchers might engage in public discussions that both avoid contributing to the stigmatisation of particular places and communities (labels that, Pearce [2012]

notes, can be both enduring and highly mobile) and begin enabling people to ‘imagine transformation’ (Elliot et al., 2016). First, we emphasised the importance of taking care with the choice of language used to discuss health inequalities, especially when focusing on particular places or communities. Second, we argued that researchers could do more to challenge binary oppositions (e.g. ‘poor’ versus ‘rich’, ‘healthy’ versus ‘unhealthy’) and instead explore the consequences of inequality for everyone. Hence, rather than yet more research focusing on disadvantaged communities, we made a case for studying how people across the social gradient (Marmot, 2010) understand health inequalities. Third, we argued that the focus of future health inequalities research should move beyond analysing the problem of health inequalities to better understanding potential proposals for their amelioration. As part of this, we called for more experimentation with deliberative democratic forms of engagement (Blacksher, 2013) and/or with participatory practices specifically intended to overcome alienation (Blencowe et al., 2015). These findings directly informed the development of a subsequent study that combined a representative sample survey with citizens’ juries to explore public views on potential policy responses to health inequalities in the UK.

#### *4.2 What Do Surveys Tell Us About Public Understandings of Health Inequalities and Potential Policy Responses to These Inequalities in the UK?*

We designed a national cross-sectional survey that was administered online by Opinium Research in August 2016 and involved 1,717 nationally (UK) representative respondents (for full methodological details, please see Smith et al., 2021). The survey asked questions on: perceptions of health inequalities; perceptions of 12 potential policy responses, selected on the basis that an earlier survey found they attracted significant support among researchers (Smith & Kandlik Eltanani, 2014); the role of government in tackling health inequalities; perceptions of income inequalities in the UK; sense of fairness; factors affecting participants’ health and key sociodemographic characteristics. For the purposes of this chapter, we are going to highlight three key findings.

First, the results suggest that ~70% of respondents were aware richer people live longer but most people did not seem to think poorer people were more likely to experience key NCDs (heart disease and cancer),



mental ill health or accidents. In other words, while people are aware of overarching inequalities in life expectancy, they seem less aware of the morbidity and mortality patterns underlying this overarching pattern. In this respect, the results were surprisingly similar to a survey undertaken almost two decades earlier, in 1997, described by Macintyre et al. (2006). This suggests public recognition of health inequalities and the patterns of ill health underlying health inequalities has not increased since 1997. Given the amount of policy attention that has been invested in health inequalities in the UK in the intervening period (Mackenbach, 2011; Marmot, 2010; Smith, 2013), this was surprising.

The second and third key findings draw on survey responses to a series of questions that used a Likert scale to ask respondents how likely they felt particular policy responses were to reduce health inequalities in the UK, with 5 signalling strongly agree and 1 strongly disagree. Table 1 presents an overview of the mean scores and standard deviation for each policy proposal included in the survey and uses colour shading to distinguish distinctive types of policy response.

The second key finding is that, when it comes to public views about proposals for tackling health inequalities, support seems particularly strong for the notion that the National Health Service (NHS) can and should play a key role in responding to health inequalities (the top two proposals focus on the NHS—a general investment in the NHS and a specific investment in GP services). The popularity of these two policy proposals is unsurprising in the context of research undertaken by The Health Foundation around the same time demonstrating that the NHS is held in very high regard by members of the UK public (Gershlick et al., 2015). However, this finding is important because it is out of line with the views of many health inequalities researchers, who tend to believe that the NHS (a service primarily designed to treat—rather than prevent—ill health) can play only a limited role in tackling health inequalities (Smith, 2013; Smith & Kandlik Eltanani, 2014).

The third key finding is that, contrast to the beliefs of the interviewees in my earlier research (see Sect. 3 of this chapter), most respondents supported most of the macro-level policy proposals included in the survey as likely to be effective responses to health inequalities. This included two economic proposals focusing on wealth, increasing the minimum wage and introducing higher taxes for richer people, as well as a range of proposals to provide various forms of social support, broadly with a view to improving living and working conditions. The three proposals

**Table 1** Average public support for policy proposals for tackling health inequalities according to the national sample survey (from most to least popular)

Specific policy proposal	Broader policy approach (colour coded)	Average public support within national survey (n=1717)		Ranking (most support = 1, least support = 12)
		Mean (SD)	% agree /strongly agree	
Spend more money on the National Health Service (NHS)	Health Services	4.33 (0.93)	79%	1.
Spend more money on General Practitioner (GP) services	Health Services	4.12 (0.95)	73%	2.
Provide more support for unemployed people to find jobs	Social support	3.91 (0.98)	65%	3.
Spend more money on support services	Social support	3.90 (1.02)	65%	4.
Limit advertising of unhealthy products	Regulatory driven behavioural change	3.86 (1.17)	62%	5.
Increase the Minimum Wage	Economy-wealth	3.86 (1.12)	61%	6.
Spend more money on social housing	Social support	3.75 (1.12)	58%	7.
Provide the public with more health information	Health promotion	3.59 (1.08)	50%	8.
Introduce higher taxes for richer people	Economy-wealth	3.54 (1.30)	53%	9.
Plain packaging for cigarettes	Regulatory driven behavioural change	3.36 (1.37)	43%	10.
Increase the price of unhealthy products	Fiscally driven behavioural change	3.32 (1.32)	45%	11.
Spend more on smoking cessation services	Health promotion	3.20 (1.17)	37%	12.

that performed least well in the survey, the only three to achieve less than 50% of respondents agreeing/strongly agreeing they were likely to reduce health inequalities, were all targeted at trying to achieve behavioural change (two focused on smoking). Here, the findings suggest public views are more in line with researchers' own views about the kinds of policy responses that are likely to be effective in reducing health inequalities (Smith, 2013; Smith & Kandlik Eltanani, 2014).

A survey like this is limited in the insights it can provide. It tells us only how the sample of participants responded at a given point in time, and it asked people to respond 'off the top of their heads', providing no additional information or opportunity for discussion. We therefore know very little about why participants answered as they did or whether, had they had an opportunity to engage with evidence and to deliberate with others, their views might have shifted. The data from the citizens' juries are much more informative in this regard.

#### *4.3 What Do Citizens' Juries Tell Us About Public Understandings of Health Inequalities and Potential Policy Responses to These Inequalities in the UK?*

Three two-day citizens' juries were undertaken in July 2016 in Glasgow ( $n = 20$ ), Liverpool ( $n = 20$ ) and Manchester ( $n = 17$ ) (total  $n = 57$ )<sup>1</sup> (again, for full methodological details, please see Smith et al., 2021). These cities were purposively sampled, as they all have large health gaps within their populations and share a similar socio-political context, including experience of post-industrial decline; all of which have led to previous comparative studies of health inequalities across the three cities (Walsh et al., 2010). Table 2 summarises the sociodemographic characteristics of the final sample.

The profile of recruits was broadly in line with the quota targets, notwithstanding a slight overrepresentation of Scottish National Party voters in Glasgow, and Green party voters in Manchester (compared to the voting profiles of those cities at the time of recruitment). To compensate individuals for the significant time commitment and to cover any travel, subsistence and caring related costs, jurors received £220 for participating.

<sup>1</sup> One participant was excluded from the quantitative analysis since they provided no demographic information so, for the quantitative data,  $n = 56$ .

**Table 2** Citizen juries sample description ( $n = 56$ )

		<i>Frequency</i>	<i>Percentage (%)</i>
Gender	Male	28	50.00
	Female	27	48.21
	Neither	1	1.79
Age	18–34	27	48.21
	35–54	14	25.00
	55+	15	26.79
Income	Low	13	24.07
	Middle	30	55.56
	High	11	20.37
Political Party 2015	Conservatives	9	16.07
	Labour	19	33.00
	Liberal Democrats	1	93.00
	Scottish National Party	12	21.43
	Green Party	6	10.71
	Did not vote	9	16.07

Across the two days, we collected data in four ways: individually, via (i) questionnaires (which mirrored the national survey) completed at the beginning (t1), mid-point (t2) and end (t3) of the juries; collectively, via (ii) ethnographic notes throughout (including during social breaks); (iii) audio recordings of all full and small group discussions and (iv) photos and notes of ‘sticky wall’ exercises, including two full group exercises where participants were asked to vote for their top policy choices. The main task given to the juries was to address the following question:

Some people think that in a fair society, the government should work to try to limit health differences between richer and poorer groups. Others think that in a fair society, it is up to individuals. Other people have opinions somewhere in between. What should the government do about these health differences, and why?

During each jury, participants undertook a range of exercises to get to know each other, to develop ‘rules of engagement’ and to find out more about health inequalities research and potential policy solutions. This included hearing from two ‘witnesses’ in person and four via pre-recorded, specially-commissioned videos (four researchers, one public health practitioner and advocate and a General Practitioner doctor [GP]).

Each provided a different perspective, with the intention of reflecting research and policy debates in the UK. Jurors were given an opportunity to develop questions in small group discussions and then to reconvene as a full group, at which time they could put their questions directly to the ‘witness’ or (for the videos) facilitators with health inequalities research expertise. Each jury culminated in a collective voting and ranking exercise over two rounds (with a discussion in between), focusing on potential policy responses to health inequalities.

Table 3 summarises the quantifiable findings from the citizens’ juries. The results demonstrate that responses between jury members and the national survey sample were similar, though not identical (compare Tables 1 and 3). It also shows that some jury members amended their

**Table 3** Average public support for policy proposals for national survey and average public support and group voting for citizens’ juries

Broader policy approach <sup>a</sup>	Average public support within Citizen Juries T1 (n=56)		Average public support within Citizen Juries T3 (n=56)		Change in individual support following deliberation	Rank position at T1 & T3 in individual responses (1=most popular)	Rank position of original proposals in group voting (1=most popular) <sup>b</sup>		
	Mean (SD)	% agree /strongly agree	Mean	% agree /strongly agree			Glasgow	Liverpool	Manchester
Spend more money on the NHS	4.75 (0.51)	96%	4.43 (0.87)	88%	-0.32	T1: 1 T3: 1	7	1	2
Spend more money on GP services	4.50 (0.75)	89%	4.41 (0.71)	91%	-0.09	T1: 4 T3: 2	6	4	8
Provide more support for unemployed people to find jobs	4.56 (0.71)	87%	4.32 (0.75)	87%	-0.24	T1: 2 T3: 3	5	3	11 tied
Spend more money on support services	4.53 (0.77)	87%	4.29 (0.71)	86%	-0.24	T1: 3 T3: 4	10	11 tied	11 tied
Spend more money on social housing	4.12 (0.92)	72%	4.16 (0.78)	80%	+0.04	T1: 7 T3: 5	9	8	5
Increase the Minimum Wage	4.43 (0.85)	87%	4.14 (0.98)	70%	-0.29	T1: 5 T3: 6	2 tied	2	3
Provide the public with more health information	4.28 (0.98)	80%	4.00 (0.97)	69%	-0.28	T1: 6 T3: 7	12	11 tied	13
Limit advertising of unhealthy products	3.84 (1.14)	62%	3.96 (1.11)	69%	+0.12	T1: 8 T3: 8	8	10	10
Introduce higher taxes for richer people	3.62 (1.20)	54%	3.62 (1.39)	54%	+/- 0	T1: 9 T3: 9	2 tied	14	1
Increase the price of unhealthy products	3.39 (1.22)	44%	3.61 (1.17)	56%	+0.22	T1: 11 T3: 10	11	6	9
Spend more on smoking cessation services	3.48 (1.19)	50%	3.31 (1.07)	44%	-0.17	T1: 10 T3: 11	15	17	15 tied
Plain packaging for cigarettes	3.25 (1.43)	37%	3.04 (1.31)	33%	-0.21	T1: 12 T3: 12	14	16	15 tied

<sup>a</sup> The colour coding of proposals mirrors that of Table 1, indicating the broad type of proposal.

<sup>b</sup> The colour coding of the rank position provides a quick visual sense of which proposals were ranked highest (green signifies top 5, orange signifies ranked 6-10, red signifies proposals were ranked outside the top 10). Some rank positions are missing because some juries included their own proposals but these are not included in Table 3 (see Table 4 & Smith et al, 2021).

views following exposure to research evidence, expert opinion and jury discussions (i.e. that the results from the questionnaire responses of individual jury members are different between time-point 1 and time-point 3, albeit often only marginally). More noticeable, however, is the fact that jury members responded differently when reporting their individual views and when voting collectively. It is particularly striking that the two economic proposals, one focusing on increasing the wealth of poorer groups by increasing the minimum wage and another focusing on more egalitarian distribution of wealth via tax increases for richer people, both performed much better in group voting (with the exception of tax increases in Liverpool). This suggests that, when groups are working collectively, they are more supportive of these kinds of policies (see also Table 4). Each jury was also encouraged to suggest additional proposals, some of which they decided to consider in the group voting (see in Table 4). These proposals also suggest a clear interest in more ‘upstream’ policy proposals, focusing on improving living and working conditions or on economic policy reform.

The qualitative data (transcriptions of group discussions and ethnographic notes) provide further insights and, in some cases, led us to reach rather different conclusions about the quantitative data than we might have otherwise done. For the purposes of this chapter, we will highlight six aspects that we I feel stand out, before taking a step back to reflect

**Table 4** The top ranked proposals in each jury in final group voting round

<i>Glasgow</i>	<i>Liverpool</i>	<i>Manchester</i>
1 Close the tax loopholes*	1 Spend more money on the NHS	1 = Introduce higher taxes for rich people
2 = Increase national minimum wage	2 Increase the national minimum wage	1 = Spend more on the NHS
2 = Introduce higher taxes for (*very) rich people	3 Provide more support for people seeking jobs	2 = Close corporate tax loopholes*
3. Reduce the price of healthy products*	4 = Spend more on GP services	2 = Increase the national minimum wage
4. Provide more support for people seeking jobs	4 = Ban zero hour contracts*	3. Invest more money in social housing

\*Signifies participants’ own addition/suggestions

on what the combined findings (Sects. 4.1–4.3) suggest about the potential of deliberative spaces to overcome the ‘stalemate’ on which this book focuses.

First, as was the case with some participants featured in the meta-ethnography (see Sect. 4.1), some participants were resistant to the idea of health inequalities:

We don’t necessarily agree a hundred percent with the fact that if you’re wealthy you’re healthy and if you’re unwealthy you’re unhealthy. (Male participant, Glasgow)

It seemed like [...] it was like everyone was saying you’re a stereotype that if you’re there you’re that and if you’re there you’re that. [...] It’s stereotyping the actual character isn’t it? That poor people are like this, and the rich people are like this. It’s wrong. (Female participant, Manchester)

These responses can be understood as resisting a message experienced as disempowering and, at times, stigmatising (Smith & Anderson, 2018). This concern was so great in the Liverpool discussions that one member proposed an additional policy response of tackling ‘stereotyping of people in poverty’. This perspective, which was often linked to a sense of poor health being down to serendipity, potentially undermined the value of the whole exercise since, if participants did not believe that anything other than luck explained health differences, it implied there was no issue for policy to address. However, despite evidence of this perspective in all three juries, it was far from dominant, and everyone continued to engage in discussions. Moreover, the space that the juries provided to discuss health inequalities in depth seemed to increase participants’ willingness to explicitly acknowledge their existence (there were far fewer references to this view on day two of each jury compared to day one). Reflecting this, the idea that nothing should be done to tackle health inequalities was unpopular in group voting (no one voted for it in Glasgow or Liverpool and only one person voted for this option in Manchester). This suggests that providing spaces to explore health inequalities in depth may increase people’s willingness to explicitly acknowledge the issue (a necessary foundation of meaningful discussions about potential policy responses).

Second, mirroring the results of the national sample survey, Table 3 shows that health service based responses remain the most popular

but that, beyond this, public views on the kinds of policy responses likely to reduce health inequalities are relatively well-aligned with those of researchers (Smith & Kandlik Eltanani, 2014), with a clear focus on improving living and working conditions and (especially in group voting) improving the material and economic circumstances of poorer groups.

Third, the qualitative data did not always appear well aligned with the quantitative data or, at least, provided a rather different perspective on the quantitative findings. Two examples illustrate this. First, although health service (NHS and GP) focused policy proposals were among the most popular proposals in individual group voting across time-points 1 and 3 (as they had been in the national survey), the qualitative data suggest these kinds of investments were nonetheless contested, usually on the basis of concerns about efficiency and management:

We could probably do it more [invest in the NHS] but I think there's more than enough there, or there's nearly enough there I should say. But we're constantly mopping a bath that's flooding instead of turning the tap off. (Male participant, Liverpool)

I think the NHS thing with GP services, I agree with that. I think it's a case of restructuring them rather than actually throwing more money at it.... (Female participant, Glasgow)

But it's because everybody's so hung up about the NHS has got to have more money, but is it being managed correctly? (Manchester participant, female)

Hence, although these proposals were popular (and it was also clear from discussions that health service staff, especially doctors, were held in high regard), they were accompanied by some consistent reservations (in contrast to many of the other proposals).

The second example of the varying insights provided by different elements of the data relates to an archetypal health promotion proposal; to provide the public with more health information. In jury discussions, participants often referred to this as 'health education'. However, in using this language we noticed there appeared to be some quite different perspectives on what this proposal involved:



I think a wee bit more education for some people to, instead of taking their kids to McDonald's and spending £10 or £15 on that, they could buy a bag of shopping, buy fresh fruit, fresh veg, go somewhere. [...] So if they actually had that bit of background on how to make all these things, it would maybe help them. (Glasgow participant, female)

Thank you very much. Anyone who has something that is more or less related? (Facilitator)

I agree with that because it talks about education which I think is the fundamental. It's the level that you educate people. It allows them to make the right choice with whatever resources they've got. The more money that's thrown at education across the board, and the earlier it starts. [...] Education, it underpins everything else, it underpins everything we do. It informs our choices, it explains your actions, it does everything. Unless you have it, you don't really have much. (Glasgow Jury, male participants)

The female participant quoted above framed health education as health promotion (teaching people about healthier eating), which was how we (the research team) also interpreted this proposal. In contrast, the male participant appeared to be envisioning a much broader policy, involving an investment in education 'across the board' (which we would have categorised as a rather different kind of policy response). This is important because it highlights that respondents' understandings of the proposals put forward varied, sometimes fundamentally. Hence, this was a proposal that, while not especially popular according to the quantitative data, nonetheless appeared to garner consensus within discussions and this appeared to be, at least in part, because there were varying interpretations about what this proposal would involve.

The fourth aspect of the data worth highlighting is that proposals involving tax increases (whether via income tax increases for richer people or increased taxes on unhealthy products) were relatively popular in individual responses and in group voting but generated considerable controversy in group discussions. For example:

I do think the more you earn, the more income you earn the more tax you should pay, I just think that's how it should be. Not like extortionate amounts but people can. (Female participant, Liverpool)

Yeah, well we think if you've worked hard to get to the top, why take your wages off you and bring you down? I don't think that's right. (Female participant, Liverpool)

As we see above, whether increased taxation was supported appeared to relate partly to participants' individual perceptions of fairness. Other aspects of the qualitative data suggest views changed, depending on the tax rate and income threshold being proposed, perhaps because this affected who, within the juries, would have to pay more tax, as one participant in Glasgow suggested.

The juries in Glasgow and Manchester both discussed the threshold for being 'rich' in detail, with varying views about who increased taxation would (and should) impact. The Glasgow jury agreed the threshold for increased taxation should be £200,000+ (a threshold advocated by a vocal male participant and formally agreed by the group, though quietly criticised by three female participants who felt it should be around £50,000), whereas the Manchester jury agreed it should be £100,000+. Overall, although the proposal to require richer people to make more tax achieved significant support, these variations and discussions underline the contested nature of this proposal. Discussions around the proposal to increase taxes on unhealthy products fared similarly, though with this proposal, the transcripts capture more examples of participants trying to persuade others to support the proposal on the basis of efficacy in reducing consumption and a 'polluter pays' type principle, as well as the potential to raise public revenue.

Fifth, beyond the discussions around specific policy proposals, the data suggest that at least three factors intersected to reduce (the relatively high) support for macro-level policy proposals. As Table 5 illustrates, this included a lack of trust in (local and national government) and discourses of individualism and fatalism.

The three factors outlined in Table 5 sometimes coalesced to challenge support for macro-level policy proposals, though not consistently. For example, while the lack of trust in government consistently undermined support for proposals involving taxation (whether via income tax changes or unhealthy product taxes), discourses around individual responsibility were sometimes used to reinforce arguments against tax-based proposals but, at other times, were used to support tax increases on unhealthy commodities since these were positioned by some jurors as maintaining choice, while reducing consumption.

**Table 5** Three intersecting factors that appeared to reduce (the relatively high) support for macro-level policy responses to health inequalities

<i>Factor</i>	<i>Illustrative data extract</i>
Lack of trust in local and national governments	‘I don’t really think politicians know what they’re doing. [...] The politicians, they can’t do anything about it [health inequalities], they can’t even run the country for god’s sake, so you know. We’re lost really aren’t we?’ (Female participant, Liverpool) ‘Councils steal money’ (Male participant, Glasgow)
A prevalent discourse around individual responsibility	‘I get that the Government plays a part, no one’s denying that, on advertising and marketing and things. But when it comes down to it, it is individual responsibility, you’re responsible for your own health. You’re responsible for your own life’ (Female participant, Glasgow) ‘it’s all up to the individual how they conduct and live their lives. If they want to eat healthy fine, if you don’t, fine’ (Female participant, Liverpool)
Fatalistic discourses about human nature	‘People have smoked and drank for god knows how long. It’s down to their personal choice. And people who are under large stress in society use alcohol and whatever as a form of escapism, to get away from their troubles and the worries. [...] You can lead the horse to water but you can’t make it drink’ (Female participant, Liverpool) ‘So some people find happiness in comfort food, smoking, alcohol, all these different things [...] even if they know they’re unhealthy, they know the health risks, they’ve been educated but they don’t care. They actually just enjoy it and want to do it. Should they be convinced or should they just be allowed to do what they want?’ (Male participant, Manchester)

Sixth, at least some jury members adjusted their responses following exposure to evidence, expert views and discussions with one another (Table 3). All three sources were also drawn on in the discussions around the group voting exercises. This suggests that allowing people to find out about an issue via research and expert testimony, and to discuss and deliberate on the issue with a view to making policy recommendations, does result in a rather different ‘public view’ than opinion polling. Here, the qualitative data suggest that expert testimony from trusted sources (academic researchers, policy advisors, a health advocate and a GP) had a greater impact on jury members than quantified evidence (e.g. graphs and statistics that they were shown in presentations and also had in individual participant packs). The most persuasive evidence, however, appeared to be jury members’ accounts of their own personal experiences, perhaps because this was the most uncomfortable to openly challenge in a group setting, especially one in which respect for fellow participants had been strongly emphasised.

## 5 CONCLUDING DISCUSSION

The data presented in this chapter suggest that policy and researcher perceptions of public opinions about health inequalities in the UK are not especially well-aligned with actual public opinions. We employed multiple ways of exploring public views about potential policy responses to health inequalities and all of these methods suggested that, in contrast to policymakers’ and researchers’ perceptions (Smith, 2013), public views are relatively well-aligned with researcher perspectives on health inequalities. Both the meta-ethnography and the qualitative data generated in the citizen jury discussions suggest that people generally (but especially those with personal experience of disadvantage) have a good understanding of the ways in which social determinants shape health and of how the unequal distribution of these determinants underlies health inequalities.

The survey and citizen jury data further demonstrate that public views on potential policy responses to health inequalities are, with the exception of the consistently high public support for health service led responses, remarkably similar to the views of researchers, with evident support for more upstream policy responses that aim to improve living and working conditions and to tackle poverty and the unequal distribution of wealth. This suggests that perceived tensions between evidence, policy and publics

around the issue of health inequalities are not as great as many policy-makers and researchers appear to believe. Moreover, the citizens' juries provided a space in which members of the public became, via exposure to evidence, expert testimony and discussions with fellow jury members, more willing to acknowledge the existence of health inequalities. The jury data also demonstrate that at least some participants adjusted their policy preferences following this exposure, which suggests that the responses of this kind of informed 'mini-public' are distinct from the more spur-of-the-moment responses that opinion polls generate. It is perhaps also worth noting that the jury discussions seemed very well-received by participants, according to their exit questionnaires and the comments made to us, as organisers, as they left. This feedback suggested most participants enjoyed the experience, with several noting they felt this kind of approach should be taken more often. All of this suggests that deliberative spaces such as citizens' juries may well provide a means of helping to overcome (actual or perceived) stalemates between evidence and politics.

However, there are also three reasons to remain cautious about the potential role that deliberative forums might play in overcoming such stalemates. First, this is a much more expensive way of assessing public opinion than polling and the final results of the individual responses of the informed jury members were not radically different from the uninformed national sample (comparing Tables 1 and 3), which raises questions about the relative return on investment for policy audiences interested in public perspectives (though the group ranking results of the three juries were substantially different). Second, it proved hard to attract policy interest in the juries so, while the juries provided a very useful means of bringing researcher and professional perspectives into dialogue with members of the public, the juries lacked the kind of political-policy engagement that the original architects of citizens' juries intended (Fishkin, 1995). This may reflect the wider, much discussed tension between representative and deliberative democracy (e.g. Pickard, 1998). Finally, the small nature of the juries meant that diversity was inevitably limited; a common criticism of citizens' juries (Smith & Wales, 2006). Although we were able to include a good range of participants for some demographic characteristics (notably gender, age groups, socioeconomic position and political preferences), there are a host of potentially relevant demographic characteristics for which key groups were either not present or not well-represented (e.g. people with particular disabilities and long-term health conditions and people from specific minority ethnic groups). In sum, the small scale of

mini-publics means it is impossible to capture the diversity of the wider public in a meaningful way. This means the perspectives and experiences of some groups are inevitably under-represented; a particular concern where the issue in question relates to intersecting societal inequalities, as is the case with health inequalities in the UK.

Reflecting on the work presented in this chapter, our own conclusion is that deliberative mini-publics can be extremely insightful for research in ways that may well contribute to overcoming the stalemate between evidence and publics (i.e. key component of politics in democracies). The highly positive feedback from most participants about their jury experiences, combined with the multifaceted nature of the data they generated, left us convinced that these kinds of deliberative spaces can serve a very useful purpose as spaces of research-informed public dialogue. Moreover, for the most part, the focus on policy solutions did appear effective in reducing the potential for discussions about health inequalities to feel disempowering for those bearing the greatest burden of these inequalities. Hence, as a mechanism for bringing researchers and publics into conversation about persistent societal challenges, we feel these kinds of deliberative forums have huge potential, especially if combined with methods to address some of the significant limitations (e.g. methods to capture a wider diversity of views, such as surveys, and efforts to ensure a wide range of social groups are informing the overall data).

Viewed from a policymakers' perspective, deliberative mini-publics certainly have limitations that may reduce their capacity to overcome the stalemate between evidence and politics, not least the cost involved and some concern that these forms represent a challenge to representative democracy. However, if the idea is simply that these are useful tools to inform policy discussions within representative democracies, the case for further experimentation with mini-publics seems convincing. Indeed, since these juries were conducted, multiple policy-led deliberative forums have been undertaken with further commitments recently arising across the UK, notably in Scotland (Lacelle-Webster & Warren, 2021; Wells et al., 2021). Deliberative forums are certainly no panacea for overcoming the stalemate with which this book is concerned, and more work is needed to develop ways of ensuring minority groups are better represented, but they may be a promising means of identifying potential routes to get beyond a stalemate situation for issues in which there is a perceived gap between research-informed policy proposals and public preferences.

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