The University of Nottingham
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# Health Inequities: definition and 'causes'

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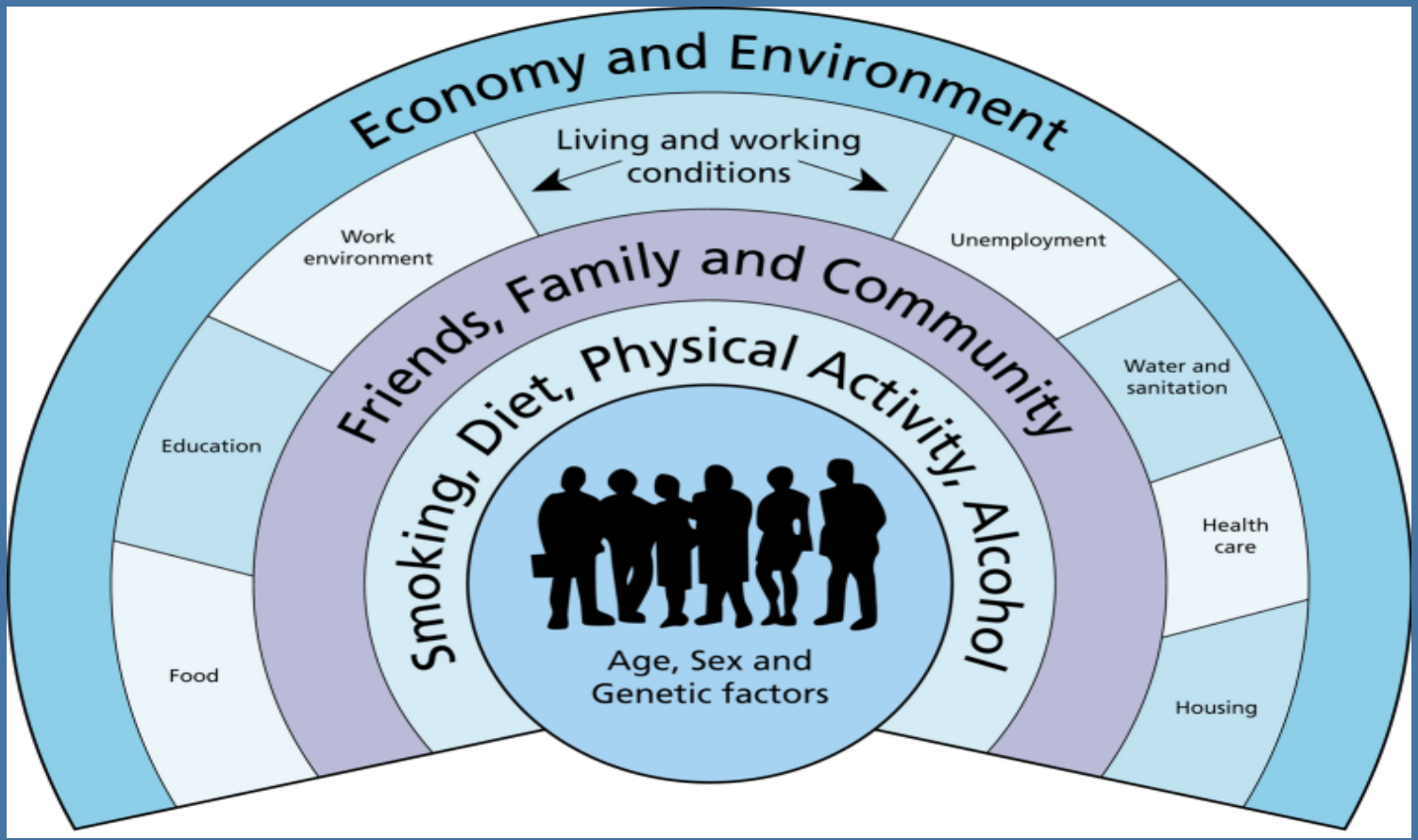
# Session learning outcomes

You should be able to:

1. Explain the difference between variations in health (health inequalities) and social inequities in health (health inequities)
2. List and describe explanations for health inequalities/inequities
3. Recognise the theoretical principles underpinning public health policy on tackling health inequities

# Health Inequalities and Health inequities

# Wider determinants of health (Dahlgren and Whitehead)



# Definition of Health Inequalities

"Health inequality is a generic term used to designate differences, variations, and disparities in the health achievements of individuals and groups"

-Kawachi et al. (2002)

***What are the implications of this?***

# Variations in health

- Individuals have varying health because of variations in genetics and constitutional factors
- Groups within a larger population also have varying health (e.g. different age-groups, gender, ethnic groups)
- Chance can affect an individual's health (exposure to a certain environmental or infectious hazard)

# Variations in health (inequalities) versus health inequities

"Three distinguishing features, when combined, turn mere variations or differences in health into a social inequity in health. They are *systematic, socially produced* (and therefore modifiable) and *unfair*."

-Dahlgren and Whitehead (2006)

# The distinction between health inequality and health inequity

"Inequalities and equality are dimensional concepts, simply referring to measurable quantities. Inequity and equity, on the other hand, are political concepts, expressing a moral commitment to social justice"

-Kawachi et al (2002)

# Identifying Health Inequalities & Health Inequities

# Step 1: Identifying health inequalities

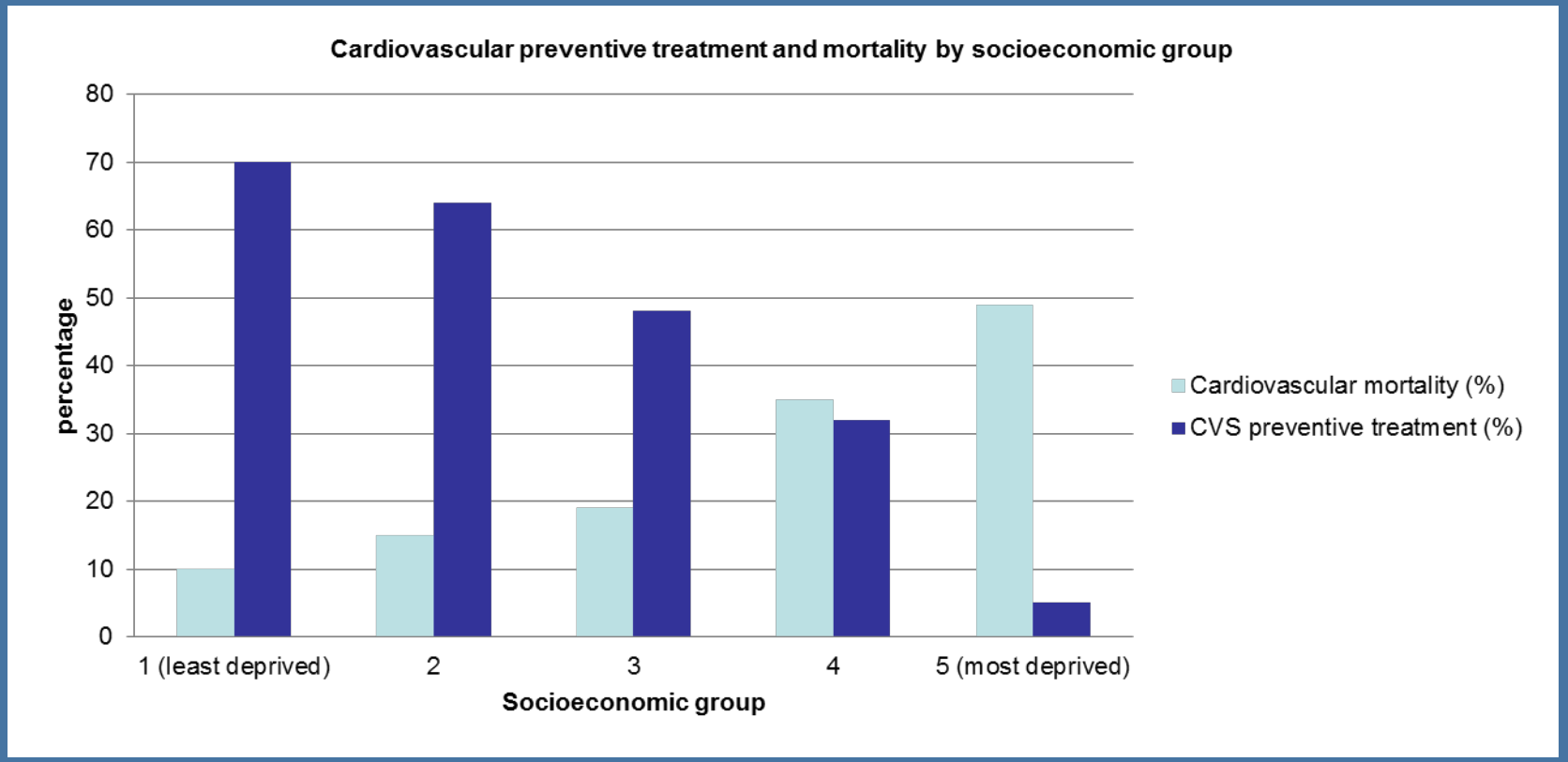
- Compare disease incidence and mortality rates across various population groups (e.g. across gender, ethnicity, socioeconomic status, rural/urban areas, geographic areas etc.)
- If you find any differences: are these ‘real’ or simply statistical artefacts?
- If the differences are ‘real’ can they be attributed to biological/genetic variations or are they socially mediated?

# Step 2: Identifying health inequities

Health Equity Audit

- Pick a 'dimension' of equity e.g. socioeconomic status, gender, geography (urban/rural) etc.
- Identify areas of 'health need' (e.g. mortality, disease rates)
- Map 'provision of treatment' or 'access to health services' for that particular 'health need' for each socioeconomic group and see if there is a difference

# Example of health equity audit findings



# Interpreting the HEA findings

- People belonging to lower socioeconomic groups were less likely to be on preventive treatment for heart disease but had higher cardiovascular mortality suggesting a health inequity
- Note: Equity of service provision ≠ equality of service provision

# The Inverse Care Law

"The availability of good medical care tends to vary inversely with the need for the population served. The inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced."

-Julian Tudor Hart (1971)

# Possible Explanations for Observed Health inequalities

*Note that I did not use the term 'Health inequities' here*

# Possible explanations for health inequalities

Black Report (1980):

1. Artefact- artificial effect due to how variables representing 'social class' and 'health' were defined/measured)
2. Natural and social selection- health influences social class and not vice versa
3. Material and structural explanations- access to money and essential services
4. Cultural and behavioural explanations: "culture of poverty" or "transmitted deprivation"

*Note: we are considering socioeconomic inequalities in health here; the Black Report used occupation as a proxy measure of social class*

# Recent explanations

- Psychosocial factors like stress
  - Key proponent: Richard Wilkinson
  - Relative deprivation rather than absolute deprivation
  - Gradient in health status and life expectancy that mirrors the social gradient (not just rich-poor divide but 'very rich> rich> middle class> poor')
  - Locus of control
  - factors like stress

# What if?

If you were born poor but then became rich when you were in your early twenties, would your health status and life expectancy be similar to your present neighbours?

***Does the duration, dose and timing of exposure to social factors matter?***

# Life course theory

- The Life course effects theory focuses on '*how health status at any given age, for a given birth cohort, reflects not only contemporary conditions but embodiment of prior living circumstances, in utero onwards*' (Krieger 2001)
- An individual is particularly vulnerable at certain points in their life course
- Early years experiences are critical in determining life-long health

# Life course theory: three hypotheses

- **Latent effects**: early life experiences and environment affect adult health independent of intervening events in a given individual's life

- **Pathway effects**: early life events and environments place an individual onto a given 'life trajectory', which affects health status over time ('chain of disadvantage')

- **Cumulative effects**: the intensity and duration of exposure to unfavourable environments and experiences accumulate over an individual's life course to affect their health ('accumulation of risk' model; dose-response relationship between unfavourable life circumstances and poor health)

# Fundamental causation

- Link & Phelan (1995): fundamental relationship between socioeconomic inequality and inequalities in health
- This relationship is largely based upon the existence of knowledge about the disease and the consequential potential for control over such diseases
- Heart of fundamental causation: access to information, resources, goods, services; financial capacity; ability for self-advocacy
- Implication: the more that is known about how to treat or prevent a given disease, the steeper the social gradient will be

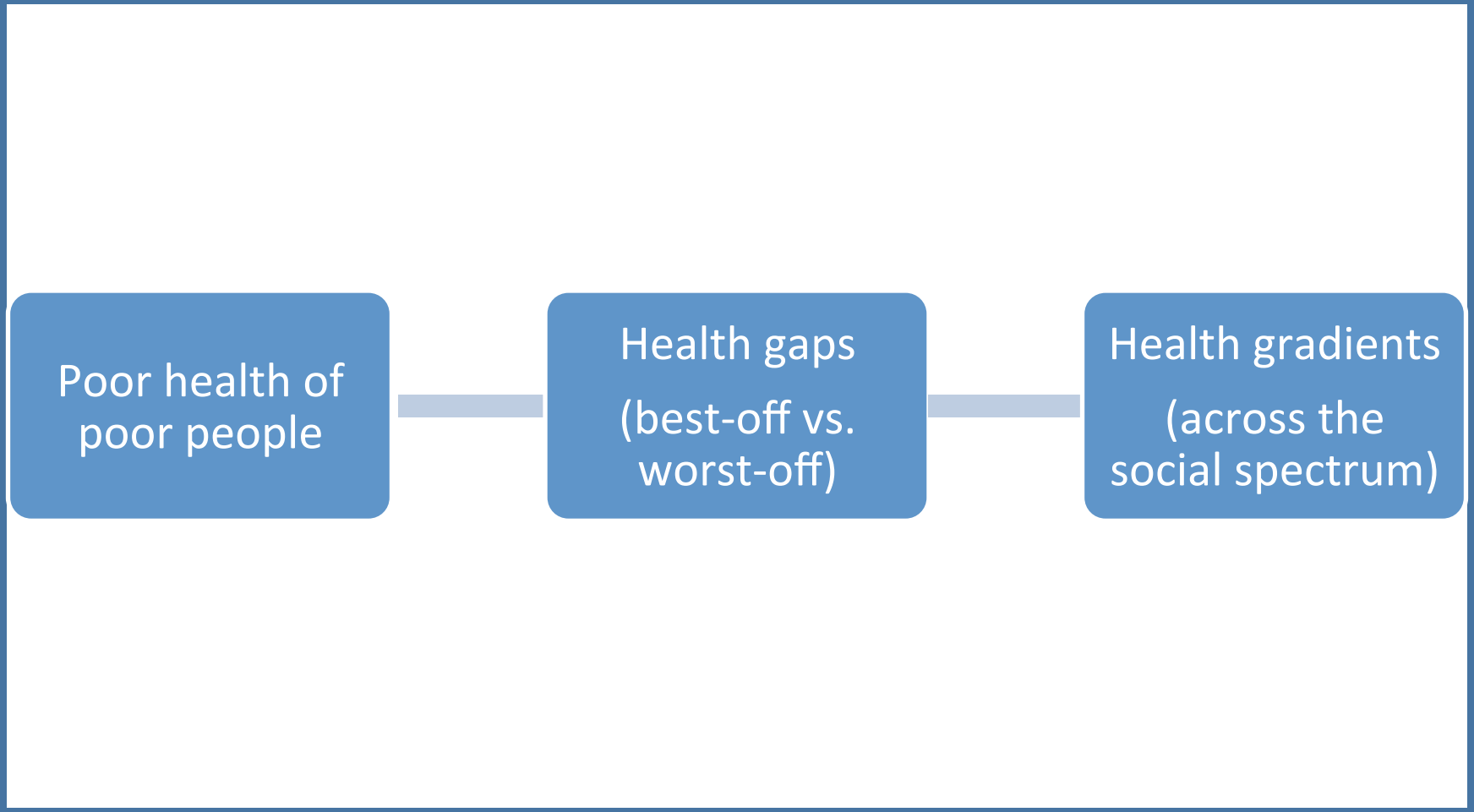
# TACKLING HEALTH INEQUITIES: POLICY OPTIONS

## Is there a difference between determinants of health and determinants of health inequities?

- Policies aimed at tackling the determinants of health do not automatically tackle the determinants of health inequities

- Tackling the determinants of health inequities is about tackling the *unequal distribution* of health determinants.

# A range of meanings of health inequities




*Note: To be revisited in the session on quantitative measurements and evaluation design*

# Tackling health inequities

Three main approaches have been tried in public health:

1. Focusing on people in poverty (targeting approach)- the aim is to improve the health status of disadvantaged groups
2. Narrowing the health divide- the aim is to reduce the disparity in health status between the extremes of the social scale
3. Reducing social inequities throughout the whole population- the aim is to equalise health opportunities across the socioeconomic spectrum

# Group Discussion

The following 2 slides list actions/strategies to reduce health inequities as proposed in The Marmot review (2010).

1. What is the possible theoretical basis for each of the proposed actions (hint: materialist/ psychosocial, life course effects, fundamental causation etc.)?
2. Think of the health inequalities continuum-are these proposed actions about improving the health of poor people, addressing health gaps or addressing the health gradient?

# Specific actions to reduce health inequities-1

The Marmot review 'Fair society, Healthy lives' (2010):

1. Children- maternity services, parenting programmes, early years childcare & education
2. 'Skills for life' teaching; training & employment opportunities
3. Fair employment
4. Minimum income for healthy living; progressive taxation

# Specific actions to reduce health inequities-2

5. Create healthy spaces and communities (good public transport links, green spaces, improving food availability i.e. Healthy, low-cost options, energy-efficient housing)
6. Strengthen disease prevention- reduction of risk factors