

HEALTH INEQUALITIES IN THE UK: AN OVERVIEW OF SOCIO- ECONOMIC DETERMINANTS

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Abstract

Health inequality has been a major cause of concern across the world largely among policy planners, medical professionals and citizens. Despite higher levels of per capita income, substantial differences in health status are found within developed countries. This can be attributed to a shift in disease burden from communicable diseases such as diarrhoea, tuberculosis, malaria to non-communicable diseases such as hypertension, diabetes, cardiovascular diseases etc. as the economy grows. This article provides an overview of the socio-economic determinants of health inequality within the UK and other developed countries despite higher per capita income. These fundamental causes are also applicable to developing countries, especially in urban areas.

Keywords: Health Inequality, Psycho-social factors, Social capital, Unequal Access

Introduction

Life expectancy on an average reduces by 7 years as one travels 7 km east from Westminster on the Jubilee Line of the London underground towards Canning town. Male life expectancy in Westminster is 77.7 years and in Canning town is 71.6 years. Female life expectancy also decreases from 84.6 years to 81.4 years between the two areas (London Public Health Observatory, 2021). Life expectancy at birth is one of the most frequently used health status indicators. 'Life expectancy at birth is defined as numbers of years; on average, a new-born can expect to live if current death rates do not change' (OECD Data, 2021). Health inequality is the difference in health experience and health status between countries, regions and socio-economic groups (Pomerleau & McKee, 2005). Health inequality also refers to a systematic difference in the health of people

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across different sections of society (Graham, 2009). This essay presents an overview of health inequalities and socio-economic determinants in the UK context.

Status of health inequalities in the UK and its relationship with income and income inequalities

Health inequalities have been persistent in the UK for a long time. The 1970-72 Decennial supplement of occupational mortality report revealed that men among unskilled workers class had 2.5 times more chances of dying before the age of 65 years than men belonging to the managerial and professional classes (Petrie 1978). The Black report released in the year 1982 disclosed that health inequality in the UK had widened and suggested that social inequalities like income, education, housing, and improvements in work conditions have to be addressed (Townsend et al., 1992). Further, the disability-free life expectancy (DFLE) worsened with an average difference of 17 years between the least deprived area to the most deprived area in the UK (Marmot M., 2010). Besides, women's life expectancy in the most deprived area in the UK has fallen between the year 2010-12 and 2016-18 meaning that the health status of the women in these areas has declined (Marmot M., 2020).

Poverty or material deprivation is a critical determinant of health as it is associated with poor hygiene conditions, dirty potable water, damp houses, and inadequate sanitation facilities. As an economy develops and per capita income grows, life expectancy usually improves with the containment of contagious diseases. After a certain income level, the curve flattens, and there is not much change in life expectancy even as the national income per capita further improves (Figure 1 reproduced from Wilkinson & Pickett, 2009).

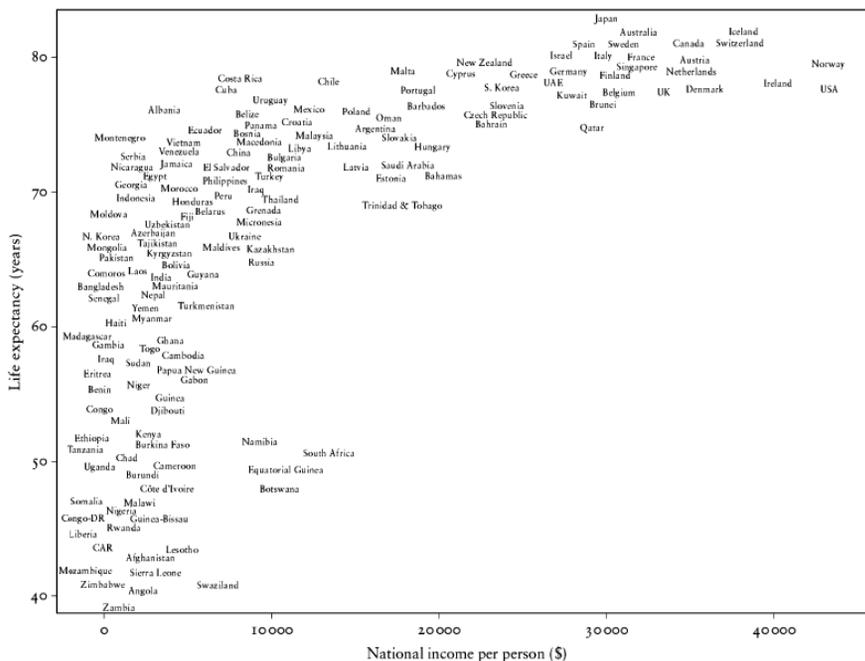


Figure 1. Relation between life expectancy and national income per person (Wilkinson & Pickett, 2009)

It can be observed that among the developed countries, the life expectancy for black men in the USA is 9 years lower than men in Costa Rica and life expectancy in Greece is better than the USA even when the average real income in Greece is half as compared to the USA (Marmot & Wilkinson, 2001). While the Preston curve implies a causal link from wealth to health, the national income per capita does not influence health outcomes; however, income inequality within a developed country has an impact on its health indicators. Preston’s seminal paper (1975) presents two ‘stylized facts’ in favour of this stance. ‘The first is a strong, positive relationship between national income levels and life expectancy in poorer countries, though the relationship is nonlinear as life expectancy levels in richer countries are less sensitive to variations in average income. The second is that the relationship is changing, with life expectancy increasing overtime at all income levels’ (Bloom and Canning, 2012). There are different pathways through which income affects health, including improvements in nutrition, access to clean water and sanitation, and medical treatment. In this essay, income inequality for a country is measured as the ratio of income received by the top 20 per cent to the bottom 20 percent of the population. In developed countries, life expectancy has a declining trend

from the least deprived area to the highest deprived area (Wilkinson & Pickett, 2009). Often, economic factors like poverty, unemployment, work conditions, income inequalities etc are reflected in the differences in access to educational opportunities, safe jobs, health care, and the social bases of self-respect. Apart from economic factors, the WHO Commission highlights social determinants of health such as social exclusion, stigma, and discriminations responsible for poor health and health inequalities (Marmot 2005; Wilkinson & Marmot, 2003).

In the remaining part of the essay, three important causes of health inequalities (1) Psycho-social factors (2) Social Capital (3) Unequal access to health services, will be discussed in some details with specific reference to the UK, but these are applicable for all developed countries. These causes are fundamental to not only health inequalities but also to underlying various social problems like unemployment, inequality in education, drugs, violence and so on.

Psycho-social factors

Social status, social network and stress in pre and early life period are vital psycho-social factors. In a study on civil servants in the UK, Whitehall II, it was found that low job status in civil services in the UK is related to high risk of heart disease, chronic lung disease and some types of cancer. All civil servants are well-paid and are not affected by problems of poverty or unemployment (Bosma et al., 1997). The mechanism is when people have low control over their work or life; they are always in chronic stress. Chronic stress has a direct physiological effect on the body and is associated with obesity, diabetes, and chronic constriction of blood vessels leading to hypertension and heart disease. A study based on primates shows a rapid build-up of arteriosclerosis, the worst ratio of high to low-density body fats, and a tendency towards central obesity and insulin resistance due to stressful conditions (Shively & Clarkson, 1994). A similar psycho-social effect has been observed among socially excluded minority communities. Aboriginal and Torres Strait Islander people have a life expectancy 20 years less than the mainland Australians (Marmot M., 2005).

The healthy social network and community life is another crucial psycho-social factor impacting health as these reduce stress. People with poor relationships and bad marriages are at a higher risk of ill health due to stress caused by loneliness or conflicting relations. Studies have shown that people with good social support have three times the chances of survival after a cardiac arrest as compared to others (Berkman, 1995). People with

friends have fewer chances of getting infections, and they have a better immune system (Cohen et al., 1997). Stress in early life is also a crucial psycho-social factor affecting health throughout life and also affects physical growth, emotional, social and cognitive development. In a developed country like the UK, lower birth weight is associated with mental stress among mothers (Phillips et al., 2000). It is shown that lower birth weight is a predictor of heart disease, stroke, and diabetes in later life (Barker, 1998). Low birth weight along with psycho-social factors often leads to inferiority complexes and social anxiety among the disadvantaged sections of the society.

Social capital

It has been widely acknowledged that social capital implicitly promotes health. Social capital is defined as the 'features of social organization, such as civic participation, norms of reciprocity, and trust in others' (Putnam, 2001). These features are highly contextual, providing the protective health benefits that can come from residing in a place with cohesive social ties and supportive community structures (Wolf, et al 1974). Social capital is regarded as the potential mediator of the relationship between income inequality and mortality rates (Kawachi et al., 1997). The health benefits of social relationships manifest in the form of social support that is, the information leading a person to believe that they were cared for, esteemed and valued, and belonged to a network of communication and mutual obligation (Cobb, 1976). Social capital reflects the actual or potential economic, cultural, political, and psychosocial resources that are inherent within people's network ties and thus could be used for health-related activities (Carpiano, 2006). Similarly, similar social relations and norms have the consequence of constraining access and creating and perpetuating health disparities (Hatzenbuehler et al., 2013).

Social trust plays a critical role in physical and psychological health in communities. In Fig 2, it is evident that when income inequalities are high, trust among people reduces. Social breakdown due to relative deprivation is the reason for more death rates in English counties (Wilkinson R. G., 1998). Income inequality leads to more death rates due to poor social environments (Kawachi & Kennedy, 1997). The relationship between income inequality and life expectancy can be seen in Fig 3. During Hurricane Katrina in the year 2005, 80% of the city New Orleans was underwater, at least 1,836 people were killed, and 700 were missing or

unaccounted. After the storm, there was a massive shortage of baby food and medicine but the police and military were more involved in patrolling for arrests and shootouts instead providing relief to the population. The main reason for that was the lack of trust between the police authorities and poor black citizens. People felt that the authorities had biased perceptions about black citizens which led to citizens being seen as looters rather than as victims. Lack of trust led to higher numbers of deaths as people did not help each other, and authorities did not address the problems faced by vulnerable groups (Wilkinson & Pickett, 2009).

The survival percentage of black American men is less than men in the Indian state of Kerala because black men in America are more deprived. Despite a much lower income level in Kerala, its health and education indicators are far better due to its social capital and community involvement (Sen, 1999). During the recent COVID 19 crisis in the state of Kerala, local village councils started community kitchens to provide food to the vulnerable population and encouraged villagers to accommodate in their houses, the poorest who did not have sufficient space for social isolation at their own homes. This is the reason Kerala has been able to contain the recent COVID 19 pandemic more successfully as compared to other states resulting in decreased mortality (BBC News 2020; Kurian, 2020).

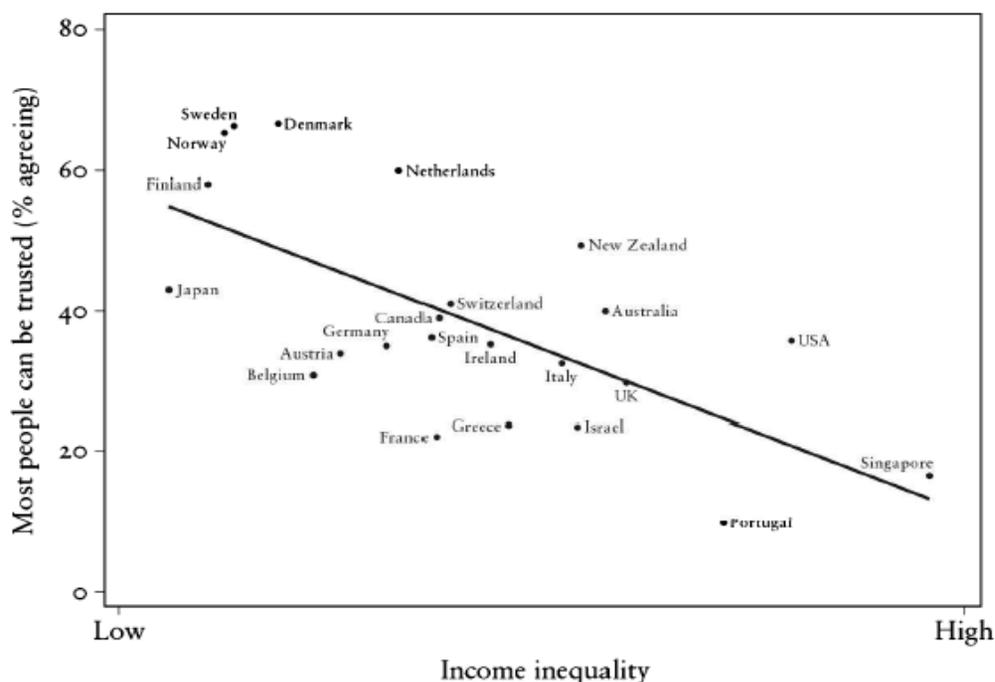


Figure 2. The relation between the percentage of people agreeing that most people can be trusted and income inequality in developed countries (Wilkinson & Pickett, 2009)

Unequal access to health services

Access to health services implies the availability of a full range of health services – that are timely, appropriate, sensitive, and easy to use - across different segments of the population in different areas. Often women, elderly people, and socially excluded groups like homeless, etc receive less care relative to their needs, or more inappropriate or sub-optimal care than others, resulting in poorer experiences, outcomes, and health statuses (Bowling & McKee, 2010). Most of the time, it is found that the availability of good medical care tends to vary inversely with the need for the population served. Historically, it was found that there was a shortage of doctors in the industrial and mining areas in the UK. In these areas, the volume of patients was high and the waiting time for patients was long (Hart, 1971). It is also found that high-income groups had a

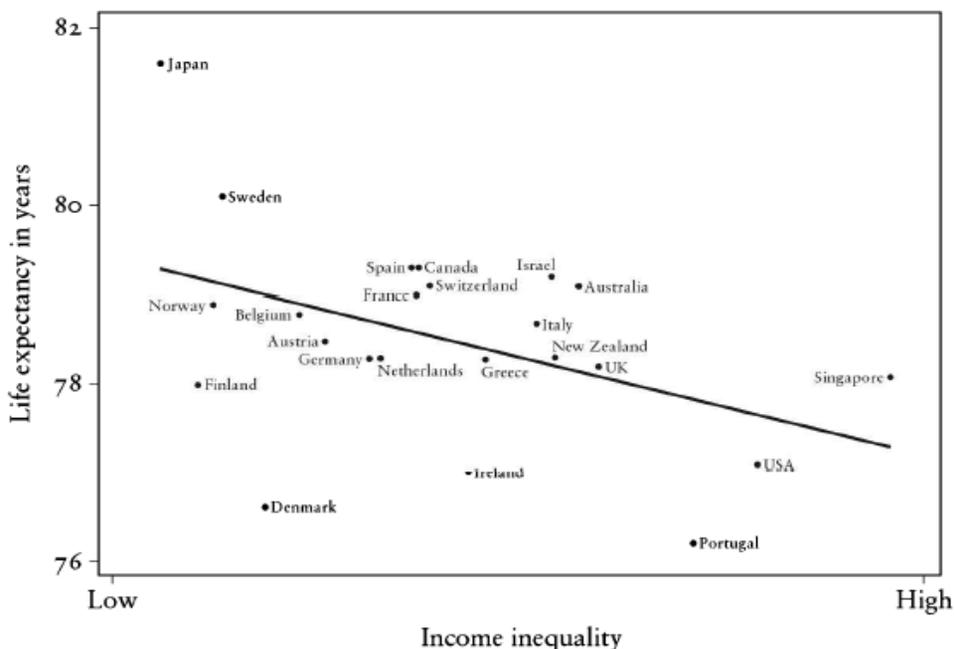


Figure 3. Relation between life expectancy and income inequality in developed countries (Wilkinson & Pickett, 2009)

greater utilization of health services both in preventive and curative healthcare. The high-income group opted for more elective surgeries, better maternal care, and more psychiatric services as compared to the low-income group and manual workers (Rose, 1971). Manual or unskilled workers have more chances of loss of wages in case of medical consultations or due to the long waiting time. The quality of consultation in high-income groups is also better due to superior knowledge and awareness. In the Millennium-cohort study (Hansen et al. 2008), it was found that in the year 1998, the immunization rate of Mumps Measles and Rubella vaccine was lower in lone parents, larger families, and children living in disadvantaged areas. Though there was no apparent reason to refuse vaccination, most of the mothers of unimmunized children expressed practical constraints (such as loss of wages, long waiting time, lack of awareness etc) for not being immunized. If a large number of children are left out from vaccination then the society as a whole does not get the advantage of herd immunity, thus impacting the health of all children.

Conclusion

To conclude, differences in life expectancy in the UK context can be explained through differential growth in per capita income as well as income distribution within the society. Higher-income inequalities often lead to erosion of social trust impacting health adversely. Further, social determinants like psycho-social factors and social capital— manifesting through cohesion, participation, and network connections – facilitate access to health services. Hence there is a need for a more flexible health services policy in the relatively greater deprived areas in the UK. Health services have to be more sensitive to different concerns, questions, and beliefs of the disadvantaged sections of society.

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Annexure I

