Social Inequalities and Health

Lectures 2 and 3
Social Determinants of Health and Health Inequalities

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Last week, you were presented with some information about how health has improved over time; and how this is has been associated with significant demographic changes, especially in relation to population growth.

You were also given some information about the pattern of mortality and illness worldwide ... what do people die from; where; and at what age

You will have seen that health is associated with wealth – richer countries have higher LE; and lower mortality rates. Richer countries also have different patterns illness and mortality.

In the next two lectures, we are going to discuss what is meant by social inequalities in Health; and begin to examine how social factors impact on health.

Health Inequalities

- Health differences between individuals
- Health differences between population groups
- Health differences between groups occupying unequal positions in society

There are different levels of health inequalities

Health differences between individuals - called pure health inequalities because they only relate to one dimension (health) – variation in health.

Health differences between population groups looks at two dimensions (health and social group). But it can do so in a way that doesn’t suggest any relationship to social position.

Third approach = second approach but with an emphasis on social position /hierarchy. Differences that exist between groups with different levels of social advantage or disadvantage.

Do you understand the subtle differences?

Note: WHO report used pure inequalities approach in 2000 report

Social Inequities in Health

not inequalities

- Social inequities in health are differences in health status between different socio-economic groups that are *systematic*, *socially produced* (therefore modifiable) and *unfair*

(one of *many* definitions!)

Systematic

- Non-random
- Patterned
- Distribution across a ‘social gradient’

Describing this pattern is a core function of social epidemiology

Socially produced

- Relate to an underlying social hierarchy that is socially produced
- Because they are social produced, they are potentially changeable

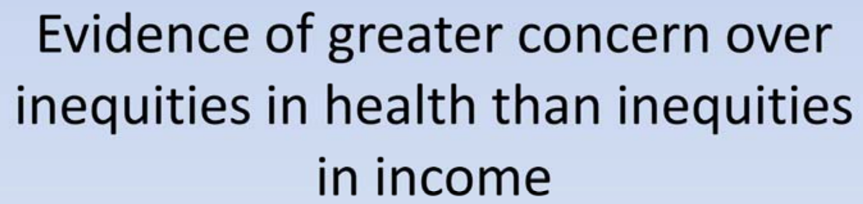
Some people believe that a social hierarchy is natural ....

Unfair

- ‘Where systematic differences in health are judged to be avoidable by reasonable action they are, quite simply, unfair. It is this that we label health inequity.’ (CSDH)
- Inequality describes differences .....

  but which may not necessarily imply moral judgement.
- Inequity is concerned with social justice.

Takes us beyond health research – into moral and political philosophy



Evidence of greater concern over inequities in health than inequities in income

Health Differences Between Men and Women .....

- Biological differences (natural)
- Health differences between men and women which are mediated through social factors (socially determined)
- Systematic differences caused in part because of differences in social hierarchy / position between men and women (social inequality)

Use example of HIV .....

Use example of geographic differences

The case of physical disability

- Diseases and injuries will cause limitations and impairments
- Can be socially modulated by
  - The disabling nature of the physical environment
  - Prejudicial attitudes
- Impairment: the functional limitation within the individual caused by physical, mental or sensory impairment
- Disability: the loss or limitation of opportunities to take part in the life of a community on an equal basis with others due to external (physical and social) barriers

Social Hierarchy / Social Stratification

- A key issue ....

Social Stratification

- Income / wealth
- Occupation / Class / Caste
- Educational status
- Physical ability
- Gender
- Ethnicity / Race / Religion
- Geography
- Nationality

Differential levels of advantage and access to resources

Resources: power; wealth; influence; status; prestige; control ... physical resources / political and cultural resources / education and intellectual resources

Bourdieu: Social class in post-industrial societies is forged not only through peoples' position in the labour market and their ownership of property. While economic power continues to be important, class privilege and advantage also relies on other kinds of resources and, in particular, the possession of cultural resources and command over social resources.

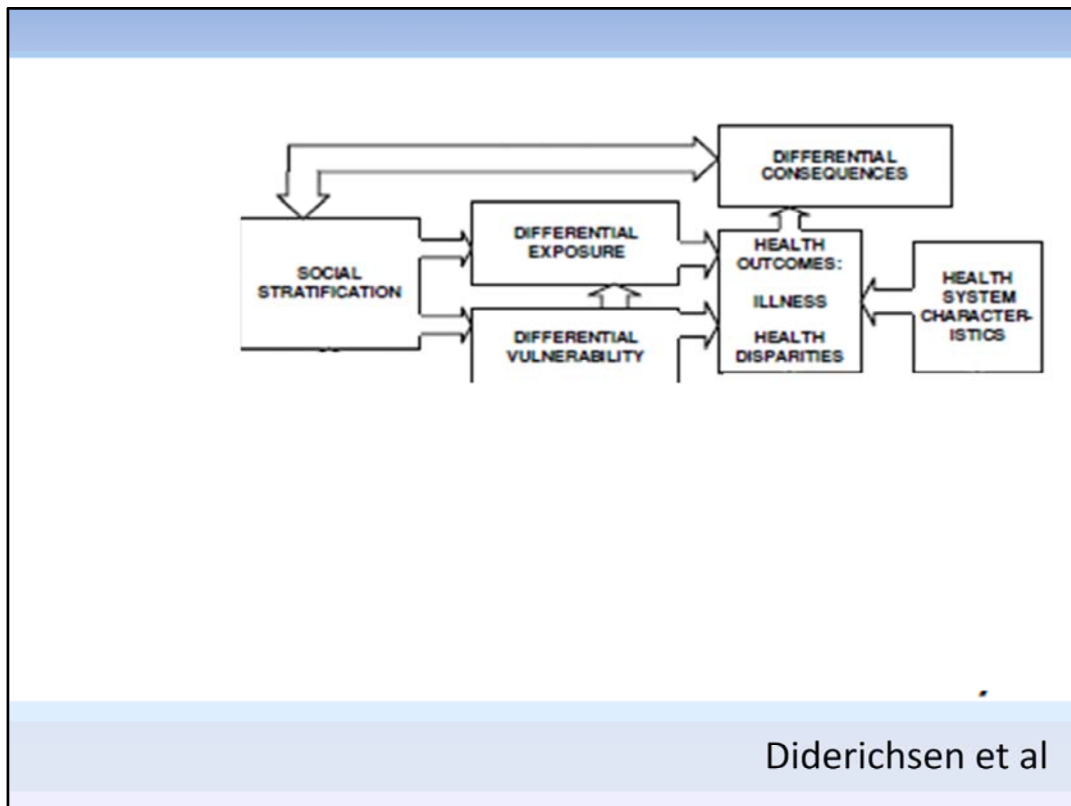
Social connections / networks / access to power and influence /

'cultural capital' and 'habitus' (habitual ways of thinking, acting and feeling)

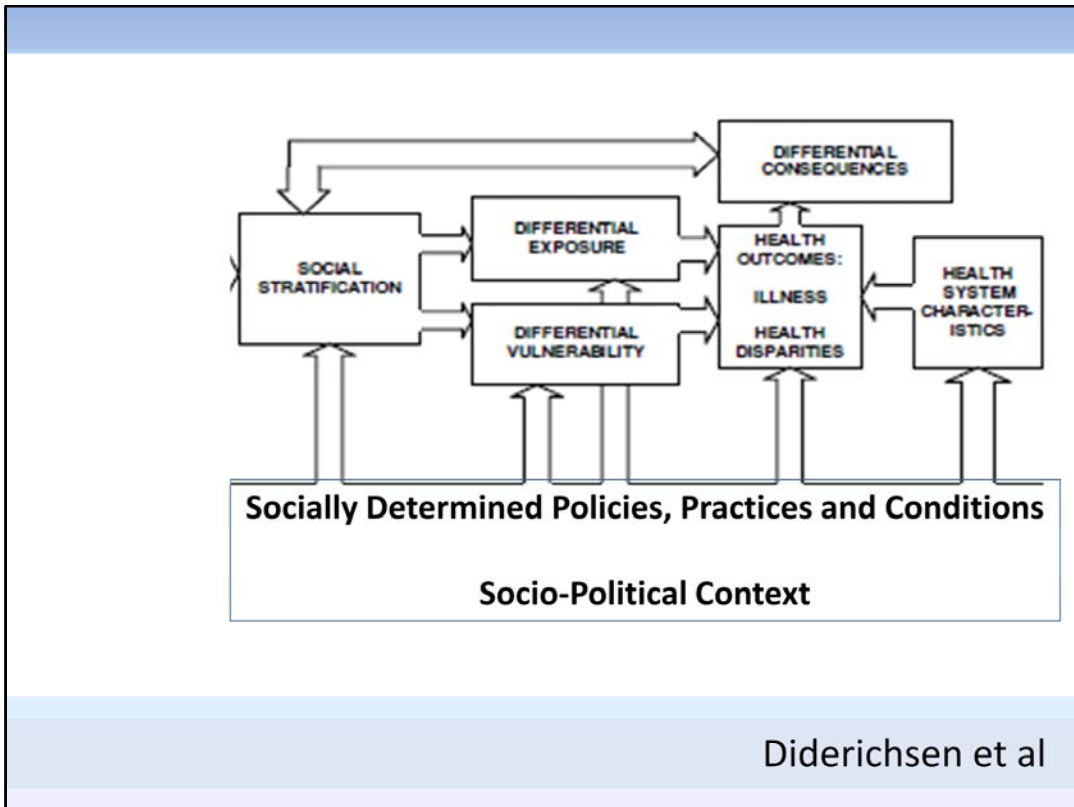
Measurement issues

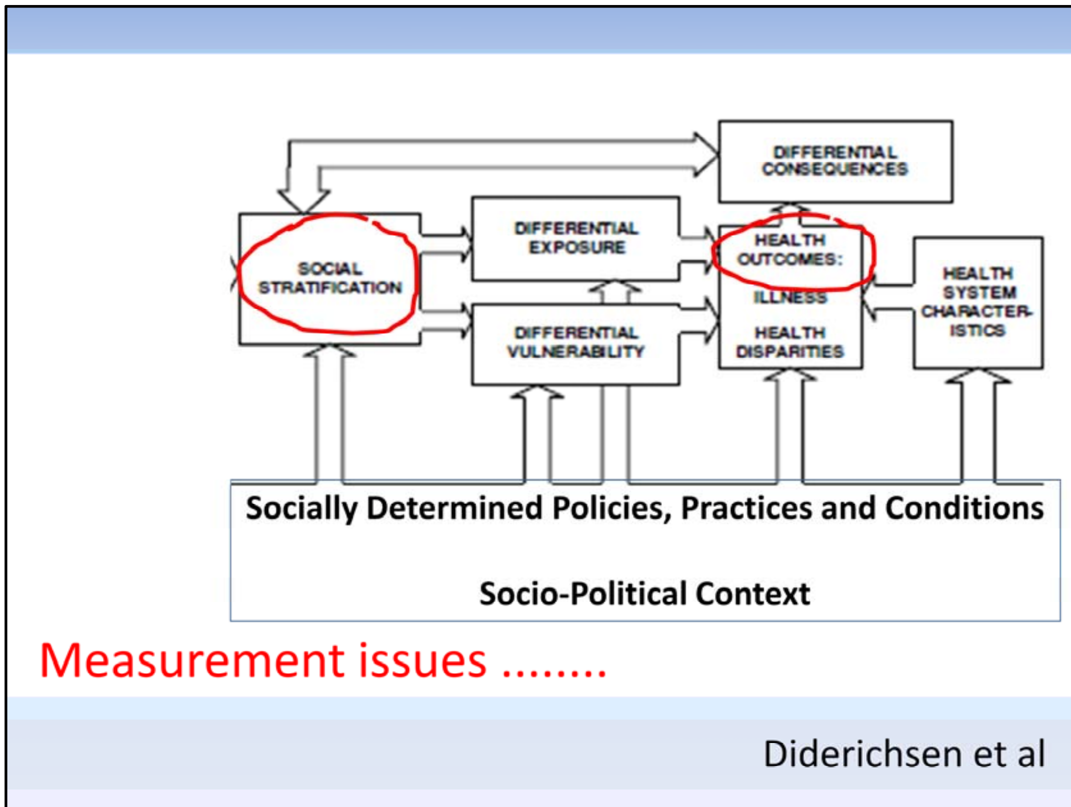
Importance of correlation ...
There isn't a single, one dimensional hierarchy ..... Different factors are involved amd interact with each other

Questions??



Diderichsen and colleagues [68](p. 14) identify "four main mechanisms – social stratification, differential exposure, differential vulnerability, and differential consequences – that play a role in generating health inequities.“


DIFFERENTIAL CONSEQUENCES
SOCIAL STRATIFICATION
DIFFERENTIAL EXPOSURE
DIFFERENTIAL VULNERABILITY
HEALTH OUTCOMES:
ILLNESS
HEALTH DISPARITIES
HEALTH SYSTEM CHARACTER-ISTICS
Socially Determined Policies, Practices and Conditions
Socio-Political Context
Diderichsen et al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Measurement issues ....
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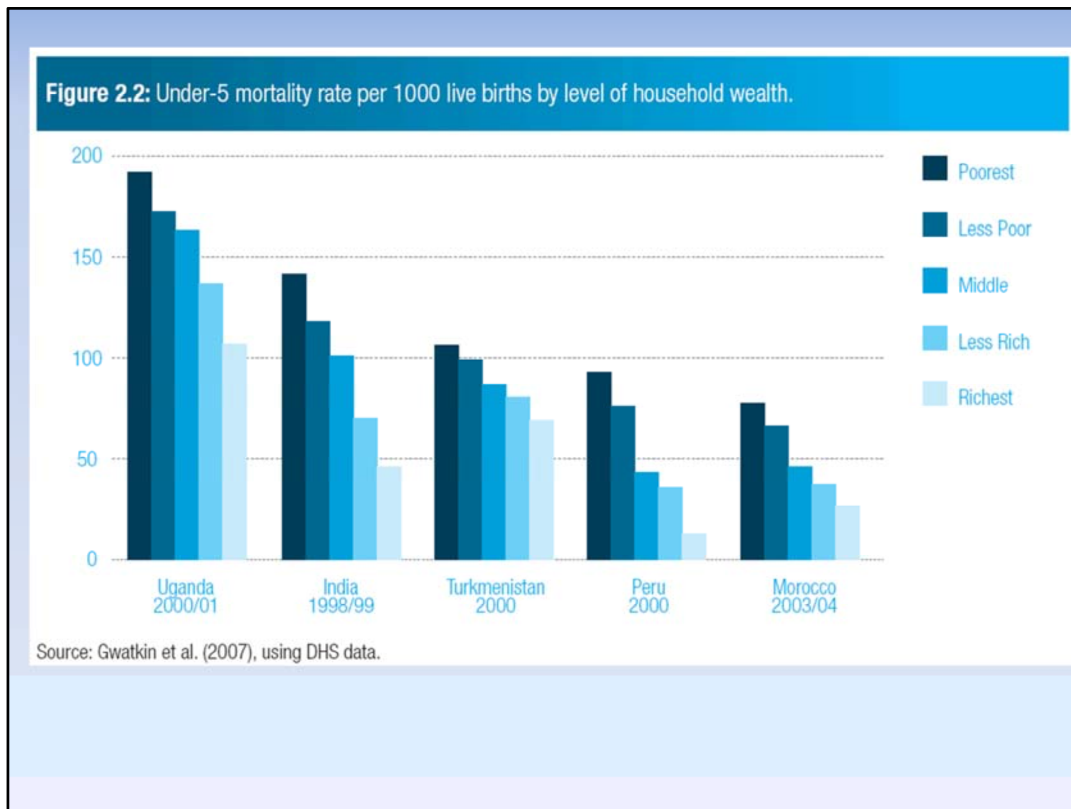
Social Determinants of Health

- No consistent / uniform definition
- The conditions in which people live and work that affect their opportunities to lead healthy lives (CSDH)
- Some argue for using just "determinants of health" – because the word "social" may imply an exclusion of political, environmental, economic, cultural, psychological, spiritual or individual behavioural determinants.
- Others use the word "social" as an umbrella term encompassing ***all*** determinants that are not biological

Social Inequalities in Health is not the same as the social determinants of health

What are they?



Let's apply a little of the theory we've learnt to some real life examples .....

Gradient across all groups

Degree of gradient varies

Average U5MR varies

Composite measure of inequality

Often, the reference group is the most advantaged group—e.g., the wealthiest/highest-income group for disparities by wealth/income, or the dominant racial/ethnic group for racial/ethnic disparities. At times, the disadvantaged group may be compared with the average level in the population, but this practice generally reflects data limitations and is not featured in the work of experts. Comparing the health of a disadvantaged group with average levels of health may not be very informative about social inequalities in health. For example, in a setting in which a large proportion of a population is disadvantaged, the health of the most disadvantaged may be markedly different from that of the best-off social group but not very different from the average; it would be erroneous to assess the magnitude of disparities as small.

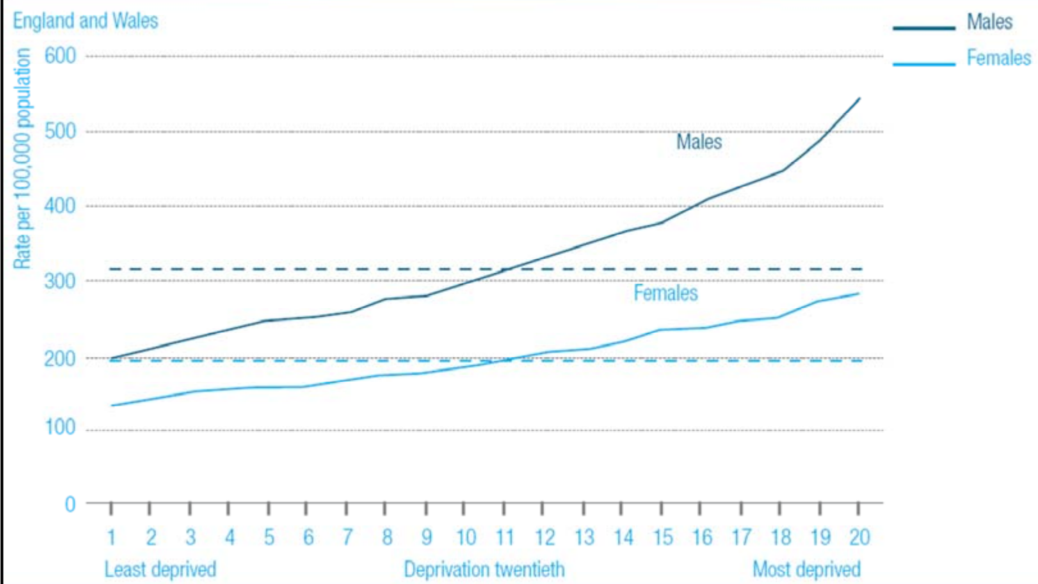
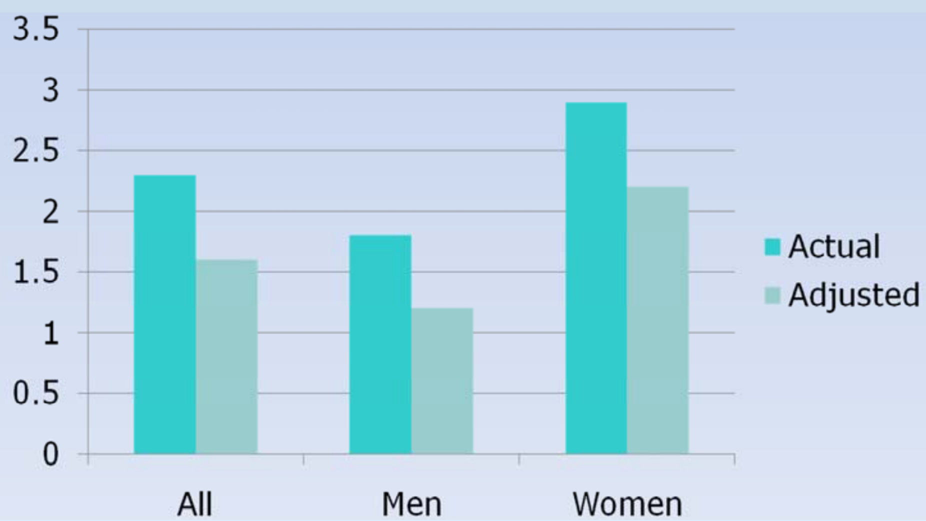
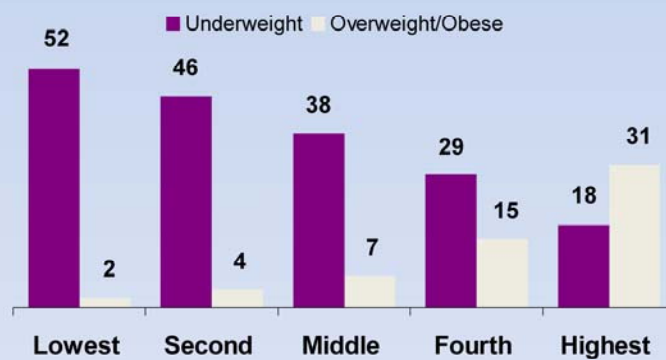


Figure 2.3: Death rates, age standardized, for all causes of death by deprivation twentieth, ages 15–64 years, 1999-2003, United Kingdom (England and Wales).
England and Wales
Males
Females
Rate per 100,000 population
600
500
400
300
200
100
0
Males
Females
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20
Least deprived
Deprivation twentieth
Most deprived


Mortality ratios, black versus white in USA
(adjusted for family income)
3.5
3
2.5
2
1.5
1
0.5
0
All
Men
Women
Actual
Adjusted

Underweight and Overweight/ Obesity among Women by Wealth

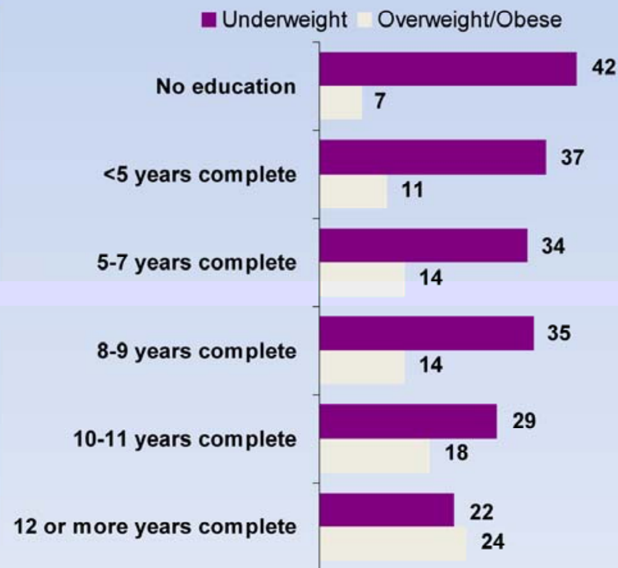
More than half of women in the highest income quintile are underweight.
In contrast, almost one-third of women in the highest income quintile are overweight or obese



Underweight and Overweight/Obese Women by Education

Prevalence of undernutrition is nearly two times higher among women with no education than among those with 12 or more years of schooling.

Prevalence of overweight and obesity is three times higher among women with 12 or more years of schooling than those with no education.



Theories of Social Inequalities in Health

- How does social position influence differential exposures and vulnerabilities, which in turn cause differences in health?

Material and neo-materialist theories

- Relationship between income inequality and health is to be found in material factors

- Those at the bottom of the socio-economic hierarchy suffer from worse health because they lack resources
  - Poor living and housing conditions
  - Poor nutrition
  - Hazardous working environments

(Neo-material)

- Public resources and infrastructure may moderate or modulate the degree to which private resources are important in the production of health
- Public provision of resources (e.g. social housing; welfare benefits; and public provision of health care) helps explain why the same levels of household wealth in different countries may yield different levels of health

Material and neo-materialist theories

- Having fewer resources = having fewer opportunities to be healthy + having greater vulnerabilities and susceptibilities

- **But this does not explain the relationship between *inequality* and health**