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"How the other half live": Lay perspectives on health inequalities in an age of austerity

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ABSTRACT

This paper examines how people living in two socially contrasting areas of Stockton on Tees, North East England experience, explain, and understand the stark health inequalities in their town. Participants displayed opinions that fluctuated between a variety of converging and contrasting explanations. Three years of ethnographic observation in both areas (2014–2017) generated explanations which initially focused closely on behavioural and individualised factors, whilst 118 qualitative interviews subsequently revealed more nuanced justifications, which prioritised more structural, material and psychosocial influences. Findings indicate that inequalities in healthcare, including access, the importance of judgemental attitudes, and perceived place stigma, would then be offered as explanations for the stark gap in spatial inequalities in the area. Notions of fatalism, linked to (a lack of) choice, control, and fear of the future, were common reasons given for inequalities across all participants. We conclude by arguing for a prioritisation of listening to, and working to understand, the experiences of communities experiencing the brunt of health inequalities; especially important at a time of austerity.

1. Introduction

Considerable research attention has been paid to identify and explain how health and place interrelate, and the resultant impact upon health inequalities (Bambra, 2016; Bernard et al., 2007; Curtis and Rees Jones, 1998; Macintyre et al., 2002; Sloggett and Joshi, 1994; amongst others). Geographical research has been dominated by the debate between compositional (population characteristics of people living in particular areas including demographic, health behaviours and individual-level socio-economic status) and contextual (area-level factors including the social, economic and physical environment) explanations. This academic debate - about the causes and complexities of geographical inequalities in health – could benefit from lay perspectives on health and place and the causes of health inequalities particularly from people living in the most and least deprived communities.

To date, research by Popay et al. (2003), Macintyre et al. (2005) and Davidson et al. (2006, 2008) has examined lay perspectives in socio-economically contrasting areas of cities across northern England and Scotland. Other studies (such as Blaxter, 1983, 1997; Parry et al., 2007; Mackenzie et al., 2016) have examined the perspectives of people living in the most deprived areas. These studies have employed mixed methodologies, including surveys, focus groups, and in-depth interviews; ethnographic research which explores the everyday lived realities of health inequalities is notably absent. Davidson et al. (2008: 168) have recognised this gap in the literature, and noted how "even fewer studies have specifically focused on the relationships between the types of place people reside in, and their experiences of, and attitudes to, health inequalities". Mackenzie et al. (2016) evidence not only material factors, but also explanations of the interplay between power and politics, with an explicit focus on how behavioural explanations can be integrated into such explanations.

This paper, in keeping with Popay (Popay et al., 2003), Macintyre (Macintyre et al., 2005), and Davidson et al (2006, 2008), directly explores the lived experience of- and perspectives on-geographical inequalities in health of people from socio-economically contrasting areas. Following Backett (1992: 257) in her research into lay health moralities in middle class families, the key purpose of this study was to "develop understandings of how beliefs and behaviours which may have implications for health are part of the fabric of daily life". In particular, this study focused upon people's everyday awareness and understanding of living in a place with severe health inequalities, and to question how this might be

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affected at a time of austerity. As such, it is one of the first studies to examine lay perspectives on health inequalities during austerity.

1.1. Geographical inequalities in health

Neighbourhoods that are the most deprived have worse health than those that are less deprived – and this follows a spatial gradient with each increase in deprivation resulting in a decrease in average health. In England, the gap between the most and least deprived areas is 9 years average life expectancy for men and around 7 years for women. As noted earlier, geographical research has tried to explain these differences through looking at compositional and contextual factors – and their interaction (Cummins et al., 2007).

The compositional explanation asserts that the health of a given area is the result of the characteristics of the people who live there in terms of demographic [age, sex and ethnicity], health-related behaviours [smoking, alcohol, physical activity, diet, drugs] and socio-economic [income, education, occupation]) factors. There is an extensive literature linking socio-economic status to health: people with higher occupational status (e.g. professionals such as teachers or lawyers), education or income have better health outcomes than non-professional workers (e.g. manual workers), or those with lower levels of education or income. Health follows a social gradient – the higher the social position, the better the health. Health inequality is therefore not an issue just of poverty, but is related to economic inequality more widely (Wilkinson and Pickett, 2010).

The literature suggests that there are several interacting pathways linking individual-level socio-economic status and health: behavioural, material, psychosocial, and life course (Bartley, 2004). The 'materialist' explanation argues that it is income-levels and what a decent or high income enables compared to a lower one such as access to health-benefitting goods and services (e.g. health care access, schools, transport, social care) and limiting exposures to particular material risk factors (e.g. poor housing, inadequate diet, physical hazards at work, environmental exposures). The 'behavioural-cultural' theory asserts that the causal mechanisms are higher rates of health-damaging behaviours in lower socio-economic groups – which may be more culturally acceptable amongst lower socio-economic groups. The 'psychosocial' explanation focuses on the adverse biological consequences of psychological and social domination and subordination, superiority and inferiority. The 'life course' approach combines aspects of the other explanations, thereby allowing different causal mechanisms and processes to explain the social gradient in different diseases. It also highlights the role of the accumulation of disadvantage over the 'life course' – combining the amount of time different people have spent in more/less disadvantaged circumstances.

The contextual approach instead focuses on the health effects of the economic, social, physical and political environment of a place, arguing that regardless of individual factors, where you live also matters (Bambra, 2016). Health promoting environments are more likely to be found in affluent as compared to deprived areas. Area-economic factors that influence health include area poverty rates, unemployment rates, wages, and types of employment in the area. Social place-based factors include opportunity structures and collective social functioning and practices - the services provided (publicly or privately) to support people in their daily lives as well as the reputation and history of an area as well as local cultures (Macintyre et al., 2002). In terms of the physical environment, there is a sizeable literature, for instance, on the positive health effects of access to green space (Mitchell and Popham, 2007), as well as the negative health effects of brownfield or contaminated land (Bambra et al., 2014) as well as air pollution (Stafford and McCarthy, 2006) or neighbourhood regeneration (Egan et al., 2015). Compositional and contextual factors though are not separate phenomena: they interact and shape one another (Cummins et al., 2007).

This paper examines whether and how lay perspectives reflect these contextual and compositional theories of geographical inequalities in health.

1.2. Austerity and health inequalities

Although spatial inequalities in health within the UK have been much discussed, there is less empirical assessment of the effects of the current programme of austerity on these inequalities (Pearce, 2013) - manifested as large-scale cuts to central and local government budgets, as well as an NHS funding freeze and cuts to welfare services and benefits (Bambra and Garthwaite, 2015). However, recent (primarily quantitative) research has indicated that austerity and welfare reforms are having adverse effects on the most vulnerable in society. In their study on self-harm, Barnes et al. (2016:1) reported that "economic hardships resulting from the recession and austerity measures accumulated or acted as a 'final straw' to trigger self-harm". They emphasised that "changes in welfare benefits may have contributed" to this rise (2016: 132). Niedzwiedz et al. (2016) found that reductions in spending levels or increased conditionality may adversely affect the mental health of disadvantaged social groups. Highest levels of foodbank use have occurred where there have been the highest rates of benefit sanctioning, unemployment, and cuts in central welfare spending (Loopstra et al., 2015).

Accompanying austerity measures and ongoing reforms to the social security system is a dominant narrative that characterises people living on a low income as 'feckless', lacking in aspiration, and engaging in poor lifestyle choices (Garthwaite, 2016a), which can lead to stigma, a worsening of already poor mental health and the risk of widening health inequalities (Hatzenbuehler et al., 2013; Scambler, 2006). Pearce (2013: 1922) has emphasised an (arguably surprising) lack of attention on this issue from a geographical perspective:

> "whilst there is a voluminous literature evaluating the role of various forms of discrimination in understanding health and inequalities, geographical accounts of discrimination have been thin on the ground."

Pearce observes how austerity measures evident in the UK, as well as other European countries, will undoubtedly have implications for health inequalities which are yet to be experienced or documented. Making a link between this process and stigma production, Pearce argues that "one of the likely implications of reducing investment into communities with a multitude of social problems is that such places will become increasingly stigmatised, which is likely to be detrimental to the health of local residents" (2013: 1924). This research project is situated at this nexus, and the findings reported here will draw attention to the relationship between place, health inequalities, and austerity through the lay perspectives of those living in the most and least deprived areas of Stockton-on-Tees, the North East town with the largest health inequalities in England. This paper will therefore add to the health inequalities literature in terms of strengthening our understanding of lay perspectives and their relationship with existing theories, whilst being one of the first studies to examine lay perspectives in a period of austerity.

1.3. Lay perspectives

The importance of lay knowledge has emerged as being central