Understanding health inequalities: theories, concepts and evidence

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- Rates of mortality are consistently higher among those with a lower, than among those with a higher socio-economic position.
- Inequalities in mortality start early in life and persist into old age.
- Inequalities in health are found for most but not all specific causes of death.
- Inequalities in health affect men and women but tend to be larger among men.
- Rates of morbidity are usually higher among those with a lower educational, occupational or income level.
- People with lower socio-economic positions live shorter lives and spend a larger number of years in ill-health.
Conditions of the working class

‘That a class which lives under the conditions already sketched and is so ill-provided with the most necessary means of subsistence cannot be healthy, and can reach no advanced age, is self-evident...They are given damp dwellings... They are supplied bad, tattered, or rotten clothing, adulterated and indigestible food. They are exposed to the most exciting changes of mental condition, the most violent vibrations between hope and fear...They are deprived of all enjoyments except that of sexual indulgence and drunkenness, are worked every day to the point of complete exhaustion of their mental and physical energies, and are thus constantly spurred on to the maddest excess in the only two enjoyments at their command... How is it possible, under such conditions, for the lower class to be healthy and long lived? What else can be expected than an excessive mortality, an unbroken series of epidemics, a progressive deterioration in the physique of the working population?’ (Friedrich Engels 1982 [1892], The Conditions of the Working Class in England in 1844, London: Panther).
Poor health in the working class, 1844: correlates and causes

- Low incomes (‘ill-provided’)
- Sub-standard housing (‘damp dwellings’)
- Inadequate clothing (‘tattered or rotten’)
- Poor diet (‘adulterated and indigestible’)
- Psycho-social stress (‘violent vibrations’)
- Bad occupational conditions (‘worked to complete exhaustion’)
- Unhealthy behaviours (‘sexual indulgence and drunkenness’)
- Power and control
Inequality and social stratification

Three main dimensions:

• Social class (economy, money, material resources)

• Social status or ‘honour’ (esteem, reputation, respect)

• Political power (control, authority, autonomy)
Explaining health inequalities


- Artefact
- Social selection
- Culture/behaviour
- Material/structural conditions

Primacy given to material/structural conditions, later supported in The Health Divide (1987)
DIRECT SELECTION

HEALTH

HEALTH

SOCIAL POSITION
INDIRECT SELECTION

BEHAVIOURS

HEALTH

SOCIAL POSITION

Personal characteristics
...x, y, z
Indirect selection

- Factors in early life (genetics, germs, ante/post-natal care) set the foundations
- These then are the ‘causes’ of social position
- They also influence health related behaviours
- Health behaviours ‘determine’ health
- No direct causal link between adult social position and adult health

(Adapted from Mel Bartley, 2005)
Cultural/behavioural

• Forms of culture influence ‘salutogenic’ and unhealthy behaviours
• Use of unhealthy behaviours as a diversion from daily difficulties (food, drink, drugs)
• Interpersonal behaviours: crime, violence, homicide, suicide/self-harm
• Long-term sick role behaviour as an escape from pressures of everyday life
Materialist/Structural

- Material conditions have a direct impact on health inequalities
- Absolute and relative poverty and deprivation
- Distribution of income and wealth
- Educational provision and opportunity
- Specific factors related to socio-economic position: poor or crowded housing; insecure employment; manual occupations; inadequate diet
Recent developments in explanation

- **Psycho-social** (effects of stressful conditions; status differences; control and autonomy at work; neighbourhood ‘cohesion’)

- **Life-course** (pre-natal events and processes or in childhood ‘accumulate’ ‘risk’ and ‘resilience’ to influence health in adulthood)

- **Political economy** (political processes and distribution of power affect access to services, assets and resources; neighbourhood ‘social capital’)

Mental health, social cohesion and neighbourhood low income
Why might income inequality damage health and well-being?

- ‘Income inequality’ may influence aspects of social relationships: relative importance of domination versus mutual support.
- It might be acting as an indicator of other social institutions such as welfare, education, housing, transport.
Social inequalities, social cohesion and health inequalities

• Inequalities create sense of unfairness and breakdown in social cohesion – breakdown of support for communal structures, loss of private investment and commitment

• Individual perceptions of inequality lead to feelings of shame, envy, worthlessness, stress, loss of mutuality and reciprocity, loss of respect

• Combinations of circumstances and perceptions lead to: debt, overwork, ‘unhealthy’ coping behaviours (‘demoralisation’)

How does it feel?

Five examples from empirical research
A sense of unfairness

‘Look around and see the dirt and filth we are now living in… We have poor housing, high unemployment, all the shops are closing down. People now have to travel further for their needs. It’s a very poor area in which to live’

(Elderly woman, Salford, England)
Feelings of stress

‘I think the biggest health risk is mentally… ‘cause it’s a lot of pressure and there’s nothing really for you to do… you’re sort of segregated all the time’.

(White, middle-aged man, Salford, England)
Feelings of worthlessness

‘The doctor put me on Prozac a few months ago, for living here, because it’s depressing. You get up, you look around, and all you see is junkies. I know one day I’ll come off, I will get off here. I mean I started drinking a hell of a lot more since I’ve been on here. I have a drink every night just to get to sleep. I smoke more as well. There’s a lot of things…’

(Young single mother, Lancaster, England)
Economy, environment and behaviour

‘Smoking and drinking and drug taking. I put it down to one thing… until money is spent on these areas… there doesn’t seem to be much point in trying to stop people smoking and what else. As long as the environment is going down the pan the people will go down with it’

(Middle-aged woman, Salford, England)
Going down the pan

In the space of six months about two years ago I buried five drug-related [deaths]. The youngest was 18 [years of age] and the oldest was a 27 year old mother who lived in one of the streets up here. And I knew her parents fairly well, and she left a three-year old boy for her parents to look after’

(Church Minister, Blaenau Gwent, south Wales)
[In South Wales] This was not just a case of localised economic decline but rather one of cultural crisis. The collapse of coalmining undermined a range of mechanisms of social regulation that were grounded in the politics of the workplace and the trades unions, but spread more widely into local society and politics. There was an acute sense of loss in places in which coalmines closed after decades of existence.’

(Katy Bennett et al Coalfields Regeneration: Dealing with the Consequences of Industrial Decline, 2000)
Acheson (1997): beyond Black’s four explanations?
Interpreting the boxes and arrows

‘The important effects of not having adequate power and resources to control one’s circumstances, being made to feel inferior, depression, hostility and lack of support from a friendly social network are central… to understanding why the quality of social life in modern societies has not kept pace with improvements in material life’ (Richard Wilkinson, *The Impact of Inequality*, 2005)
Life-course, environment, resilience and capability

• Health inequality is the result of processes that operate over the life course
• Social environments are potential sources of capability and resilience
• Social environment influences individual development and resilience through relationships over time
• Social and economic policies influence adequacy of individual resources for health and quality of life = ‘capability’
Policy Levels for Tackling Inequalities in Health

1. Strengthening individuals
2. Strengthening communities
3. Improving infrastructure and access to services
4. Making structural changes to economic, cultural and environmental conditions