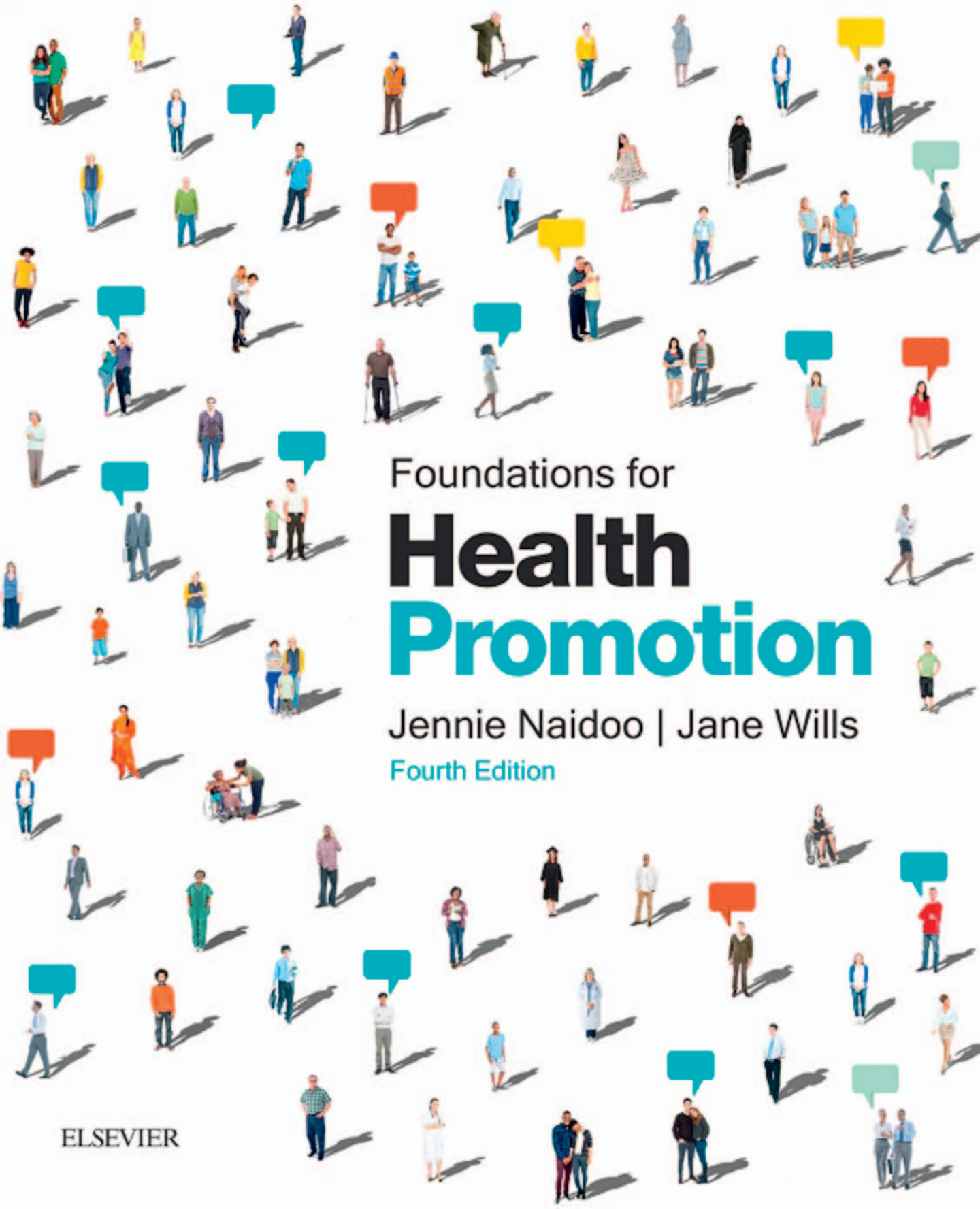

Foundations for

Health Promotion

Jennie Naidoo | Jane Wills

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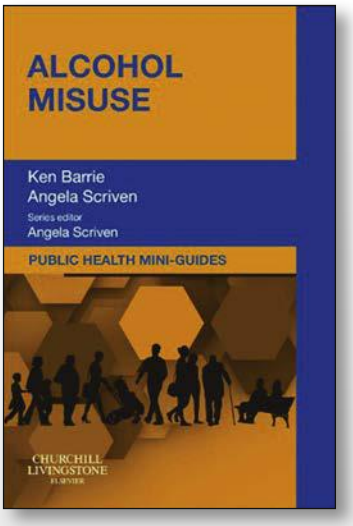

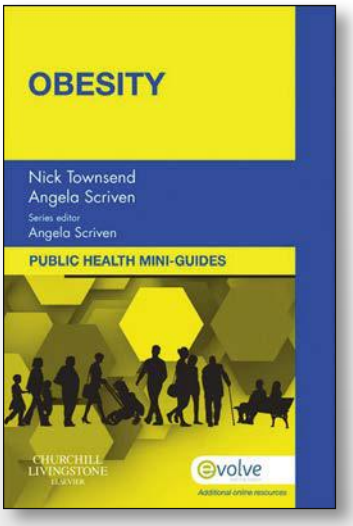

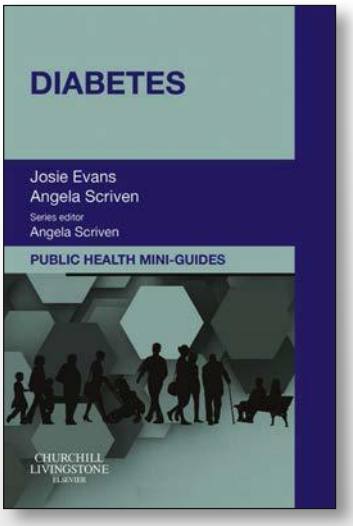

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Designer: *Christian Bilbow*
Illustration Buyer: *Amy Naylor*

Foundations for Health Promotion

FOURTH EDITION

Jennie Naidoo

Principal Lecturer, Health Promotion and Public Health,
University of the West of England, Bristol, UK

Jane Wills

Professor of Health Promotion, London South Bank
University, London, UK

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Contents

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Preface

Health promotion is a core aspect of the work of a wide range of healthcare workers and those engaged in education and social welfare. It is an emerging area of practice and study, still defining its boundaries and building its own theoretical base and principles. This book aims to provide a theoretical framework for health promotion, as this is vital to clarify practitioners' intentions and desired outcomes. It offers a foundation for practice which encourages practitioners to see the potential for health promotion in their work, to be aware of the implications of choosing from a range of strategies and to be able to evaluate their health promotion interventions in an appropriate and useful manner.

This fourth edition of *Health Promotion: Foundations for Practice* has been comprehensively updated and expanded to reflect recent research findings and major organizational and policy changes over the last decade. Our companion volume, *Public Health and Health Promotion: Developing Practice* (Naidoo and Wills, 2010), discusses in more detail some of the challenges and dilemmas raised in this book, e.g. partnership working, tackling inequalities and engaging the public.

The book is divided into four main parts. The first part provides a theoretical background, exploring the concepts of health, health education and health promotion. Part One concludes that health promotion is working towards positive health and well-being of individuals, groups and communities. Health promotion includes health education but also acknowledges the social, economic and environmental factors which determine health status. Ethical and political values inform practice, and it is important for practitioners to reflect upon these values and their implications. Part One embraces the shift towards well-being rather than a narrow interpretation of health, and the move away from a simple focus on lifestyle changes as the goal of health promotion. Its aim is to enable readers to understand and reflect upon these theoretical drivers of health promotion practice within the context of their own work.

Part Two explores strategies to promote health, and some of the dilemmas they pose. Using the Ottawa Charter (World Health Organization, 1986) framework to identify the range of strategies, the potential, benefits and challenges of adopting each strategy are discussed. Examples of interventions using the different strategies are presented. What is reflected here is how health services have not moved towards prioritizing prevention, although there is much greater acceptance and support for empowerment approaches in work with individuals and communities. While policies that impact on health still get developed in isolation from each other, there is a recognition of the need for health in all policies, and for deliberative democracy and working methods that engage with communities as the ways forward.

Part Three focuses on the provision of supportive environments for health, identified as a key strategy in the Ottawa Charter. Part Three explores how a range of different settings in which health promotion interventions take place can be oriented towards positive health and well-being. The settings discussed in this part – schools, workplaces, neighbourhoods, health services and prisons – have all been targeted by national and international policies as key for health promotion. Reaching specific target groups, such as young people, adults or older people, within these settings is also covered in Part Three. There is much debate about the need for systems thinking and seeing such settings more broadly as environments where physical, social and economic drivers come together, and not just as places in which to carry out health education and lifestyle behaviour interventions.

Part Four focuses on the implementation of health promotion interventions. Each chapter in this part discusses a different stage in the implementation process, from needs assessment through planning to the final stage of evaluation. This part is designed to help practitioners to reflect on their practice through examining what drives their choice of

practical implementation strategies. A range of real-life examples helps to illustrate the options available and the criteria that inform the practitioner's choice of approach.

This book is suitable for a wide range of professional groups, and this is reflected in the choice of examples and illustrative case studies, which have been completely updated for this edition. In response to reader feedback about the ways to engage with a textbook, we have changed the format for this edition. Each chapter has between 6 and 15 learning activities which encourage readers to engage with the text and extend their learning. Indicative feedback about the points that a reader or student might wish to consider is provided at the end of the chapter. Each chapter also includes at least one case study and research example to provide the reader with examples of application and encourage a focus on topics. Further questions at the end of each chapter encourage readers to reflect on their practice, values and experience, and to debate the issues. To reflect the huge changes in information management since this book was first published in 1994, website addresses are given for resources and further reading where possible.

The book is targeted at a range of students, including those in basic and post-basic training and qualified professionals. By combining an academic critique with a readable and accessible style, this book will inform, stimulate and encourage readers to engage in ongoing enquiry and reflection regarding their health promotion practice. The intention, as always, is to encourage readers to develop their practice through considering its foundation in theory, policy and clear principles.

Jennie Naidoo
Jane Wills
Bristol and London

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It is 21 years since the publication of the first edition of this book, which was initially prompted by our teaching on the first postgraduate specialist courses in health promotion. Students and colleagues at the University of the West of England and London South Bank University have, as always, contributed to this edition through their ideas, debates and practice examples. We continue to be committed to the development of health promotion as a discipline.

We dedicate this fourth edition to our children, Declan, Jessica, Kate and Alice.

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Part One

The theory of health promotion

Part One explores the concepts of health, health education and health promotion. Health promotion draws upon many different disciplines, ranging from the scientific (e.g. epidemiology) and the social sciences (e.g. sociology and psychology) to the humanities (e.g. ethics). This provides a wealth of theoretical underpinnings for health promotion, ranging from the scientific to the moralistic. This in turn means that health promotion in practice may range from a scientific medical exercise (e.g. vaccination) or an educational exercise (e.g. sex and relationships education in schools) to a moral query (e.g. end-of-life options). An important first step for health promoters is to clarify for themselves where they stand in relation to these various different strategies and goals. Are they educators, politicians or scientists? In part this will be determined by their background and initial education, but health promotion is an umbrella which encompasses all these activities and more. Working together, practitioners can bring their varied bodies of knowledge and skills to focus on promoting the health of the population, and achieve more significant and sustainable results than if they were operating on their own.

This first part of the book explores different understandings of the concept of health and well-being, and the ways in which health can be enhanced or promoted. The effect on health of structural factors such as income, gender, sexuality and ethnicity and the way in which social factors are important predictors of health status are explored in Chapter 2. The different ways in which health is measured reflect different views on health, from the absence of disease to holistic concepts of well-being, and these are discussed in Chapter 3. Chapters 4 and 5 debate what health promotion is, adopting an ecological model in which change in health is said to be influenced by the interaction of individual, social and physical environmental variables. Chapters 6 and 7 will help those who promote health to be clear about their intentions and how they perceive the purpose of health promotion. Is it to encourage healthy lifestyles? Or is it to redress health inequalities and empower people to take control over their lives?

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Chapter **One** 1

Concepts of health

Learning Outcomes

By the end of this chapter you will be able to:

- define the concepts of health, well-being, disease, illness and ill health, and understand the differences between them
- discuss the nature of health and well-being, and how culture and populism influence our definitions
- understand the elements of the medical model of health and how it influences healthcare practice.

Key Concepts and Definitions

Biomedicine Focuses on the causes of ill health and disease within the physical body. It is associated with the practice of medicine, and contrasts with a social model of health.

Disease Is the medical term for a disorder, illness or condition that prevents an individual from achieving the full functioning of all his or her bodily parts.

Health Is the state of complete mental and physical well-being of an individual, not merely the absence of disease or illness.

Ill health Is a state of poor health when there is some disease or impairment, but not usually serious enough to curtail all activities.

Illness Is a disease or period of sickness that affects an individual's body or mind and prevents the individual achieving his or her optimal outputs.

Well-being Is the positive feeling that accompanies a lack of ill health and illness, and is associated with the achievement of personal goals and a sense of being well and feeling good.

Importance of the Topic

Everyone engaged in the task of promoting health starts with a view of what health is. However, these views, or concepts, of health vary widely. It is important at the outset to be clear about the concepts of health to which you personally adhere, and recognize where these differ from those of your colleagues and clients. Otherwise, you may find yourself drawn into conflicts about appropriate strategies and advice that are actually due to different ideas concerning the end goal of health. This chapter introduces different concepts of health and traces the origin of these views. The Western scientific medical model of health is dominant, but is challenged by social and holistic models. Working your way through this chapter will enable you to clarify your own views on the definition of health and locate these views within a conceptual framework.

Defining health, well-being, disease, illness and ill health

Health

Health is a broad concept which can embody a huge range of meanings, from the narrowly technical to the all-embracing moral or philosophical. The word 'health' is derived from the Old English word for heal (*hael*) which means 'whole', signalling that health concerns the whole person and his or her integrity, soundness or well-being. There are 'common-sense' views of health which are passed through generations as part of a common cultural heritage. These are termed 'lay' concepts of health, and everyone acquires a knowledge of them through socialization into society. Different societies and different groups within one society have different views on what constitutes their 'common-sense' notions about health.

Learning Activity 1.1 What does health mean to you?

What are your answers to the following?

- I feel healthy when…
- I am healthy because…
- To stay healthy I need…
- I become unhealthy when…
- My health improves when…
- (An event) affected my health by…
- (A situation) affected my health by…
- …is responsible for my health.

Health has two common meanings in everyday use, one negative and one positive. The negative definition is the absence of disease or illness. This is the meaning of health within the Western scientific medical model, which is explored in greater detail later in this chapter. The positive definition of health is a state of well-being, interpreted by the World Health Organization in its constitution as 'a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity' (World Health Organization, 1946).

Health is holistic and includes different dimensions, each of which needs to be considered. Holistic health means taking account of the separate influences and interaction of these dimensions.

Figure 1.1 shows a diagrammatic representation of the dimensions of health.

The inner circle represents individual dimensions of health.

- Physical health concerns the body, e.g. fitness, not being ill.
- Mental health refers to a positive sense of purpose and an underlying belief in one's own worth, e.g. feeling good, feeling able to cope.
- Emotional health concerns the ability to feel, recognize and give a voice to feelings, and to develop and sustain relationships, e.g. feeling loved.
- Social health concerns the sense of having support available from family and friends, e.g. having friends to talk to, being involved in activities with other people.
- Spiritual health is the recognition and ability to put into practice moral or religious principles or beliefs, and the feeling of having a 'higher' purpose in life.
- Sexual health is the acceptance and ability to achieve a satisfactory expression of one's sexuality.

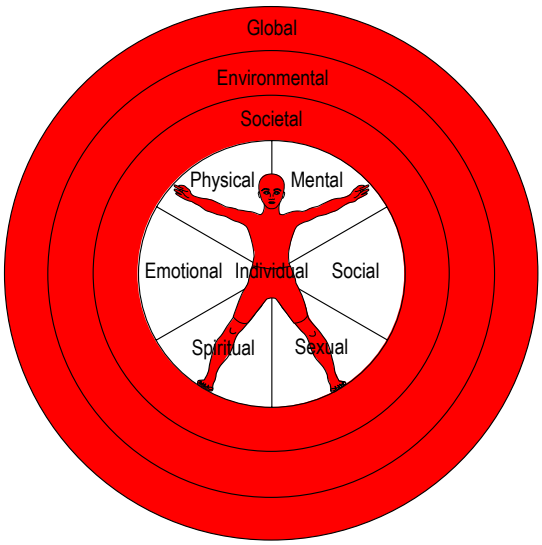

Fig 1.1 ● Dimensions of health.

The three outer circles are broader dimensions of health which affect the individual. Societal health refers to the link between health and the way a society is structured. This includes the basic infrastructure necessary for health (such as shelter, peace, food, income), and the degree of integration or division within society. We shall see in Chapter 2 how the existence of patterned inequalities between groups of people harms the health of everyone. Environmental health refers to the physical environment in which people live, and the importance of good-quality housing, transport, sanitation and pure-water facilities. Global health involves caring for the planet and ensuring its sustainability for the future.

Learning Activity 1.2 Holistic model of health

What are the implications of a holistic model of health for the professional practice of health workers?

Well-being

'Well-being' is a term widely used to describe 'what makes a good life'. It is also used in healthcare discourse to broaden views on what health means beyond the absence of illness. Feeling good and functioning well are seen as important components of mental well-being. This, in turn, leads to better physical health, improved productivity, less crime and more participation in community life (DH, 2010). The New Economics Foundation has developed the Happy Planet Index (New Economics Foundation, 2012) as a headline indicator of how nations compare in enabling long and happy lives for their citizens. In 2012:

- eight of the nine countries that are achieving high and sustainable well-being are in Latin America and the Caribbean
- the highest-ranking Western European nation is Norway in 29th place, just behind New Zealand in 28th place.
- the USA is in 105th position out of 151 countries.

Similarly, the UNICEF index of child well-being (UNICEF, 2013) shows that well-being is greater in more egalitarian countries, such as Norway and other Scandinavian countries.

Evidence (Government Office for Science, 2008) suggests that there are five methods or steps that individuals can take to enable themselves to achieve well-being:

- connect
- be active
- take notice
- give
- keep learning.

More recently, 'Care (about the planet)' has been added to this list.

Learning Activity 1.3 Five steps to well-being

What evidence is there for each of the steps to well-being?

Disease, illness and ill health

Disease, illness and ill health are often used interchangeably, although they have very different meanings. Disease derives from *desaise*, meaning uneasiness or discomfort. Nowadays, disease implies an objective state of ill health, which may be verified by accepted canons of proof. In our modern society these accepted canons are couched in the language of scientific medicine. For example, microscopic analysis may yield evidence of changes in cell structure, which may in turn lead to a diagnosis of cancer. Disease is the existence of some pathology or abnormality of the body which is capable of detection. Disease can be due to exogenous (outside the body, e.g. viral infection) or endogenous (inside the body, e.g. inadequate thyroid function) factors.

Illness is the subjective experience of loss of health. This is couched in terms of symptoms, for example the reporting of aches or pains, or loss of function. One way that illness is given meaning is through the narratives we construct about how we fall sick. The process of making sense of illness is a task most sick people engage

in to answer the question 'why me?' Illness and disease are not the same, although there is a large degree of coexistence. For example, a person may be diagnosed as having cancer through screening, even when there have been no reported symptoms; thus a disease may be diagnosed in someone who has not reported any illness. When someone reports symptoms, and further investigations such as blood tests prove a disease process, the two concepts of disease and illness coincide. In these instances, the term ill health is used. Ill health is therefore an umbrella term used to refer to the experience of disease plus illness. Health is the normal functioning of the body as a biological entity. Health is both not being ill and the absence of symptoms.

Social scientists view health and disease as socially constructed entities. Health and disease are not states of objective reality waiting to be uncovered and investigated by scientific medicine; rather, they are actively produced and negotiated by ordinary people. Cornwell's (1984) study of London's East-enders used three categories of health problems.

1. Normal illness, e.g. childhood infections.
2. Real illness, e.g. cancer.
3. Health problems, e.g. ageing, allergies.

Illness has often been conceptualized as deviance – as a different state from the healthy norm and a source of stigma. Goffman (1968) identified three sources of stigma.

1. Abominations of the body, e.g. psoriasis.
2. Blemishes of character, e.g. human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS).
3. Tribal stigma of race, nation or religion, e.g. apartheid.

The subjective experience of feeling ill is not always corroborated by an objective diagnosis of disease. When this lack of corroboration happens, doctors and health workers may label sufferers 'malingerers', denying the validity of subjective illness. This can have important consequences. For example, a sick certificate, and therefore sick pay, may be withheld if a doctor is not convinced that someone's reported illness is genuine. The acceptance of reported symptoms as signs of an illness leads to a debate about how to manage the illness. Several conditions, such as chronic fatigue syndrome and repetitive strain injury, have taken a long time to be recognized as legitimate illnesses.

Learning Activity 1.4 The medicalization of health

What examples are there of a condition or behaviour where its medicalization has led to its acceptance or otherwise?

It is also possible for an individual to experience no symptoms or signs of disease, but to be labelled sick as a result of medical examination or screening. Hypertension and pre-cancerous changes to cell structures are two examples where screening may identify a disease even though the person concerned may feel perfectly healthy.

Figure 1.2 gives a visual representation of these discrepancies. The central point is that subjective perceptions cannot be overruled, or invalidated, by scientific medicine.

The Western scientific medical model of health

In modern Western societies, and in many other societies as well, the dominant professional view of health adopted by most healthcare workers during their training and practice is labelled Western scientific medicine. Western scientific medicine operates within a medical model using a narrow view of health,

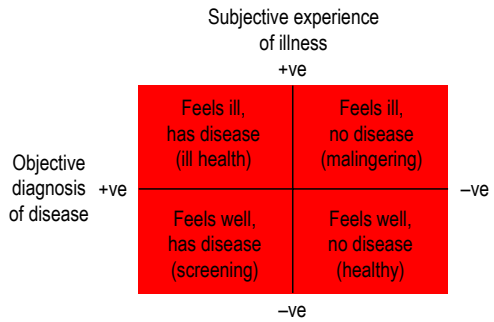

Fig 1.2 ● The relationship between disease and illness.

which is often taken to mean the absence of disease and/or illness. In this sense, health is a negative term, defined more by what it is not than by what it is.

This view of health is extremely influential, as it underpins much of the training and ethos of a wide variety of health workers. Its definitions become powerful because they are used in a variety of contexts, not just in professional circles. For example, the media often present this view of health, disease and illness in dramas set in hospitals or documentaries about health issues. By these means, professional definitions become known and accepted in society at large.

The scientific medical model arose in Western Europe at the time of the Enlightenment, with the rise of rationality and science as forms of knowledge. In earlier times, religion provided a way of knowing and understanding the world. The Enlightenment changed the old order, and substituted science for religion as the dominant means of knowledge and understanding. This was accompanied by a proliferation of equipment and techniques for studying the world. The invention of the microscope and telescope revealed whole worlds which had previously been invisible. Observation, calculation and classification became the means of increasing knowledge. Such knowledge was put to practical purposes, and applied science was one of the forces which accompanied the Industrial Revolution. In an atmosphere when everything was deemed knowable through the proper application of scientific method, the human body became a key object for the pursuit of scientific knowledge. What could be seen, and measured and catalogued was 'true' in an objective and universal sense.

This view of health is characterized as:

- *biomedical* – health is assumed to be a property of biological beings
- *reductionist* – states of being such as health and disease may be reduced to smaller and smaller constitutive components of the biological body
- *mechanistic* – this conceptualizes the body as if it were a machine, in which all the parts are interconnected but capable of being separated and treated separately
- *allopathic* – this works by a system of opposites; if something is wrong with a body, treatment consists of applying an opposite force to correct the sickness, e.g. pharmacological drugs which combat the sickness
- *pathogenic* – this focuses on why people become ill
- *dualistic* – the mind and the body can be treated as separate entities.

Health is predominantly viewed as the absence of disease. This view sees health and disease as linked, as if on a continuum, so that the more disease a person has, the further away he or she is from health and 'normality'.

The pathogenic focus on finding the causes for ill health has led to an emphasis on risk factors, whether these are health behaviours or social circumstances. Antonovsky (1993) called for a *salutogenic* approach which looks instead at why some people remain healthy. He identifies coping mechanisms which enable some people to remain healthy despite adverse circumstances, change and stress. An important factor for health, which Antonovsky labels a 'sense of coherence', involves the three aspects of understanding, managing and making sense of change. These are human abilities which are in turn nurtured or obstructed by the wider environment.

The medical model focuses on etiology, and the belief that disease originates from specific and identifiable causes. The causes of contemporary long-term chronic diseases in developed countries are often 'social'. Medicine and medical practice thus recognize that disease and the diseased body must be placed in a social context. Nevertheless, the professional training of many healthcare workers provides an exaggerated view of the benefits of treatment and pays little attention to prevention. In part this is due to the dominant concern of the biomedical model with the organic appearance of disease and malfunction as the causes of ill health.

Research Example 1.1 Carers' health

An ageing population means that caring for the elderly will become a more common experience for younger adults or even children. This has significant implications for the health of the population as a whole. Research studies have reported a clear association between caring and

Continued

care givers' poor mental and physical health, emotional distress and increased mortality. A more intense caring role (e.g. having to provide 24-hour cover, or caring for someone with both mental and physical ill health) is associated with poorer health outcomes on the part of the carer. Yet evidence also shows that not all carers report poor health. Indeed, caring has the opposite effect on some carers, conferring positive benefits through feelings of altruism, fulfilment of familial obligations and personal growth. It is likely that the impact of caring on the health of carers will be to some extent dependent on the existence, or lack, of a supportive environment, including, for example, community activities and respite opportunities. It also seems likely that the existence of personal religious and faith beliefs is associated with improved health and caring, as religion provides an overarching rationale for existence, even if this is compromised by poor health. Religious centres often provide supportive and caring activities for members of their faith, enabling carers to cope better with their burden of care, and providing some respite care for people with disabilities.
See for example Awad et al., 2008; Rigby et al., 2009; Vellone et al., 2008.

Table 1.1 contrasts the traditional views of a medical model with those of a social model of health.

Table 1.1 The medical and social model of health

Medical model	Social model
• Health is the absence of disease • Health services are geared towards treating the sick and disabled • High value is placed on specialist medical services • Health workers diagnose and treat, and sanction 'the sick role' • The pathogenic focus emphasizes finding biological causes for illness	• Health is a product of social, biological and environmental factors • Services emphasize all stages of prevention and treatment • Less emphasis is placed on the role of specialists – there is more attention to self-help and community activity • Health workers enable people to take greater control over their own health • A salutogenic focus emphasizes understanding why people are healthy

A critique of the medical model

The role of medicine in determining health

The view that health is the absence of disease and illness, and that medical treatment can restore the body to good health, has been criticized. The distribution of health and ill health has been analysed from a historical and social science perspective. It has been argued that medicine is not as effective as is often claimed. The medical writer Thomas McKeown (McKeown, 1976) showed that most of the fatal diseases of the nineteenth century had disappeared before the arrival of antibiotics or immunization programmes. McKeown concluded that social advances in general living conditions, such as improved sanitation and better nutrition made available by rising real wages, have been responsible for most of the reduction in mortality achieved during the last century. Although his thesis has been disputed, there is little disagreement that the contribution of medicine to reduced mortality has been minor when compared with the major impact of improved environmental conditions.

Learning Activity 1.5 The impact of medicine

- What effects do medical advances in knowledge have on death rates?
- What other reasons could account for declining death rates?

The rise of the evidence-based practice movement (see Chapter 20) is attributed to Archie Cochrane (1972). His concern was that medical interventions were not trialled to demonstrate effectiveness prior to their widespread adoption. Instead, many procedures rest on habit, custom and tradition rather than rationality. Cochrane advocated greater use of the randomized controlled trial as a means to gain scientific knowledge and the key to progress.

The role of social factors in determining health

Most countries are characterized by profound inequalities in income and wealth, and these in turn are associated with persistent inequalities in health (see www.who.int/social_determinants/sdh_definition/en/). The impact of scientific medicine on health is marginal when compared to major structural features such as the distribution of wealth, income, housing and employment. Tarlov (1996) claimed that medical services contributed only 17 percent to the gain in life expectancy in the twentieth century. As Chapter 2 shows, the distribution of health mirrors the distribution of material resources within society. In general, the more equal a society is in its distribution of resources, the more equal, and better, is the health status of its citizens (Wilkinson and Pickett, 2009).

Medicine as a means of social control

Social scientists argue that medicine is a social enterprise closely linked with the exercise of professional power. Foucault (1977) argues that power is embedded in social organizations, expressed through hierarchies and determined through discourses. Medical power derives from its role in legitimizing health and illness in society, and the socially exclusive and autonomous nature of the profession. The medical profession has long been regarded as an institution for securing occupational and social authority. Access to such power is controlled by professional associations that have their own vested interests to protect (Freidson, 1986). The 1858 Medical Act established the General Medical Council, which was authorized to regulate doctors, oversee medical education and keep a register of qualified practitioners. The Faculty of Public Health Medicine opened membership to non-medically qualified specialists in 2003, becoming the Faculty of Public Health.

Medicine is a powerful means of social control, whereby the categories of disease, illness, madness and deviancy are used to maintain a status quo in society. Doctors who make the diagnoses are in a powerful position. The role of the patient during sickness as conceptualized by Parsons (1951) is illustrated in Table 1.2. Increasingly, too, doctors are involved in decisions relating to the beginning and ending of life (terminations, assisted reproduction, neonatal care, euthanasia). The encroachment of medical decisions into these stages of life subverts human autonomy and, it is argued, gives to medicine an authority beyond its legitimate area of operation (Illich, 1975).

Table 1.2 The sick role

Rights	Responsibilities
• Patient is relieved of normal responsibilities and tasks • Patient is given sympathy and support • Patient has the right to a diagnosis, examination and treatment	• Patient must want to recover as soon as possible and only then can he or she be seen as 'sick' • Patient must seek professional advice and comply with treatment

Medicine as surveillance

Public health medicine has been concerned with the regulation and control of disease. Historically this included the containment of bodies, such as those infected with the plague, tuberculosis or venereal disease. Mass-screening programmes have given rise to what has been called medical surveillance. The wish to identify the 'abnormal' few with 'invisible' disease justifies monitoring the entire target population. Another critique of the pervasive power of medicine suggests the mapping of disease and identification of risk have subtly handed responsibility of health to individuals. This may invite new forms of control in the name of health, e.g. random drug testing or linking deservingness for surgery to lifestyle factors. The ability to identify risk also means there can be a moral discourse in which reducing one's risk factors, e.g. eating 'sensibly' and living 'well', is seen as a good thing.

Medicine as harm

According to Illich (1975), doctors and health workers contribute to ill health and create harm (iatrogenesis).

- Clinical iatrogenesis is ill health caused by medical intervention, for example

Case Study 1.1 Reducing antibiotic dependence

European Antibiotic Awareness Day on 18 November 2013 supported a campaign to reduce people's dependence on antibiotics, as their overuse is leading to resistance. Running noses and green phlegm do not mean patients need antibiotics. Such symptoms are often caused by viruses, and the use of antibiotics is leading to viral resistance.

Public Health England (https://www.gov.uk/government/news/green-phlegm-and-snot-not-always-a-sign-of-an-infection-needing-antibiotics) said its own research showed that 40 percent of people thought antibiotics would help a cough if the phlegm was green, while very few thought it would make a difference to clear-coloured phlegm.

side-effects caused by prescribed medicine, dependence on prescribed drugs and cross-infection in medical settings such as hospitals.
- Social iatrogenesis is the loss of coping and the right to self-care which have resulted from the medicalization of everyday life.
- Cultural iatrogenesis is the loss of the means whereby people cope with pain and suffering, which results from the unrealistic expectations generated by medicine.

Challenges to medicine

The dominance of medicine has been challenged in recent years by:
- managerialism and challenges to clinical autonomy
- a rise in complementary therapies
- consumerism and a rise in the number of informed patients who are using the internet
- social movements and advocacy, e.g. the home birth movement
- patient-centred care and shared decision-making.

These trends are related to wider forces that challenge the expertise of professionals. The response of most professions, including medicine, has been to introduce democratic decision-making, giving far more credence to lay knowledge. This has led to new concepts such as the 'expert patient'.

Learning Activity 1.6 The changing practice of medicine

In your lifetime as a patient, what changes have you noticed in the practice of medicine and healthcare?

Case Study 1.2 The active birth movement

A cultural concern with safety, science, professionalism and technology has ensured the medical domination of midwifery. At the same time the alternative birth movement has resisted hegemonic understandings about childbirth as a medicalized issue. The active birth movement, initiated by Janet Balaskas in the early 1980s, challenged the medicalization of birth, whereby women were placed in stirrups or the lithotomy position with their feet above or at the same level as their hips, rendering them passive recipients of medical care and attention. The active birth movement campaigns for women to give birth in whatever position feels most comfortable and natural, thereby taking control of their bodies and their childbirth. Balaskas had researched birthing positions across different cultures, and found the Western preferred position (flat on the back) reduced the diameter of the pelvic outlet, rendering the birth process longer and more painful. The active birth movement is a challenge to the increasing medicalization of childbirth. Current statistics show that 25 percent of current births are caesareans, with large local variations. NHS Information Centre statistics show that a third of babies born at London's Chelsea and Westminster NHS Trust are delivered by caesarean section, a figure more than double that in Nottingham (http://www.hscic.gov.uk/catalogue/PUB12744).

Lay concepts of health

For people concerned with the promotion of health, there is another problem with the dominance of scientific medicine: the focus within medicine on illness and disease, and the neglect of health as a positive concept in its own right. Many researchers have studied the general public's beliefs about health or lay concepts of health. The findings present an interesting picture, where there are continuities in definitions but also differences attributable to age, sex and class.

Blaxter (1990) identified five common concepts of health.

1. 'Health as not-ill' – health is the absence of symptoms or medical input; widely used by all groups.
2. 'Health as physical fitness' – health as having energy and strength; mostly used by younger men.
3. 'Health as social relationships'; mostly used by women.
4. 'Health as function' – health as the ability to carry out tasks and activities; mostly used by older people of both sexes.

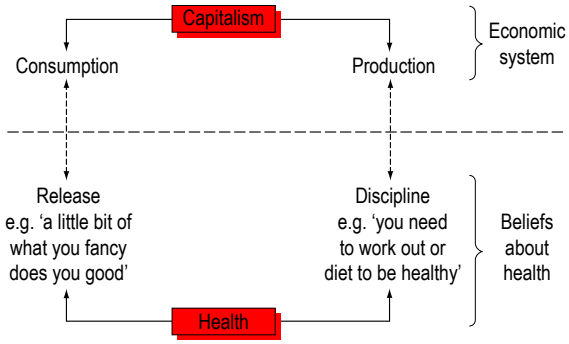

Fig 1.3 ● Cultural views about health in capitalist society. Adapted from Crawford (2000).

5. 'Health as psychosocial well-being'; less used by young men, most used by higher socioeconomic groups.

The concepts of 'control' and 'release' are also commonly found in lay accounts. Release is the taking of known risks (e.g. binge drinking), whereas control is the management of health.

As illustrated in Figure 1.3, Crawford (2000) suggests that capitalism also requires individuals to be healthy consumers, having fun and seeking immediate gratification. Adherence to a healthy lifestyle has to be offset by pleasure or release. In capitalist societies we are encouraged to be disciplined and controlled about pleasures such as alcohol. This is couched as being balanced and moderate.

Researchers have found these issues of control and release in many accounts of health, together with a moral view about taking risks. The following extract is from a study of laymen's views:

> *I eat healthy food generally and I cheat now and again. Alcohol is bad for you, but we all drink. Mostly everyone I know likes a drink 'cause its good for you, it actually cheers you up… we've got like this throwaway society and I think people's perceptions are changing, everybody wants everything yesterday… and that's it, get fit one day, get drunk the next*
>
> Robertson (2006), p. 179.

Learning Activity 1.7 Moral identities and health

How do morality and moral identities influence the ways in which people experience health and ill health?

There is often a difference between lay and professional concepts of health. The gap between the two has been identified by health workers as a problem, giving rise to concern. The concern centres around two issues.

1. The perceived lack of communication or poor communication between health worker and client.
2. Clients' lack of compliance with prescribed treatment regimens.

However, there is also a crossover between lay and professional beliefs about health. Health workers acquire their professional view of health during training. These beliefs overlie their original views of health adopted at an early age from family and society, so professionals are familiar with both. The general public is also aware of, and operates with, both sets of beliefs. In searching for meaning, lay patients frequently adopt professionals' explanations and interpretations about health and illness. So the two sets of beliefs, scientific medicine and lay public, are not discrete entities but overlap each other and exist in tandem.

Cornwell (1984) describes how people operate with both official and lay beliefs about health. Her study of London's Eastenders found that accounts of health were either public or private. Public accounts are couched in terms of scientific medicine and reflect these dominant beliefs. Health and illness are related to medical diagnosis and treatment, and medical terms and events are used to explain health status. These public accounts were offered first in Cornwell's interviews. What she terms 'private accounts' reflect lay views of health, which typically use more holistic and social concepts to explain health and illness. For example, private accounts related health to general life experiences, such as employment, housing and perceived stress. Private accounts were offered in subsequent interviews, when a relationship had

been established between Cornwell and the women she was interviewing. Cornwell suggests that people are therefore aware of both systems of beliefs and can use either when asked to talk about health. In encounters with strangers who are perceived as professionals, people use public accounts; but in more informal settings they use private accounts.

Cultural views of health

We are able to think about health using the language of scientific medicine because that is part of our cultural heritage. We do so as a matter of course, and think it is self-evident or common sense. However, other societies and cultures have their own commonsense ways of talking about health which are very different. Many cultures view disease as the outcome of malign human or supernatural agencies, and diagnosis is a matter of determining who has been offended. Treatment includes ceremonies to propitiate these spirits as an integral part of the process. Ways of thinking about health and disease reflect the basic preoccupations of a society, and dominant views of the society and the world. Anthropologists refer to this phenomenon as the cultural specificity of notions of health and disease.

In any multicultural society, a variety of cultural views coexist at any one time. For example, traditional Chinese medicine is based on the dichotomy of yin and yang, female and male, hot and cold, which is applied to symptoms, diet and treatments, such as acupuncture and Chinese herbal medicine. Complementary therapists offer therapies based on these cultural views of health and disease alongside (or increasingly within) the National Health Service, which is based on scientific medicine.

Learning Activity 1.8 Understanding health beliefs

People's explanations for their health and illness are complex. Why is it important for health promoters to understand the health beliefs of those with whom they work? How might they do this?

A unified view of health

Is there any unifying concept of health which can reconcile these different views and beliefs? Attempts at such a synthesis have come from philosophers such as Seedhouse (1986) and from organizations concerned with health, such as the World Health Organization.

1. *Health as an ideal state* provides a holistic and positive definition of health. It is important in showing the interrelationship of different dimensions of health. A medical diagnosis of ill health does not necessarily coincide with a sense of personal illness or feeling unwell. Equally, a person free from disease may be isolated and lonely.
2. *Health as mental and physical fitness* is a perspective developed by Talcott Parsons (1951), a functional sociologist. It suggests that health is when people can fulfil the everyday tasks and roles expected of them.
3. *Health as a commodity* leads to unrealistic expectations of health as something which can be purchased. Health cannot be guaranteed by paying a higher price for healthcare.
4. *Health as a personal strength* is a view which derives from humanistic psychology, and suggests that an individual can become healthy through self-actualization and discovery (Maslow, 1970).

Learning Activity 1.9 Theories of health

Figure 1.4 shows four theories of health.

1. Health as an ideal state.
2. Health as mental and physical fitness.
3. Health as a commodity.
4. Health as a personal strength.

What problems can you identify with each of these four views of health?

Seedhouse (1986) suggests that these four views can be combined in a unified theory of health as the foundation for human achievement. Health is thus a means to an end rather than a fixed state to which a person should aspire.

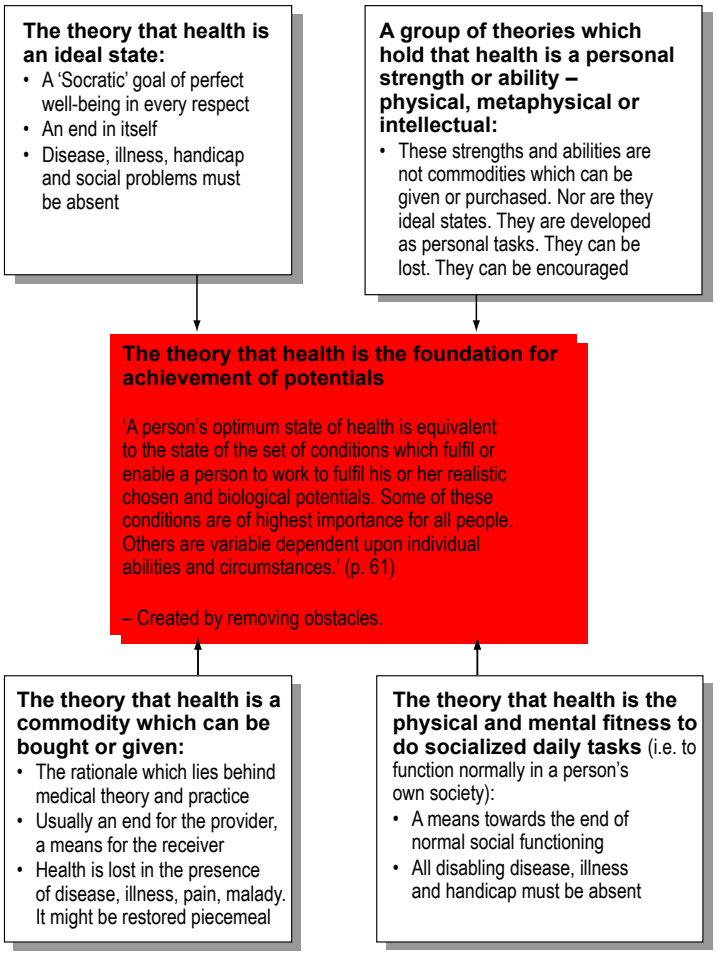

Fig 1.4 ● A summary of theories of health. Adapted from Seedhouse (1986).

> *[Health is] the extent to which an individual or group is able, on the one hand, to realize aspirations and satisfy needs; and, on the other hand, to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not an object of living; it is a positive concept emphasizing social and personal resources, as well as physical capacities.*
>
> World Health Organization (1984)

Provided certain central conditions are met, people can be enabled to achieve their potential. The task of practitioners working for health is to create these conditions for people to achieve health:

- basic needs of food, drink, shelter and warmth
- access to information about the factors influencing health
- skills and confidence to use that information.

This definition acknowledges that people have different starting points which set limits for their potential for health. It encompasses a positive notion of health which is applicable to everyone, whatever their circumstances. However, it could be argued that this definition does not acknowledge the social construction of health sufficiently. People as individuals have

little scope to determine optimum conditions for realizing their potential.

> *By health I mean the power to live a full, adult, living, breathing life in close contact with what I love… I want to be all that I am capable of becoming.*
>
> Mansfield (1977), p. 278.

The view of health as personal potential is attractive because it is so flexible, but this very flexibility causes problems. It leads to relativism (health may mean a thousand different things to a thousand different people), which makes it impracticable as a working definition for health promoters.

Health is regarded by the World Health Organization as a fundamental human right, and there are certain prerequisites for health, which include peace, adequate food and shelter and sustainable resource use.

Looking at health this way establishes it as a social as well as an individual product, and it emphasizes its dynamic and positive nature. Health is viewed as both a fundamental human right and a sound social investment. This view was publicly affirmed by the Jakarta Declaration, which linked health to social and economic development (World Health Organization, 1997). This definition provides a variety of reasons for supporting health which are likely to meet the concerns of a range of groups. It establishes a broad consensus for prioritizing health, and legitimizes a range of activities designed to promote it. For example, in addition to the more acceptable strategies of primary healthcare and personal skills development, the World Health Organization also identified in the Ottawa Charter the more radical strategies of community participation and healthy public policy as essential to the promotion of health (World Health Organization, 1986). However, it could still be argued that such a broad definition makes it difficult to identify practical priorities for health promotion activities.

There is no agreement on what is meant by health. Health is used in many different contexts to refer to many different aspects of life. Given this complexity of meanings, it is unlikely that a unified concept of health which includes all its meanings will be formulated.

Conclusion

There are no rights and wrongs regarding concepts of health. Different people are likely to hold different views of health and may operate with several conflicting views simultaneously. Where people are located socially, in terms of social class, gender, ethnic origin and occupation, will affect their concept of health. The medical model has dominated Western thinking about health, yet its value for health promotion is limited.

- It relies on a concept of normality that is not widely accepted.
- It ignores broader societal and environmental dimensions of health.
- It ignores people's subjective perceptions of their own health.
- The focus on pathology and malfunction leads to practitioners responding to ill health rather than being proactive in promoting health.

There is such a range of meaning attached to the notion of health that in any particular situation it is important to find out what views are in operation. Clarifying what you understand about health, and what other people mean when they talk about health, is an essential first step for the health promoter.

Questions for further discussion

- How would you describe your own concept of health? What have been the most important influences on your views?

Summary

Definitions of health arise from many different perspectives. While scientific medicine is the most powerful ideology in the West, it is not all-embracing. Social sciences' perspectives on health produce a powerful critique of scientific medicine, and point to the importance of social factors in the construction and meaning of health. Lay concepts of health derived from different cultures coexist alongside scientific medicine. Attempts to produce a unified

concept of health appear to founder through over-generalization and vagueness.

Further reading and resources

Barry, A., Yuill, C., 2012. Understanding the Sociology of Health: An Introduction, third ed. Sage, London. *An accessible introduction to the sociology of health and illness exploring key concepts and the social structures that shape and pattern health.*

Lupton, D., 2012. Medicine as Culture: Illness, Disease and the Body in Western Societies, third ed. Sage, London. *An interesting account of the dependence on, and disillusionment with, medicine.*

Naidoo, J., Wills, J., 2015. Health Studies: An Introduction, third ed. Palgrave Macmillan, Basingstoke. *An accessible introduction to different disciplinary perspectives on health including sociology, culture and anthropology and biology.*

Feedback to learning activities

1.1 Health is a complex concept that encompasses different dimensions, including physical, mental, social and emotional health. Some theorists suggest there is a hierarchy of health, whereby physical health needs are the most basic, and it is only once these needs have been met that people can move on to identify and meet mental, social and emotional health needs. Maslow (1943) identified a hierarchy of needs (often represented as a pyramid), with the most basic need (the base of the pyramid) being physiological, moving through safety, belonging and esteem to self-actualization (the tip of the pyramid).

1.2 A holistic model of health implies that professional health workers can only address some aspects or causes of health or ill health (and not necessarily the most basic or important causes). Many of the most important factors affecting health, such as social equality or environmental quality, are beyond the remit of health workers. A holistic model of health also implies that health workers need to work collaboratively with others (e.g. social workers or environmental health officers) in order to achieve optimum results.

1.3 Evidence suggests that a small improvement in well-being can help to decrease some mental health problems and also help people to flourish. The New Economics Foundation, on behalf of Foresight, presented a document which sets out five actions to improve personal well-being based on this evidence (www.neweconomics.org).

- Connect: Having social support and relationships is beneficial to well-being and acts as a buffer against mental ill health.
- Be active: Regular physical activity is associated with a greater sense of well-being and possibly delays cognitive decline.
- Take notice: Being aware of sensations, thoughts and feelings enhances well-being. Being in a state of mindfulness (being attentive to, and aware of, what is taking place in the present) is positive.
- Give: Mutual cooperation is associated with feelings of regard. Active participation in social and community life is associated with positive affect.
- Keep learning: Learning is important in social and cognitive development, enhances self-esteem and encourages interaction.

1.4 According to Hart and Wellings (2002), homosexuals, formerly considered to be sinners, were labelled as ill up to the late 1970s in the USA. Commitments to mental institutions, hormonal treatments and castrations were used to deal with their unwanted sexual behaviour. In 1973 the American Psychiatric Association redesignated homosexuality as non-pathological.

1.5 There were few effective medicines or therapies available to combat infectious diseases before the mid-1930s, so medical care did not play an important role during this period. Historical epidemiologists, such as McKeown (1976), observed that a large share of the decline in infectious disease mortality during the twentieth century preceded the advent of medical treatments, and concluded that rising living standards, better nutrition and public health measures that improved water supplies, sanitation systems and household hygiene were responsible for the drop in mortality rates. Since the late twentieth century the principal causes of mortality have been attributed to 'lifestyles', and medical advances such as the treatment of hypertension and diabetes and the medical and surgical treatment of coronary artery disease have contributed to increased life expectancy.

1.6 You may have mentioned receiving more lifestyle advice; less willingness of GPs to prescribe medication; and more attempts to find out your wishes. If you have a chronic condition, you may use tele-healthcare and have the condition monitored electronically at home. Healthcare has become more patient-centred and consumer-driven, pushed by three fundamental forces: availability of information, choice and control.

1.7 Moral identity, such as strength of character and personal control, is frequently cited in lay accounts of health. In a survey of disadvantaged areas, Popay et al. (2003) found that some respondents suggested that stress mediated the relationship between the experience of disadvantage and poor health. As you will find in Chapter 2, psychosocial pathways provide an important conceptual link within lay understandings to the moral framework within which explanations for health and illness are 'constructed'. Individual resilience and strength of character are seen as the means to avoid ill health.

1.8 There is often a gulf between healthcare professionals' and patients' knowledge, expectations and values regarding illness and healthcare. Healthcare professionals often assume their prioritization of Western scientific medicine and associated values is universal and shared by all their patients. However, this is not the case. Patients' cultural values vary widely and have a significant impact on their understanding of medical diagnoses and prescribed care, as well as their ability to manage illness, disability and death. Gender and position within the family may also impact on patients' ability to understand and cope with ill health. Cultural values impact on all stages of ill health, from receiving and understanding a diagnosis, through management of illness and treatment, to coping with death and bereavement.

1.9 Definitions of health.

- The definition of health as a complete state of well-being is unrealistic and does not help health professionals or lay people set practical or achievable goals. The requirement for complete health means that most people are unhealthy most of the time. This view therefore supports the tendencies of the medical technology and drug industries, in association with professional organizations, to redefine diseases, detect more and more abnormalities through screening, and thus expand the scope of the healthcare system (see Huber et al., 2011).
- The definition of health as normal social functioning ignores the fact that people can be contented and healthy but unable to fulfil social roles (e.g. employee) due to factors such as chronic illness or disability.
- The definition of health as something that can be acquired (e.g. through medicine) suggests health can be slotted into different activities which have a price. However, this is not how people experience health and illness.
- The definition of health as individually defined strength ignores the fact that health and ill health are created within a social context. It is this social context, as much as the individual, which determines what is perceived and recognized to be health and ill health.

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Chapter **Two**

2

Influences on health

Learning Outcomes

By the end of this chapter you will be able to:

- identify and critically discuss the social factors influencing health and the mechanisms by which they do so
- understand the associations between social class and health; gender and health; and ethnicity and health
- have a critical understanding of theories of social determinants of health and explanations for health inequalities
- describe the range of policy interventions to address health inequalities aimed at individuals and populations.

Key Concepts and Definitions

Health inequalities The avoidable and unfair differences in health status between groups of people who are united by their shared socio-economic status or gender rather than by any health-related attributes, e.g. medical conditions such as diabetes.

Inequity is a lack of equity or fairness.

Social class describes a group of people united through having the same educational, social or economic status, e.g. working-class.

Social determinants are economic and social factors (e.g. income, social class, gender) that have a profound effect on health. These differences are not natural, but are created and maintained by social and economic policies and legislation.

Importance of the Topic

Chapter 1 showed that there is a wide range of meanings attached to the concept of health, and different perspectives are offered by the scientific medical model and social science. It emphasized the importance of social factors in the construction and meaning of health. This chapter shows how the major influences on mortality and morbidity are social and environmental factors. It summarizes the considerable body of research suggesting that the existence of inequalities in health status between groups of people reflects structural inequalities linked to social class, gender and ethnicity.

Determinants of health

Since the decline in infectious diseases in the nineteenth and early twentieth centuries, the major causes of sickness and death are now cancers (30%), circulatory disease, including coronary heart disease (CHD) and stroke (29%) and respiratory disease (14%) (Office for National Statistics, 2013a; Fig. 2.1).

In the last 20 years cancers have become the leading cause of mortality in both men and women. This is a considerable change from 100 years ago, when bronchitis was the leading cause of death, killing more than 39,000 people, and tuberculosis and pneumonia were among the 10 leading causes. Alzheimer's disease and dementia currently account for 5.1% of deaths in men and 10.3% of deaths in women. Nearly 40% of deaths occur in people over the age of 85 and 0.6% of deaths in those under the age of one.

In the UK increased longevity and the current average lifespan of women of 82 years and men of 79 years account for the increase in degenerative diseases in the population as a whole. Despite the increase in life expectancy, epidemiologists who study the pattern of diseases in society have found that not all groups have the same opportunities to achieve good health, and that there are population patterns which make it possible to predict the likelihood of people from different groups dying prematurely (Case Study 2.1).

As well as differences within countries, there are also differences across countries.

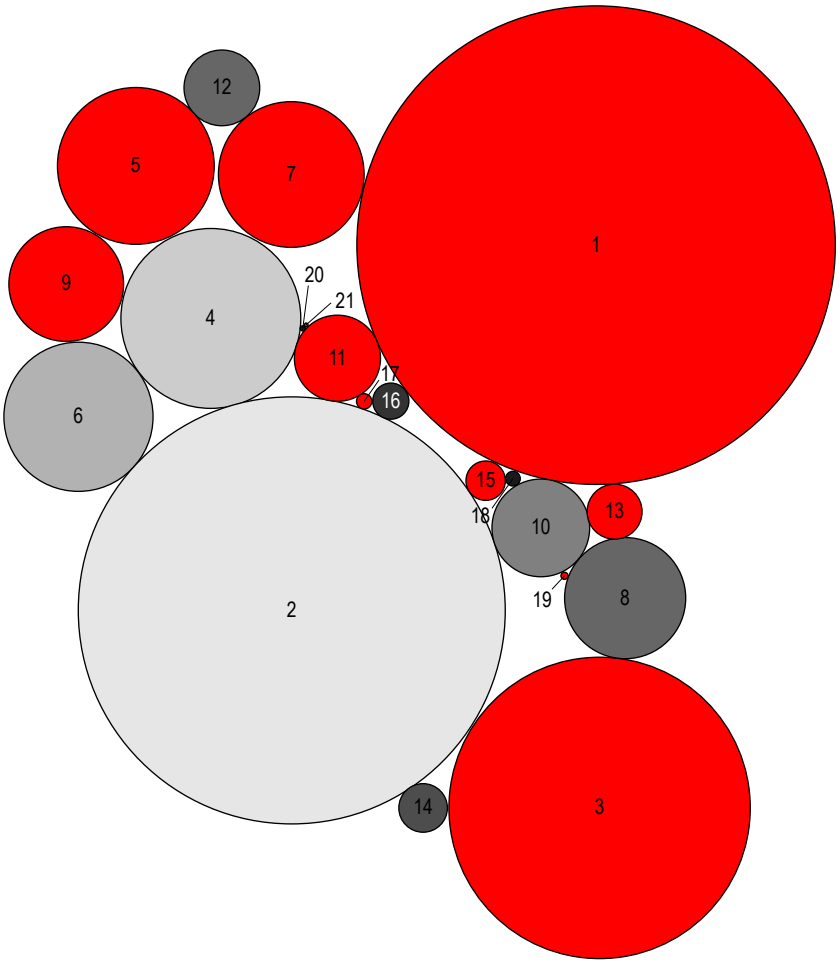
- In South Africa the death rate from HIV/AIDS per 100,000 is 555.7. In Finland it is 0.1 per 100,000.
- In Afghanistan the death rate from birth trauma is 30.8 per 100,000, while in Ireland it is 0.2 per 100,000.
- In India the death rate from lung disease is 142.1 per 100,000, while in Japan it is 4.0 per 100,000 (www.healthdata.org/gbd).

In trying to determine what affects health, social scientists and epidemiologists seek to compare at least two variables: firstly, a measure of health, or rather ill health, such as mortality or morbidity; and secondly, a factor such as gender or occupation that could account for the differences in health. Of course, effects on health can be due to several variables interacting together. For example, research into CHD has linked the disease with a large number of factors, including high levels of blood cholesterol, high blood pressure, obesity, cigarette smoking and low levels of physical activity. Other research indicates there may be links between CHD and psychosocial factors, such as stress and lack of social support, depression and anger (Marmot and Wilkinson, 2006). Many studies have tried to establish whether there is a coronary-prone personality that is competitive, impatient and hostile (known as type A). We also know that mortality from CHD is higher among lower socio-economic groups, among men rather than women and among South Asians (British Heart Foundation, 2012). Figure 2.2 illustrates in a simple form how health status can be accounted for not by one variable, but by many factors interacting together. It shows that some factors have an independent effect on health while others may be mediated by intervening variables. While physical inactivity, smoking and raised blood cholesterol are the major risk factors for CHD, it is important to look 'upstream' and understand the causes of these risk factors and their roots in the social context of people's lives.

What is clear is that ill health does not happen by chance or through bad luck. A report by Lalonde (1974), published in Canada, was influential in identifying four fields in which health could be promoted.

1. Genetic and biological factors which determine an individual's predisposition to disease.
2. Lifestyle factors and health behaviours, such as smoking, which contribute to disease.
3. Environmental factors, such as housing and pollution.
4. The extent and nature of health services.

Genetic factors remain largely unalterable, and what limited scope there is for intervention lies in the medical field. Chapter 1 outlined McKeown and Lowe's (1974) work showing that medical interventions in the form of vaccination had remarkably little impact on mortality rates. This suggests that factors other than the purely biological determine health and well-being, and that probably the greatest opportunities to improve health lie in the environment and individual lifestyles.



1	Circulatory diseases	2,114,550	12	Musculoskeletal system and connective tissue	52,438
2	Cancer and neoplasms	1,686,133	13	Neonatal (no cause registered)	26,620
3	Respiratory diseases	836,894	14	Skin	20,468
4	Digestive diseases	300,225	15	Congenital malformations, deformations and chromosomal abnormalities	14,695
5	Mental and behavioural disorders**	227,377	16	Blood diseases	12,230
6	External causes of morbidity and mortality	207,576	17	Babies dying before, during or after childbirth	2,446
7	Diseases of the nervous system	199,409	18	Drug-resistant tuberculosis*	2,275
8	Other causes	135,516	19	Pregnancy and childbirth	539
9	Genitourinary diseases	122,446	20	Diseases of the ear and mastoid process	269
10	Endocrine, nutritional and metabolic diseases	87,890	21	Diseases of the eye and adnexa	158
11	Certain infectious and parasitic diseases	68,123			

*Drug-resistant tuberculosis was given its own special code but could be considered with the certain infectious disease grouping.

**The number of deaths registered as being due to mental and behavioural disorders was particularly affected by the switch between volumes due to vascular dementia being pushed into this category.

Fig. 2.1 ● The distribution of causes of mortality in England in the twenty-first century. (Adapted from The Office for National Statistics, 2013a. Licenced under the Open Government Licence v.3.0. Available online at: http://www.theguardian.com/news/datablog/interactive/2013/oct/24/how-people-died-21st-century.)

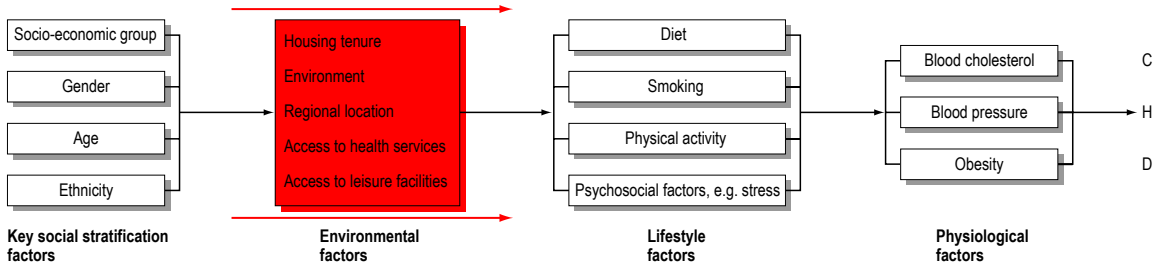


Fig. 2.2 ● Factors influencing the development of coronary heart disease (CHD).

Case Study 2.1 Differences in health in the UK

- Women live around four years longer than men, but the gap has been shrinking and is expected to shrink further over time.
- Black African women who are asylum seekers are estimated to have a mortality rate seven times higher than white women.
- Black Caribbean and Pakistani babies are twice as likely to die in their first year compared to Bangladeshi or white British babies.
- Three times as many men as women commit suicide, and rates are particularly high for younger men aged 25 to 44.
- Evidence suggests that lesbian, gay, bisexual and transgender people may have an increased risk of attempted suicide.
- Children from ethnic minorities are up to twice as likely as white British children to be involved in road traffic accidents while walking or playing.
- The risk of mental health problems is nearly twice as likely for Bangladeshi men as for white men.

Equality and Human Rights Commission (2011).

Learning Activity 2.1 Influences on health

Lifestyles are frequently the focus of health promotion interventions. Figure 2.3 shows a whole range of factors that may influence behaviour. Take one of the lifestyle factors implicated in CHD, e.g. physical activity, and identify the influences on that health behaviour.

Dahlgren and Whitehead (1991) thus talk of 'layers of influence on health' that can be modified (Fig. 2.3):

- personal behaviour and lifestyles, and the knowledge, awareness and skills that can enable change in relation to, for example, diet or physical activity
- support and influence within communities which can sustain or damage health
- living and working conditions, and access to facilities and services
- economic, cultural and environmental conditions, such as standards of living or the labour market.

In all societies, health behaviours and physical and mental health vary between social groups. The main axes of variation include socio-economic status, gender, ethnicity and place of residence. The specific features and pathways by which societal conditions affect health are termed the social determinants. The social determinants of health refer to factors determined by social policies which affect health, e.g. working conditions, housing and the physical environment. These social policies in turn are determined by political beliefs and economics (see Chapters 7 and 11). The medical model of health tends to focus on individuals and their biological bodies rather than socially patterned behaviours. For example, poor diet is linked to many causes of ill health and premature mortality, and most medical advice is focused on trying to persuade individuals to change their dietary behaviour. Yet the social forces implicated in unhealthy dietary choices (advertising, pricing and availability of products) remain untouched, because they are viewed as economic or political factors beyond the remit of the health services.

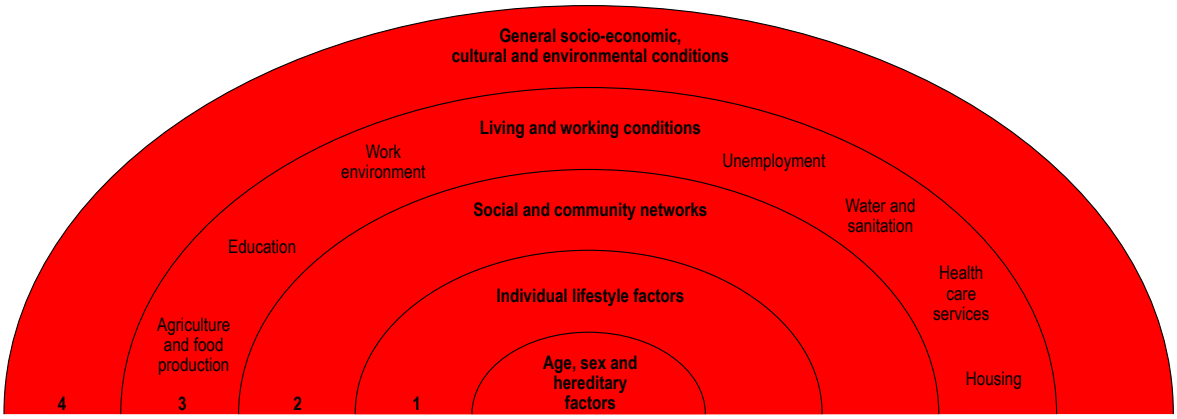


Fig. 2.3 ● The main determinants of health. (From Dahlgren, Whitehead, M., 1991. Policies and Strategies to Promote Social Equity in Health. Institute for Future Studies, Stockholm.)

There is a large body of research supporting the link between socio-economic status and health in all countries (CSOH, 2008). This research shows there is an undisputed link between lower socio-economic status and poorer health. While describing and documenting health inequalities are now a key part of research and policy, addressing such inequalities requires a distinction between inequality and inequity. Inequalities refer to differences between groups which are largely avoidable. If these differences are deemed inequitable, this implies a judgement that they are not only avoidable but also unfair and unjust.

There are three types of health inequalities.

1. Inequalities in the determinants of health, e.g. education, employment and housing, which can all have an influence on health status.
2. Inequalities in health outcomes, e.g. there is a 6-year difference in life expectancy at birth across different boroughs in London (see http://life.mappinglondon.co.uk).
3. Inequalities in access to healthcare, e.g. refugees and homeless people often have difficulty in obtaining access to primary healthcare services, such as registering with a general practitioner (GP).

It is important to understand social stratification in order to analyse and assess how inequalities are created and perpetuated, how different groups are perceived and understood, and the impact of this on policy.

Social class and health

Most research in the UK which has sought to identify the major determinants of health and ill health has focused on the links between social class and health. A report was published of a Department of Health and Social Security working group on inequalities in health (Townsend and Davidson, 1982). Known as the Black Report after the group's chairman, Sir Douglas Black, it provided a detailed study of the relationship between mortality and morbidity and social class.

The terms social class, social disadvantage, socio-economic status and occupation are often used interchangeably. The classification of social class derives from the Registrar General's scale of five occupational classes, ranging from professionals in class I to unskilled manual workers in class V. This was largely unchanged from 1921 (although class III was divided into manual and non-manual work in 1971). From 2001 the National Statistics Socio-Economic Classification (NS-SEC) has been used for all official statistics and surveys (Table 2.1).

Although social class classification is not a perfect tool, it does serve as an indicator of the way of life and living standards experienced by different groups. It correlates with other aspects of social position, such as income, housing, education and working and living environments.

The Black Report and a later report commissioned by the Health Education Authority, *The Health Divide* (Whitehead, 1988), found significant differences in death rates between socio-economic classes. More recently, another government inquiry (Marmot, 2010) drew together data which show that, far from ill health being a matter of bad luck, health and disease are socially patterned, with the more affluent members of society living longer and enjoying better health than disadvantaged social groups. Although the health of the whole population has steadily improved, there is still a strong relationship between socio-economic group and health status.

Table 2.1 Social class classification

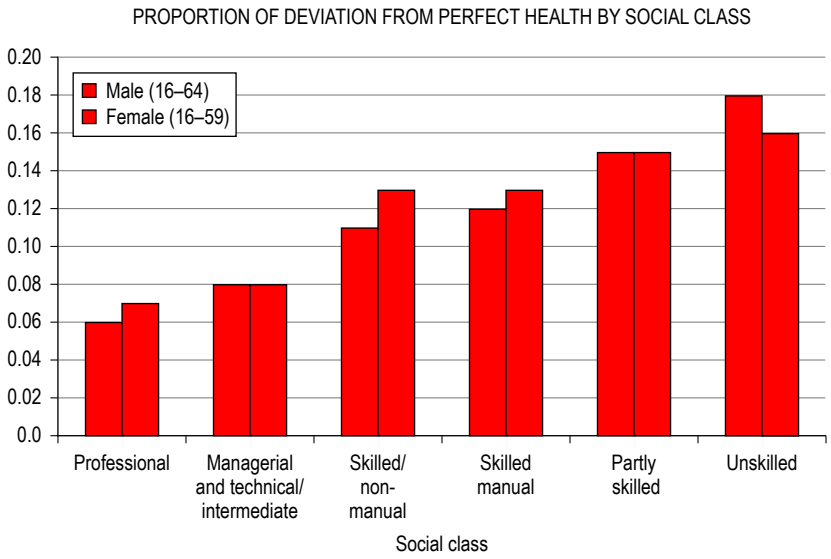
1. Higher managerial and professional
   1.1 e.g. company directors, bank managers, senior civil servants
   1.2 e.g. doctors, barristers and solicitors, teachers, social workers
2. Lower managerial and professional, e.g. nurses, actors and musicians, police, soldiers
3. Intermediate, e.g. secretaries, clerks
4. Small employers and own-account workers, e.g. publicans, playgroup leaders, farmers, taxi drivers
5. Lower supervisory, craft and related occupations, e.g. printers, plumbers, butchers, train drivers
6. Semi-routine occupations, e.g. shop assistants, traffic wardens, hairdressers
7. Routine occupations, e.g. waiters, road sweepers, cleaners, couriers
8. Never worked and long-term unemployed

Source: NS-SEC.

A wealth of research has shown the relationship between socio-economic status and health status in most Western countries. People from lower socio-economic groups have much poorer health than those in higher groups. This is evident in relation to disease prevalence, life expectancy and infant mortality.

Figure 2.4 shows the step-wise social gradient in health whereby the poorest have the worst health and the richest enjoy the best health. In general, and in all countries, the lower an individual's socio-economic position, the worse is his or her health. This health gradient is evident in death rates as well as in reports of ill health.

Although infant deaths are declining, children from manual backgrounds are more likely to die in the first year of life or from accidental injury. Low birth weight is probably the most important predictor of death in the first month of life and this is clearly



Note: Based on QALY measure of self-reported health. Does not cover Scotland and Wales.

Fig. 2.4 ● Self-reported health and social class. (Open government licence/Crown copyright.)

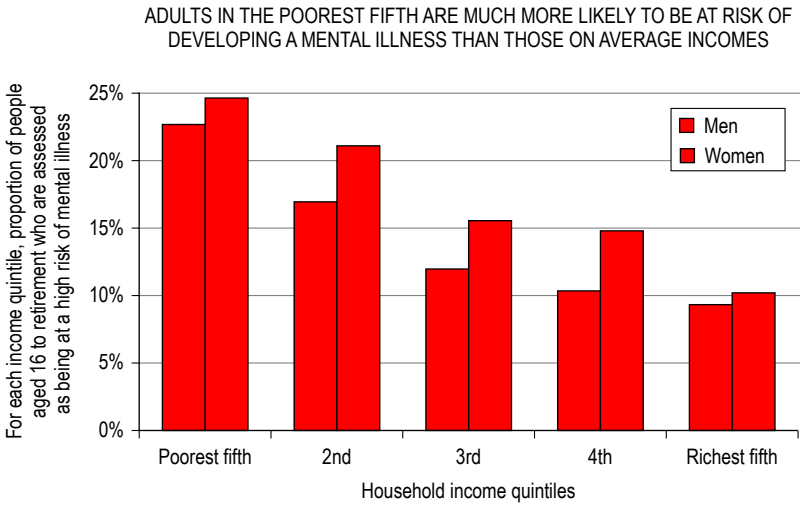


Fig. 2.5 ● The social gradient of mental ill health. (Source: Health Survey for England, DH; the data is the average for 2008 and 2009; England; update Mar 2011.)

class-related, with two-thirds of babies weighing under 2.5 kg being born to mothers in social class V (Office for National Statistics, 2013a). Although it is common to talk of 'diseases of affluence', such as CHD, being the major killers in contemporary Europe, most disease categories are more common among lower socio-economic groups. Particularly large differentials have developed for respiratory disease, lung cancer, accidents and suicide. An exception to this is the death rate from breast cancer, which is evenly distributed across all social groups. People from lower socio-economic groups experience more sickness and ill health, and measures of mental health and well-being also reflect a social gradient, as shown in Figure 2.5.

In our companion book *Public Health and Health Promotion: Developing Practice* (Naidoo and Wills, 2010) we discuss the determinants of health in more detail. The most immediate causes of socio-economic inequalities in health were summarized by Macintyre (2007) as:

- exposures, e.g. damp housing, hazardous work, adverse life events
- behaviours, e.g. smoking, diet, exercise
- personal strengths and capabilities (see Chapter 1).

The pathways by which members of different socio-economic status groups are at risk of such exposures and vulnerabilities are often due to political and economic forces and social stratifications in society. Some of these pathways are discussed in the next section.

Income and health

Better health is strongly associated with income. The UK is the world's sixth-largest economy, yet one in five of the UK population live below the official poverty line, meaning that they experience life as a daily struggle (see www.poverty.org.uk). Those most likely to be in this category are the unemployed, pensioners, lone parents, families with three or more children and the low paid.

Poverty can affect health directly by, for example, children not having enough to eat, eating a high-processed diet and having limited access to food outlets. Across the UK dietary initiatives such as breakfast clubs, cookery clubs and community cafés promote healthy eating in low-income communities (e.g. see www.communityfoodandhealth.org.uk in Scotland).

In low-income countries, infectious diseases such as diarrhoeal illness and malaria are associated with lack of income resulting in lack of access to clean

water, food and medical services. Disease then further impoverishes the poor, preventing people from working and incurring high medical costs.

Research Example 2.1 Children, poverty and health

A systematic review of 34 studies, mainly from America but including some British research, found a strong causal link between household income and children's achievements in education, their well-being and positive behavioural outcomes. Children in richer households were more likely to do better in all spheres of life, including education and health. The link between household income and childhood well-being appears to be due to money rather than any other confounding factors such as parental expectations. While a parent's level of education, attitude towards bringing up children and other parental factors have a bearing, research shows that having more money has a direct positive impact on children's social and behavioural development and educational achievement. The evidence is strongest for a link between income and educational outcomes. Conversely, reductions in family income, including benefit cuts, are likely to have wide-ranging negative effects. Money seems to have more of an effect among low-income families.

Research evidence supports two theories as to why income matters so much. The family stress model focuses on the stress and anxiety caused by low income, while the investment model focuses on parental ability to invest in services and goods that support child development. Research findings are more supportive of the family stress model than the investment model.

Cooper and Stewart (2013).

Housing and health

Frank Dobson, briefly health minister in 1997, remarked: 'everyone with a grain of sense knows that it's bad for your health if you don't have anywhere to live'. The issues of housing stock, dampness, inadequate heating and energy efficiency are recognized as key determinants of health (Parliamentary Office of Science and Technology, 2011).

For example, there are 40,000 excess winter deaths (deaths which would not be expected if the average death rate for the rest of the year applied in winter) each year in the UK. These are attributable to:

- energy efficiency
- level of occupancy
- income
- cost of fuel.

Cold and damp housing has been shown to contribute to illness. Children living in damp houses are likely to have higher rates of respiratory illness, symptoms of infection and stress. These will be exacerbated by overcrowding. The high accident rates to children in social class V are associated with high-density housing where there is a lack of play space and opportunities for parental supervision. Psychological and practical difficulties accompany living in high-rise flats and isolated housing estates, which may adversely affect the health of women at home and older people.

Employment and health

Work is important to consider as a social determinant of health because:

- it determines income levels
- it affects self-esteem
- the type of employment may itself directly affect health.

The traditional focus of occupational health has been to consider how particular types of employment carry high occupational health risks. This may be because of the risk of accidents (e.g. in mining), exposure to hazardous substances or stress. Some occupations encourage lifestyles which may be damaging to health. Publicans, for example, are at high risk of developing cirrhosis.

There has been considerable interest in how the psychosocial environment of work can affect health (Marmot et al., 2006). Most research has identified high demands and low control over work decisions

as contributing to job stress and cardiovascular risk. These factors, together with the amount of social support people get at work, have been confirmed in workplace studies in many developed countries (see Chapter 14 for further discussion). There is also a considerable body of evidence, mostly gathered in the 1980s, that unemployment can damage health (McLean et al., 2005). It is, however, uncertain whether unemployment itself can lead to a deterioration in health or whether it is the poverty associated with unemployment which contributes to the poor health of the unemployed.

Research Example 2.2 The Whitehall studies

The Whitehall studies are important because they have followed employees of the British Civil Service over a number of years, and have shed light on the causation of ill health among employees. The original Whitehall study began in 1967 and studied the careers and health of 18,000 men. The study found that premature death was more prevalent among men in the lowest employment grades. Furthermore, it appeared to be the lower employment status rather than any other confounding factors (such as smoking) that was responsible for the increased mortality rate. The second Whitehall study, started in 1985, recruited over 10,000 employees, including women, and has collected data from 10 cohorts of civil servants. The study sought to clarify risk factors for ill health and premature mortality. Consistent findings are that psychosocial factors (e.g. work-related stress and conflict, unfairness at work, domestic conflict) make a significant contribution to poor health outcomes. The study also found that environmental changes were more effective than targeting individuals in getting employees to change their behaviour, e.g. to quit smoking. The Whitehall studies support the view that social hierarchy is an important factor impacting on health, and that the more subordinate individuals lower down in the hierarchy suffer increased ill health and premature death due to their low status. The impact of social position is greater than that of individual risk behaviours such as smoking.

More details available at http://www.ucl.ac.uk/whitehallII/history.

Learning Activity 2.2 Unemployment and health

Consider the following evidence concerning the effects of unemployment on health. What could account for this relationship?

1. The unemployed report higher rates of mental ill health, including depression, anxiety and sleep disturbance.
2. Suicide and parasuicide rates are twice as high among the unemployed as among the employed.
3. The death rates among the unemployed are at least 20% higher than expected after adjustment for social class and age.
4. The unemployed have higher rates of bronchitis and ischaemic heart disease than the employed.
5. Over 60% of unemployed people smoke, compared to 30% of employed people.

Moller (2012).

Gender and health

Gender refers to the social categorization of people as men or women, and the social meaning and beliefs about sexual difference. Some of the sex differences in morbidity have been viewed as an artefact of measurement of the use of health services. Women are more likely to report illness, as they are less likely to be in full-time employment and have easier access to primary care, or because they are more inclined to take care of their health, resulting in increased consultation rates. However, this does not explain the sex difference in mortality. Nor is there a consistent tendency for women's greater willingness to consult: women are no more likely than men to visit their GPs for musculoskeletal, respiratory or digestive problems.

The biological explanation suggests that women are more resistant to infection and benefit from a protective effect of oestrogen, accounting for their lower mortality rates. Paradoxically, female hormones and the female reproductive system are claimed to render women more liable to physical and mental ill health. But biological explanations are unable to account for the social class difference in women's health, whereby women in professional and managerial

social classes experience better health than women in lower socio-economic groups. It is also important to note that greater female longevity only arose in the twentieth century, and is mostly attributable to the dramatic decline in infectious disease mortality and a decline in the number of births. It is not evident in low-income countries.

Lifestyle explanations argue that women are socialized to be passive, dependent and sick. Women readily adopt the sick role because it fits with preconceived notions of feminine behaviour. Men, by contrast, are encouraged to be aggressive and risk-taking, both at work and in their leisure time. The higher rates for accidents and alcoholism among men are cited as evidence for this. Men are far less likely to take part in weight-management programmes and the national bowel cancer screening programme, or to set quit dates for smoking cessation (see https://www.menshealthforum.org.uk/professionals/search?f%5B0%5D=im_field_pro_content_type%3A30).

Learning Activity 2.3 Men's health

What could account for why men under the age of 45 visit their GPs only half as often as women (www.menshealthforum.org.uk)?

More recently, the focus has been on the distinct roles and behaviours of men and women in a given culture, dictated by that culture's gender norms and values, and how these give rise to gender differences. Globally, there is considerable concern about how women, because of gender norms, are disempowered from, for example, receiving healthcare because they cannot travel alone to a clinic, or protecting themselves against HIV because of their male partners' promiscuity or refusal to use a condom.

In most societies, when compared with men, women tend to have:

- lower status
- lower income
- lower power
- limited access to financial and other assets
- lower educational status
- lower levels of participation in legal and political institutions, and hence less influence on decision-making
- limited access to work
- increased likelihood of being victims of domestic violence.

Yet women often have greater health needs (e.g. pregnancy and child-related care). In most cases women take the leading role in caring for children and dependants, and are also expected to look after the house and work in the fields producing food.

Case Study 2.2 Gender-based interventions: football fans in training

The prevalence of obesity in men in the UK is among the highest in Europe, but men are less likely than women to use existing weight-loss programmes. Developing weight-management programmes which are appealing and acceptable to men is a public health priority. Football Fans in Training (FFIT), a men-only weight-management programme delivered to groups of men at top professional football clubs, encourages men to lose weight by working with, not against, cultural ideals of masculinity. The setting enabled men to join a weight-management programme in circumstances that felt 'right' rather than threatening to them as men. FFIT is an example of how to facilitate health promotion activities in a way that is consistent with, rather than challenging, common ideals of masculinity.

More details from http://www.ffit.org.uk, including the results of a randomized controlled trial published in *The Lancet*.

Health of ethnic minorities

Race commonly refers to a biological marker of difference assigned to a group of people who are recognized as sharing common physical or physiognomic characteristics and/or a common lineage of descent, such as 'Asian' or 'Chinese'. Essentialist racism emphasizes race difference in hierarchical terms of biologic inequality, and 'scientific' categories such as the Aryan superiority assumed by the Nazis over the Jews. A racial logic becomes a system

of differentiation based upon the ascription of people to specific categories on the basis of assumed biological, physiognomic or cultural differences, usually bestowing privilege to one group. It becomes a means of exclusion and subordination, and a way of making a group of people inferior within society. In extreme cases this is demonstrated by extermination, e.g. in Rwanda and Nazi Germany.

Contemporary sociological and political theory focuses rather on 'race' as a social construct, and specifically on the ways in which racial concepts, categories and divisions structure and become embedded in areas of social life and national states. Ethnicity is a complex concept that is used to refer to those with a shared culture, social background, language or religion.

The Fourth National Survey of Ethnic Minorities in England and Wales (Nazroo, 1997) notes:

- two-fifths of Caribbeans, Pakistanis and Bangladeshis have poor general health
- Pakistanis and Bangladeshis have a greater risk of heart disease than white people
- one in 18 people from an ethnic minority group is diagnosed as diabetic
- 50% of Bangladeshi men smoke.

That particular diseases, poor perceived health or premature deaths are more common in ethnic minority groups is a complex issue. In the past, explanations tended to focus on simple differences in culture.

The factors influencing ethnic health inequalities were summarized by Bhopal (2014) as:

- culture, e.g. taboos on alcohol
- social education and economic status, e.g. knowledge of biology and health influences, languages spoken and read
- environmental, e.g. before and after migration
- lifestyle, e.g. behaviours in relation to diet, alcohol and tobacco
- access to and concordance with healthcare advice, willingness to seek health and social services, and use of complementary/alternative methods of care or treatment
- genetic and biological factors, e.g. birth weight, body composition.

Socio-economic factors have a profound impact, but it is important not to put all members of ethnic minorities into one disadvantaged category. More data would enable us to find out how many people from ethnic minority groups are disadvantaged, and in what way. It would also then be possible to determine whether the poor health of black and ethnic minority groups is associated with the low-income, poor working conditions or unemployment and poor housing shared by those in lower social classes, or whether there is, in addition, ill health resulting from other factors. Racism in service delivery, either directly or through the ethnocentrism of services which are based on the needs of the majority, is often invoked as the explanation for inequalities.

Learning Activity 2.4 Healthcare and ethnicity

In your experience, do you think that healthcare differs according to the ethnicity of the patient?

Place and health

In the 1980s mortality rates were shown to increase steadily in the UK, moving from the south-east to the north-west, with a north–south divide present for most diseases. This seemed to be associated with poverty and disadvantage. Glasgow's Shettleston, for example, has twice the national average mortality rate. In the UK, Danny Dorling has written extensively on the impact of place on health (see http://www.dannydorling.org/?page_id=70). One obvious explanation for the geographic differences in death rates might be differences in social class distribution – those areas with high mortality rates being areas with a greater proportion of people in lower socio-economic groups. Increasingly, the effect of place on health has been seen as more complex, including not only the socio-economic characteristics of individuals concentrated in particular places but also the local physical and social environment and the shared norms and traditions that might promote or inhibit health.

Explaining health inequalities

Inequality means a lack of uniformity, or difference. In this chapter we note differences in health outcomes according to gender and ethnicity. In the context of health and healthcare, the term 'inequalities' is mainly used to refer to differences that arise from socio-economic factors, including income, work, housing and location of residence. Our companion volume *Public Health and Health Promotion: Developing Practice* (Naidoo and Wills, 2010) explores these social determinants of health in more detail.

You may believe that people in the lower socio-economic groups choose more unhealthy ways of living, or you may believe they have low incomes which prevent them from adopting a healthy lifestyle and cause them to live in unhealthy conditions. There is a continuing debate over this question, and no simple answer. Explanations for health inequalities focus on cultural/behavioural, materialist/structural and psychosocial explanations which suggest that adverse environmental conditions at different points in the life course can lead to ill health.

Health inequalities as a consequence of lifestyles

This argument suggests that the social distribution of ill health is linked with differences in the prevalence of risk behaviours. These behaviours – smoking, high alcohol consumption, lack of exercise, high-fat and high-sugar diets – are more common among lower socio-economic groups.

For example, although smoking has decreased in all social classes over the last 20 years, there are still major differences in the proportion of smokers in each socio-economic group: data from the General Lifestyle Survey show that in 2010, 28% of smokers were from manual occupations, whereas 13% were from managerial and professional backgrounds. Smokers from manual backgrounds started smoking early in their lives: 48% of men and 40% of women were smoking by the age of 16, compared to 33% of men and 28% of women from managerial and professional backgrounds (Office for National Statistics, 2013b).

Behaviour cannot, however, be separated from the social context in which it takes place. Graham (1992), in many studies on smoking, has shown how the decision to smoke by many working-class women is a coping strategy to deal with the stress associated with poverty and isolation. The decision to smoke *is* a choice, but it is not taken through recklessness or ignorance; it is rather a choice between 'health evils' – stress versus smoking.

Learning Activity 2.5 Attitudes to lifestyle inequalities

Smoking is the biggest single cause of the differences in death rates between rich and poor people. Which of the following views comes closest to your own?

'Poor people bring ill health upon themselves. They don't care about their health. If they are so poor, how can they afford to smoke and drink and eat junk food?'

'People's use of tobacco and alcohol is to a large extent determined by their social relations and networks, which in turn affect their self-esteem and levels of stress. Tobacco offers a prop of sorts'.

Some writers claim that there are cultural differences between social groups in their attitudes towards health and protecting their health for the future. Thus giving up cigarettes, as a form of deferred gratification, is more likely to appeal to middle-class people who, as we saw in Chapter 1, may have a stronger locus of control and are more likely to believe that they determine the course of their lives. Working-class people, who may have to struggle to get by each day, do not make long-term plans and have a fatalistic view of health, believing it to be a matter of luck. These attitudes are passed on from generation to generation. This phenomenon is referred to as the 'culture of poverty' or 'cycle of deprivation'. According to such views, ill health can be explained in terms of the characteristics of poor people themselves and their inadequacy and incompetence. In 1986 Edwina

Currie, a newly appointed health minister, caused a storm of controversy by suggesting that the high levels of premature death, permanent sickness and low birth weights in the northern regions were due to ignorance and people failing to realize that they had some control over their lives.

A behavioural explanation, which sees lifestyles and cultural influences determining health, has considerable appeal to any government that wants to reduce public expenditure. If individuals are seen as responsible for their own health, government inactivity is legitimized. Such viewpoints, which are particularly associated with neoliberal governments (see Chapter 7), have been widely criticized as victim-blaming, in that people are seen as being responsible for factors which disadvantage them but over which they have no control.

Health inequalities as a consequence of the life course

This explanation for health inequalities suggests that early life circumstances predict future morbidity and mortality rates. There are cumulative effects of both material and psychosocial hazards over the life course of an individual that explain observed differences in health and life expectancy, as shown in Figure 2.6.

1. The early life environment has a significant impact on the later health of the adult, regardless of other health-related factors. For example, fetal exposure to passive smoking (due to maternal smoking or maternal exposure to passive smoking) may impact on fetal health and result in low birth weight. Low birth weight is linked to poorer health outcomes (e.g. greater mortality from CHD, stroke and respiratory disease) in adult life.
2. The early life environment of an individual is linked to later lifestyle factors which have a direct impact on health. For example a lower socio-economic family background is associated with poorer educational attainment and poorer housing, job security and work opportunities. Early interventions can change this association. Interventions in the early years can help individuals achieve better educational, work and social outcomes (e.g. home ownership, higher incomes), which in turn are associated with better health outcomes.

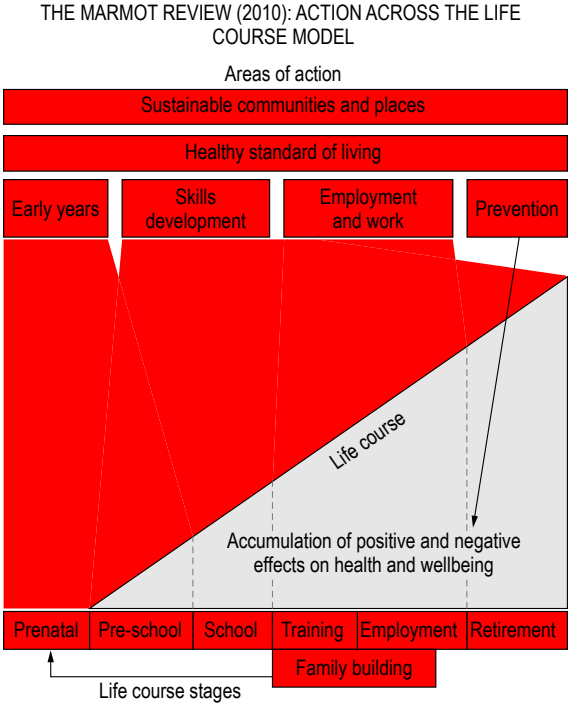


Fig. 2.6 ● The social gradient of health across the life course. (Marmot, M., 2010. Fair Society, Healthy Lives. DH, London. © The Marmot Review, Marmot Review Secretariat, Department for Epidemiology & Public Health. University College, London.)

3. The environment to which individuals are exposed is also an important factor in determining their health status. Exposure to a health-damaging environment, e.g. smoky indoor areas, will have a cumulative effect on an individual's health. The intensity and duration of the exposure are directly linked to later outcomes, e.g. mortality from cancer, CHD, strokes or respiratory illness.

The 1958 birth cohort study, which follows a group of individuals from childhood to adulthood, demonstrates that socio-economic status is linked to factors such as low birth weight and height. Childhood development in all spheres (physical, psychological, social and intellectual) is sensitive to the wider environment and is an important determinant of health status in later life (Graham and Power, 2004).

Learning Activity 2.6 The life course and health

Chart your own life course in relation to health.

- Are there any external factors which influenced your and your family's health?
- Were there any personal events which affected your physical and psychological well-being?

Health inequalities as a consequence of psychosocial factors

There is a growing body of evidence demonstrating that it is *relative* inequalities in income and material resources, coupled with the resulting social exclusion and marginalization, which are linked to poor health (Wilkinson, 1996; Wilkinson and Pickett, 2010). The key evidence on this comes from international data on income distribution and national mortality rates. In high-income countries it is not the richest nations which have the best health, but the most egalitarian, such as Sweden. While the exact mechanisms linking social inequality to ill health are uncertain, it is likely that social cohesion – as measured by levels of trust – provides the causal link between the two. The most plausible explanation for income inequality's apparent effect on health and social problems is 'status anxiety'. This suggests that income inequality is harmful because it places people in a hierarchy which increases status competition and causes stress, leading to poor health and other negative outcomes (Wilkinson and Pickett, 2010). Healthy egalitarian societies are more socially cohesive and have a stronger community life with greater social capital.

The degree to which an individual is integrated into society and has a social support network has been shown to have a significant impact on health. Wilkinson and Pickett (2010) demonstrate that people with stronger social relationships are half as likely to die as those with weaker social ties. Indicators of social relationships and networking, such as marital status, feeling lonely, size of social network and participation in social activities, are as important to health as smoking, and much more important to survival than heavy drinking, physical activity or obesity.

Learning Activity 2.7 Characteristics of a healthy society

The quality of the social life of a society is one of the most powerful determinants of health (and this, in turn, is very closely related to the degree of income equality)

Wilkinson (1996), p. 5.

Which of the following, in your view, reflects the characteristics of life in a healthy society?

1. High level of civic activities.
2. High gross national product.
3. Low crime rates.
4. High percentage of adults receiving a university education.
5. High levels of employment.
6. Narrow differences in income.
7. Sense of social solidarity and cohesion.

The negative emotional experience that arises from living in an unequal society is illustrated in the Whitehall II study (Marmot et al., 2006), a longitudinal study of civil servants and their experience of ill health (described in Research Example 2.2). Irrespective of health behaviour, those in control of their working lives (those in higher grades) are less likely to suffer from CHD, diabetes and metabolic syndrome.

Health inequalities as a consequence of material disadvantage

This explanation argues that the distribution of health and ill health in the population reflects a profoundly unequal distribution of resources in society. Thus those who experience ill health are those who are lower in the social hierarchy, are least educated and have least money and fewest resources. Low income may be the result of unemployment or ill-paid hazardous occupations. It can lead to poor housing in polluted and unsafe environments with few opportunities to build social support networks; and in turn such conditions lead to poor health. Lack of money can make it difficult for households to implement what they may know to be healthy choices.

- People on low incomes eat more processed foods, which are much higher in saturated fats and salt.

- They also eat a smaller variety of foods, due to the need to buy cheaper in bulk and from fear of potential waste.
- People living on state benefits eat less fruit and vegetables, which are less widely available and relatively expensive (Darmon and Drewnowski, 2008).

Absolute poverty is the inability to meet basic human needs such as access to food, shelter, warmth and safety. More than a billion people worldwide live in such extreme poverty. Relative poverty is determined by the standards of the rest of the society in which the individual lives. Although a person's basic needs may be met, relative poverty means he or she may be unable to afford any social participation and is then more likely to suffer from a range of physical health problems, e.g. CHD, as well as social and emotional health problems such as stress and depression, marital breakdown and addiction to drugs or alcohol.

Poverty is just one aspect of socio-economic disadvantage, and is associated with other factors:

- having a family to provide for
- being unable to work due to incapacity or illness
- being geographically isolated from services or supports
- being a young person leaving the care system
- being a single parent
- living in substandard housing or experiencing homelessness
- lacking skills.

Case Study 2.3 Food banks

Across Europe there has been a huge rise in the number of people relying on food banks for emergency supplies. Over a million people, including nearly 400,000 children, received at least three days' emergency food from the Trussell Trust's 400 food banks in 2014/15 (http://www.trusselltrust.org/resources/documents/Press/Trussell-Trust-foodbank-use-tops-one-million.pdf). In 2014 German food banks provided more than 1.5 million people (from children to senior citizens) with food (http://blogs.lse.ac.uk/europpblog/2013/07/11/germany-foodbanks/). The reliance on emergency food is said to be triggered by low wages and limited welfare with no crisis payments.

http://www.trusselltrust.org/mid-year-stats-2014.

Health inequalities as a consequence of limited healthcare

A common response to the evidence of health inequalities is to see these as a consequence of restricted access to services. The intention of the National Health Service – to provide a universal service freely available to all – might have been expected to reduce inequalities in health status. Yet in the early 1970s a GP writing in *The Lancet* put forward the radical view that good healthcare tends to vary inversely with the needs of the population (Tudor Hart, 1971):

> *In areas with most sickness and death, GPs have more work, larger lists, less hospital support and inherit more clinically ineffective traditions of consultation than in the healthiest areas; and the hospital doctors shoulder heavier caseloads with less staff and equipment, more obsolete buildings and suffer recurrent crises in the availability of beds and replacement of staff. These trends can be summed up as the Inverse Care Law: that the availability of good medical care tends to vary inversely with the needs of the population served.*
>
> Tudor Hart (1971).

Equality of access requires that, for different communities:

- travel distance to facilities is equal
- transport and communication services are equal
- waiting times are equal
- patients are equally informed about the availability and effectiveness of treatments
- charges are equal (with equal ability to pay)
- the quality of services offered does not vary between groups or locations.

Learning Activity 2.8 Equality of access to healthcare services

Even in the UK, where services are universally available and not dependent on the ability to pay, some groups are more able to access services than others. Why is this?

There is evidence of variation in the quality and quantity of care available to people in different social

groups, and between regions and different ethnic groups (House of Commons Health Committee, 2009). However, since medical care has had little impact on the overall death rate from heart disease or cancers, and probably only about 5% of deaths are preventable through medical treatment, it must be concluded that differences in health status are not wholly attributable to variations in the amount and type of care received.

Tackling inequalities in health

Life expectancy, health and health-related behaviours have shown a steady improvement over the last 50 years, but there are gross inequalities in health between countries. Life expectancy at birth, for example, ranges from 34 years in Sierra Leone to 81.9 years in Japan (World Health Organization, 2004). Within countries, too, there are inequalities. In the USA Native Americans from South Dakota can expect to live only 58 years while Asian-American women from New Jersey have the highest national life expectancy at 91 years (Murray et al., 2005). Mortality statistics can reveal a social gradient in disease in *all* countries. As we have seen in this chapter, such inequalities are linked to chronic non-communicable diseases related principally to tobacco, alcohol, diet and obesity; to poverty; to violence; to access to health services; and to the circumstances in which people live and work.

In England, the Marmot Review, *Fair Society, Healthy Lives* (Marmot, 2010), emphasizes the 'causes of the causes' of health inequalities, and the need to address these wider determinants. To tackle inequalities and reduce the steepness of the social gradient, the Marmot Review recommends actions of sufficient scale and intensity to be universal but also proportionately targeted. Strategies need to target those at the lower end of the gradient as well as throughout the whole of society, according to the level of disadvantage.

The report specifically proposes action on six policy objectives.

- Give every child the best start in life.
- Enable all children, young people and adults to maximize their capabilities and have control over their lives.
- Create fair employment and good work for all.
- Ensure a healthy standard of living for all.
- Create and develop healthy and sustainable places and communities.
- Strengthen the role and impact of ill-health prevention.

Learning Activity 2.9 Indicators for tackling health inequalities

Give an indicator for the successful tackling of each of the following.
Education.
Economic stability.
Social and community context.
Health and healthcare.
Neighbourhood and the built environment.

For example, interventions to reduce inequalities in health, e.g. in relation to diet, could address:

- the structural level, e.g. trade policy, food-labelling regulations, food fortification
- the local/community level, e.g. food gardens, free fruit and vegetables in school, food outlets
- the individual/family level, e.g. nutrition education in school or during pregnancy; mass-media campaigns, e.g. to reduce salt, weight-loss programmes.

Although many health promoters may feel powerless to effect change at a macro-structural level, it is possible to address health inequalities in planning health promotion interventions, as these examples illustrate. One of the central tasks for health promoters is to acknowledge socio-economic factors as crucial in determining individual and population health (Naidoo and Wills, 2010).

Learning Activity 2.10 What improves health?

In your experience, what long-term social policy initiatives would be most effective in bringing about an improvement in the health of your clients or patients, or people you know?

Conclusion

Health promotion is not a purely technical activity. As we have seen, even identifying the causes of ill health will lead to political judgements being made. In any area of work or discipline, there will always be debate about what constitutes good practice. It is important to clarify your thinking and where you stand, because it will affect your views on the purpose of health promotion and what would be appropriate health promotion activities. It is also important that you share these thoughts with colleagues and clients to reach a common understanding of the ideals upon which health promotion activities are based.

In practice, behavioural and structural explanations are often aligned to the right or left of the political spectrum, and have become linked with very different policies and approaches to health promotion. The behavioural approach, which focuses on individual lifestyles, has informed much of health education because it suggests that information, advice or mass-media messages can change behaviours such as smoking or sexual activity. A structural approach, which sees health as determined by social and economic conditions, and reflecting the unequal distribution of power and resources in society, requires the health promoter to become involved in political activity.

Summary

This chapter has reviewed the evidence concerning health differences in the population and the physical, social and environmental variables that are implicated in ill health: poverty, unemployment, inadequate housing, stressful and dangerous working conditions, lack of social support, and air and water pollution. It goes on to consider the ways in which risk factors associated with personal behaviour – smoking, nutrition, exercise – are influenced by the social environment.

Several explanations for inequalities in health have been discussed. None offers a complete explanation, but the chapter concludes that there is sufficient evidence to point to social and economic factors determining health. It argues that disadvantage can give rise to, or exacerbate, health-damaging behaviours such as smoking or poor nutrition, and so health behaviours should not be separated from their social context.

Further reading and resources

Commission on Social Determinants of Health CSDH, 2008. Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health. Final Report of the Commission on Social Determinants of Health. World Health Organization, Geneva. Available online at: http://apps.who.int/iris/bitstream/10665/43943/1/9789241563703_eng.pdf [accessed 16.09.15].

Marmot, M., Wilkinson, R.G. (Eds.), 2006. Social Determinants of Health, second ed. Oxford University Press, Oxford.
An overview of the factors known to affect health including unemployment, work and social support.

Useful websites include: the Institute of Health Equity at: http://www.instituteofhealthequity.org.

The Black Report can be downloaded from: http://www.sochealth.co.uk/history/black.htm.

The Marmot Review 2010 Fair Society Healthy Lives. Available online at: http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review.

Feedback to learning activities

2.1 Lifestyle behaviours are often viewed as being individual choices. While on one level this is true, many other factors influence individual behaviours. Taking the example of physical activity, it can be argued that individual motivation and willpower are all that is necessary. However, many factors will impact on the likelihood and ease of taking more physical activity, e.g. availability of suitable facilities, access to facilities and social norms depicted in the mass media.

2.2 It seems that unemployment has a profound effect on mental health, damaging a person's self-esteem and social structure. Employment, as well as providing wages which provide for people's material needs, is also often part of someone's self-identity. The higher incidence of smoking

among unemployed people appears paradoxical given the cost involved, but smoking is often used as a psychological prop. Unemployment also means lower income and material disadvantage, as well as social isolation (McLean et al., 2005).

2.3 There are several reasons why men under the age of 45 do not visit their GPs as often as women. The obvious reason is that they suffer less ill health and disease than women, but this is not corroborated by medical statistics. Some issues, e.g. contraception, are seen as being women's responsibility. Pregnancy and childbirth will also contribute significantly to women's use of GPs. The sick role and its associated features, e.g. dependency, are typically viewed as more feminine than masculine, and therefore women may feel more at ease reporting ill health and using their GPs than men. There are therefore both medical and social reasons why women visit their GPs more frequently than men.

2.4 Healthcare is a cultural as well as a medical activity and is based on various premises, e.g. that the doctor knows best, and that the patient should be passive and should cooperate with medical advice and treatment. Sometimes patients from minority ethnic groups may have different expectations about their role and treatment. If there is a disparity between the expectations and role behaviours of health staff and patients, healthcare may suffer.

2.5 The first comment suggests that individuals must take full responsibility for their health-related behaviour. The second comment recognizes that behaviours take place in social contexts, and that many factors impact on individual behaviours. While behaviour is an individual attribute, its causes, meanings and significance are all socially determined. While it is logical to think poor people should smoke less, because of the cost of cigarettes, the social reality is that smoking is often used for social bonding and as a marker of individual identity, which are both rendered precarious by poverty.

2.6 Reflecting on your own life course to date in this way will illuminate the variety of factors that have impacted on your health. These factors will probably include both external factors, e.g. the impact of economic recession or growth, and personal events, e.g. unemployment, migration or sickness. While we are encouraged to believe that we forge our own destinies, many other familial, social and societal factors and events have a profound impact on our lives.

2.7 It could be argued that all the above factors reflect a healthy society. Several factors (1, 6 and 7) are characteristic of egalitarian societies with a high level of social capital or networking, which is arguably a bedrock of good health. Other factors (2 and 5) are indicative of a thriving economy which, while it does not guarantee good health for all, provides a supportive backdrop. Factors 3 and 4 suggest a society investing in education and the next generation.

2.8 Accessing services, even when they are free and universally available, requires some initiative and confidence on the part of the user. To access NHS services, people need to negotiate with medical staff and make their needs known. This requires a degree of confidence, and such communication is much easier if the service user and service provider share a common cultural background, i.e. the user comes from the same social class as the medical staff.

2.9 There is a wide variety of indicators that could be used, including government statistics, e.g. increasing number of young people in higher education or increasing percentage of students achieving pass grades in exams; lay people's feedback and views, e.g. the percentage of people who feel their neighbourhood is safe; and service users' views, e.g. the percentage of patients who report feeling well cared for by the NHS.

2.10 Effective long-term social policy initiatives are varied, and include extending educational and business opportunities for young people (e.g. through apprenticeships), provision for older people with chronic ill health (e.g. nursing homes) and ensuring that everyone has sufficient income to meet their needs (e.g. welfare benefits).

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Chapter **Three**

3

Measuring health

Learning Outcomes

By the end of this chapter you will be able to:

- identify sources of health information
- understand and use some frequently used epidemiological terms
- use available health information to describe health needs.

Key Concepts and Definitions

Epidemiology The scientific study of the distribution and causes of health and disease in defined populations. Epidemiology is used in public health to inform policy and practice through the identification of risk factors for disease and the application of this knowledge to control health problems.

Morbidity The incidence of disease or illness in a specified population.

Mortality The number of deaths at a given time and location. The mortality or death rate is typically expressed as the number of deaths per 1000 individuals per year.

Indicator The health indicators are quantifiable characteristics of a population (e.g. life expectancy) which may be used to justify public health interventions.

Rate A measure, quantity, or frequency, typically one measured against another quantity or measure.

Importance of the Topic

We saw in Chapter 1 how people define health in different ways, and in Chapter 2 how there are different determinants of health. This would suggest that measuring health is not a simple task. This appears to be borne out by the existence of a number of ways of measuring health, and a lack of clear agreement about which are the best ways to do this and which sources of information are most useful. This chapter looks first at why we might want to measure health. It goes on to investigate the different means of measuring health currently in use, and unpacks some of the assumptions underlying their use. Finally, the uses of the different kinds of measures are explored. The practical uses of measuring health are discussed further in Chapters 18 and 19 on needs assessment and programme planning, and in Chapter 20 on evaluation.

Why measure health?

Finding a means to measure health is an important practical task for health promoters. There are several reasons why this is so.

1. *To establish priorities.* Collecting and evaluating information about the health status and health problems of a community are important ways of identifying needs.
2. *To assist planning.* Health promoters need information to assist the planning and evaluation of health promotion programmes. It is important to establish baseline data in order to plan priorities and have a standard against which health promotion interventions can be evaluated.
3. *To justify resources.* Health promotion is often in competition with other activities for scarce resources. To make a claim for resources and prove that their activities are effective, health promoters need information on the health status of populations.
4. *To assist the development of the profession.* Measurements of health gain are important to the professional development of health promoters. Unless there is a means of measuring the effect of our actions, health promotion work will remain invisible, underfunded and low priority. By demonstrating the efficacy of health promotion interventions, it is possible to argue for resources, credibility and funding.

Ways of measuring health

Depending on the purpose, different measures of health may be used or developed. The means of measuring health depend primarily on the view of health which is held. If health is basically about physical functioning, then measures of physical fitness will be an adequate measure of health. If health is defined as having no disease, then measures of the extent of disease may be used (in reverse) as measures of health. However, if health is defined as including social and mental aspects, and meaning something other than being not ill, specific measurements of health will need to be developed.

Learning Activity 3.1 Describing the health of populations

If you wanted to describe the health of the people where you live or work, what information would you need?

Community health workers who profile their communities have many different ways of building a picture of their area. Some of these are described in Chapter 18 on needs assessment. In this chapter we look at sources of information available to describe a community's health. A great deal of information is available online. For example, in the UK you can find out about your local area by visiting http://neighbourhood.statistics.gov.uk, and, for those living in Scotland, www.groscotland.gov.uk/statistics.

Case Study 3.1 outlines a profile of the borough of Tower Hamlets in London and, using a variety of indicators, paints a picture of an area of disadvantage.

Case Study 3.1 Describing Tower Hamlets in London

At the last census conducted in 2011 the population size of Tower Hamlets was 254,096. Thirty-two percent of the population classified themselves as Bangladeshi, making this the largest ethnic group in the borough (2012-12 Census 2011 Second Release - Headline Analysis FINAL VI.pdf). Tower Hamlets ranks as the seventh most deprived local authority out of 326 in England on the Index of Multiple Deprivation (Tower Hamlets Indices of Deprivation 2011 Research Briefing 2011-03). Seventy-two percent of its lower super output areas (LSOAs) are in the 20% of the most deprived LSOAs nationally; 39.6% of the population live in social housing compared to 24.1% of the population in London; 6% of males aged 16 to 74 have never worked, compared to an average in England of 4.7%; and 7.9% of the population cannot speak English well or at all, while 18% say Bengali is their preferred language.

We look next at the contribution of epidemiology in the measurement of health as a negative variable, and move on to consider the measurement of health

as a positive variable. Measuring health as a negative variable means measuring the opposite to health (e.g. disease or death) and using these results to infer the degree of health. Health is therefore being defined as a negative (health is not being ill or dead), not as a positive (health as positive well-being).

Measuring health as a negative variable (e.g. health is not being diseased or ill)

Epidemiology is the study of the occurrence and spread of diseases in the population. It is concerned with the health status (or, more usually, the ill-health status) of populations. Health promoters use epidemiological evidence to identify health problems, at-risk groups and the effectiveness of preventive measures. Figure 3.1 shows the key functions of epidemiology and Table 3.1 illustrates some of the key questions it answers.

The most common means of assessing a population's health are mortality and morbidity rates. This reflects the reductionist model of health, which sees health as a simple matter of illness or its absence. Thus data on deaths and illnesses are often used as surrogate measures of health. There are clearly shortcomings to this approach. Measuring conditions which limit health, such as illness, is not the same as measuring health itself. Measuring mortality rates does not reflect the extent of illness in the population, nor does it say anything about the quality of health experienced by people when they were alive. Conditions such as arthritis or schizophrenia cause considerable suffering and pain, but do not lead to premature death and so are not reflected in mortality rates.

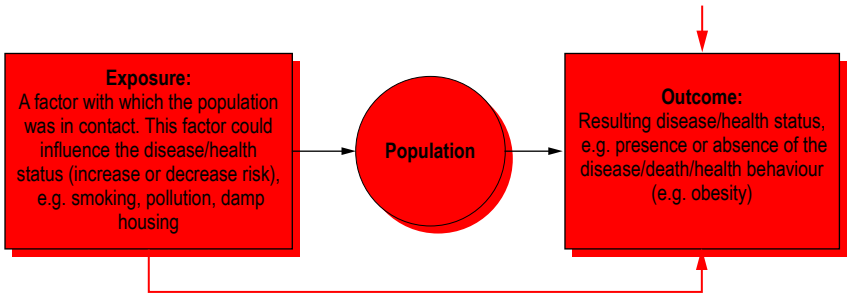

Fig. 3.1 ● The key functions of epidemiology.

Table 3.1 The application of epidemiology to public health

Distribution	Determinants
How many diseases are there?	Why do diseases happen?
How often do diseases happen (frequency)?	What determines/causes diseases/health-related events?
Where do they happen (places)?	What works to reduce the burden or risk of the disease? What is effective?
When do they happen or how do they change over time?	Is there a relationship between the disease and factors surrounding people's lives? Which factors are associated with a higher risk of getting the disease? How much higher is the risk associated with these factors?
Who has them and who does not (which population groups are at higher risk)?	What kind of factors (e.g. genetic or lifestyle) determine which populations are at risk and which populations are relatively immune?

Statistics concerning mortality are readily obtainable in developed countries. A death certificate is taken to the registrar of births, deaths and marriages and the director of public health in every health authority, and the total number of deaths, the geographic and population variations and the causes of death are all collated in each district's annual public health report. The statistics can also be used in international comparisons because most countries hold some form of database on deaths and disease rates.

All countries have systems of collecting data on the health status of the population and the use of services. Although these statistics are often presented as if they were objective facts, it is important to remember that statistics are devised by people in a social context, and are subject to assumptions, bias and error. At every stage of the data-collecting process, decisions are taken which help shape the ultimate form of information presented.

Learning Activity 3.2 Mortality rates and food hygiene as an indicator of health status

If you wished to develop a health promotion intervention to improve food hygiene, why would mortality rates be a poor indicator of its priority?

- How else could you find out about the extent of poor food hygiene in your area?
- Why might mortality statistics be a good indicator of the necessity of health promotion around food hygiene in a low-income country?

Mortality statistics

There are several different ways of expressing death rates. The crude death rate is the number of deaths per 1000 people per year. However, this figure is affected by the age structure of the population, which may vary over time and regions. An area with a high proportion of older people, such as an English south-coast retirement town, would have consistently higher death rates than a more deprived area with a higher percentage of premature deaths but a younger population, such as an inner-city area. The standardized mortality ratio (SMR) measures the death rate, taking into account differences in age structure. It is the number of deaths experienced within a population group (which may be defined by geographic or socio-economic factors) compared to what would be expected for this group if national averages applied, taking age differences into account. The overall average for England and Wales is 100, so SMRs of below 100 indicate a lower than average mortality rate, whereas SMRs of more than 100 indicate higher than average mortality rates.

Learning Activity 3.3 The International Classification of Diseases

The *International Classification of Diseases, Injuries and Causes of Death* (ICD) (World Health Organization, 2010) (http://apps.who.int/classifications/icd10/browse/2015/en) classifies death according to diagnosed diseases which cause death, for example lung cancer. Death certificates which use the ICD thus give no information about contributory risk factors, such as smoking or diet.

- What impact do you think this has on our perception of risk factors and causes of disease, and on suitable strategies for prevention and treatment?
- Is it likely to foster understanding of social, environmental or biological causes of disease?

The infant mortality rate (IMR) is another commonly used statistic: it is the number of deaths in the first year of life per 1000 live births. The IMR is strongly associated with adult mortality rates. It reflects maternal health, particularly nutrition, and the provision of social care and child welfare. The IMR is therefore capable of being used as an indicator of the general health of the population, particularly when comparisons between countries are being drawn. The perinatal mortality rate is the number of stillbirths and deaths in the first 7 days after birth per 1000 births. The neonatal death rate is the number of deaths occurring in the first 28 days after birth per 1000 live births. Both the SMR and the IMR are readily available statistics, and therefore easy to use as surrogate measures of health.

Table 3.2 illustrates the marked inequalities across countries as shown by health indicators. For example, reducing infant mortality was one of the UN Millennium Development Goals, with a target reduction of two-thirds. There has been some progress: for example,