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Health inequalities – why so little progress?

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ABSTRACT

Studies of the health of the population of Scotland over many years have provided new insights to the basis of inequalities in life expectancy across the Scottish population. Conventional descriptions of health inequalities as being due predominantly to smoking, obesity and alcohol do not fully account for the situation in Scotland. The deeper insights obtained from comprehensive analysis have prompted new approaches to narrowing the gap. Opportunities for well-being are created within the complex system of a well functioning society and novel methods are required if the outcomes of such a complex system are to improve.

Introduction

In many countries, there is a marked and growing gap in life expectancy between the poorest and most affluent members of society.[1] Differences in risk of premature death associated with wealth have been known about for many years. One of the first statistically important studies of wealth and mortality is to be found in the city records of Glasgow for 1861. John Strang, the City Chamberlain, an officer of the city who was responsible for collecting taxes, calculated the ratio of domestic servants to total population in each electoral district of the city as a proxy for economic status. He showed that in the most affluent area, where there was one domestic servant for every 2.8 residents, infant mortality was 17.8 deaths/1000 live births in the first year of life. However, in the poorest district, with one servant for every 67.8 residents, 260 of every 1000 babies born alive died in their first year of life.

Many studies since then have confirmed a striking relationship between poverty, poor health and premature mortality. In the UK, the Report on Inequalities produced by Sir Douglas Black[2] showed that, in the 1970s, unskilled workers were 2.5 times more likely to die before the age of 65 years than professional classes. More recently, figures based on mortality data from 2010 to 2012 show that male life expectancy at birth in the city of Glasgow is 72 years,[3] 15 years lower than in the most affluent areas of England. This gap is also seen within the localities of west central Scotland. Glasgow Centre for Population Health[4] reports a 15 year gap in male life expectancy at birth across neighbourhoods in the Greater Glasgow area and an equivalent 11 year gap in female life expectancy in the period 2008–12.[4]

Initially, attempts to explain these differences focused on a behavioural model.[5] The commonly held view, perhaps encouraged by a UK Government report of 1976[6] was that individuals were responsible for their own health, implying that those with poorer health at the lower end of the social scale were more likely to indulge in unhealthy behaviours and less likely to access health care. Inequalities were seen as the consequence of choices made by the poor and the remedy was to provide them with better information to make it clear that they were making the wrong choices.

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Those who recognized the poor as victims of circumstance questioned this approach. Attempts to explain inequalities as being due to decisions made by individuals have, rightly, been dismissed as 'victim blaming.' In 1980, The Black Report suggested the idea that the material circumstances in which poor people lived were the principal cause of inequality.[2] Poverty exposes people to health hazards, the report argued, because it made them more likely to live in poorly built houses which were cold and damp and often in areas affected by air pollution. While there is some evidence to support this argument in part, it is clear that it fails to explain much of the inequality in health and it does little to explain many of the other inequalities encountered in poor areas. Yes, unhealthy habits were commoner in deprived areas and these areas may have poorer environments which might contribute to inequality in health status but, as Sir Michael Marmot has often stated 'We need to look behind the obvious explanations. We need to understand 'the causes of the causes' if we are to improve the situation'.[7]

Inequality in Scotland – an alternative analysis

For many years, the explanation for the gap in mortality in Scotland, as in other countries, was assumed to be due largely to health related behaviours. The affluent were more likely to eat well, take exercise, be non-smokers and drink alcohol more sensibly than the poor. There remains, in Scotland, as in other societies, a clear association between higher levels of healthy behaviour and relative affluence. However, association tells us little about causation. In the last few decades, dissatisfaction with behavioural causes of inequality in life expectancy prompted public health practitioners to dig more deeply in to the problem and seek 'the causes of the causes'. They have produced extensive and insightful studies of the causal mechanisms for the link.

Inequality is widest in younger people

An important study was that carried out by Leyland and colleagues.[8] They examined in detail the underlying pattern of inequality across the life span of the Scottish population. Many studies simply look at overall life expectancy without giving enough consideration to the underlying patterns of death. Their work showed that the widening gap in life expectancy in Scotland is partly due to the fact that ischaemic heart disease mortality has fallen faster in wealthier areas than amongst the poor and perhaps this is a reflection of the ability of the better educated and more affluent to adopt healthier life-styles and behaviours. However, the latter decades of the 20th century saw a rise in the number of deaths in the younger working age population due to negative lifestyles. Inequality in incidence of deaths due to alcohol, drugs and assault increased significantly over this period and inequality in mortality is greatest amongst those aged between 30 and 49 years. These are not in the age groups most affected by heart disease and cancer.

The assumption that the common causes of death are driving inequality misses the fact that other, less common causes of death in a much younger population have emerged in recent decades. This emergent pattern of premature mortality is due to causes which are strongly associated with adverse social conditions. It is difficult to avoid the conclusion that much of the increase in inequality may have been precipitated by changes that took place in social structures in Scotland in the latter half of the 20th century.

Social turbulence in the latter decades of the 20th century

The widest inequalities in life expectancy in Scotland are to be found in the cities of Glasgow and Dundee. In the 1970s, both these cites experienced major loss of employment in traditional industries.[9] In Glasgow, jobs in shipbuilding and heavy engineering were lost as competition from Far Eastern countries became more intense. At the same time, the production of jute based products which, at its height, had provided employment in 130 mills in Dundee declined precipitously.

The loss of employment in traditional industries in Glasgow was accompanied by major changes in housing which compromised social cohesion in many communities.[10] A post war plan to demolish overcrowded and insanitary inner city housing led to almost one third of the population being moved from their homes. Extensive motorway and commercial property building led to whole districts being demolished and the people living in them spread across new developments, often with few facilities.

The resulting dislocation of communities, at a time when worklessness was increasing dramatically led to severe social problems in the 1960s when gang violence attracted national attention.

A credible hypothesis suggests that widening inequality in health and an increase in socially determined causes of death in the most economically deprived individuals was a consequence of large scale social turbulence. Unemployment, social dislocation due to the break up of communities and the poverty and hopelessness associated with such chaos produced psychological and social stresses.

An individual who feels he has no future is less likely to worry about his health. As a clinician in Glasgow in the 1980s, I would often encounter patients whose smoking and drinking habits had caused serious surgical illness. Cessation advice would often be met with a response which indicated a lack of concern about risk. 'Why should I worry? What have I got to live for?' The increased incidence of health damaging behaviours in people living in poverty and who have little hope that their circumstances might improve is easily understood.

Yet conventional risk factors, as argued above, do not account for the pattern of premature death which has emerged in this post industrial society. This observation prompted us to ask what was driving this increase in mortality in young, working age people due to drugs, alcohol, and violence?

Salutogenesis rather than pathogenesis

Clues as to the drivers of inequality and possible remedies are to be found in the idea of salutogenesis. This is a term introduced by the American sociologist, Aaron Antonovsky who