Does inequality kill?

What are the dimensions of inequality that matter for human health and well-being? What are the mechanisms through which inequality kills?

The history of public health is rich with examples of scholars and practitioners who have attempted to overcome an inherent tension between the biological and social sciences but it is clear that this tension between the them remains. The conventional biomedical approach to determinants of health does not generally embrace causal pathways to illness that originate in laws, tax systems, the behaviour of multinational organisations, or global financial systems. The link between social disadvantage and poor health outcomes throughout the life course is well established empirically. Therefore, the question is no longer about whether social factors influence health, but rather how social factors operate and how we can most effectively intervene to activate health-promoting pathways and interrupt health-damaging ones.

The implication of the social determinants approach, however, is that causal chains run from macro social, political, and economic factors to the pathogenesis of disease.

Health and wealth: the health gradient

Health gradient simply means taht the distribution of health and income (or other measures of economic status) are asoociated.The gradient is important both as a measure of social performance and as a guide to possible policy action. Health inequalities along the social gradient in **affluent countries** are well documented. Individuals of different socio-economic status show profoundly different levels of health and incidence of disease.

Read more about the health gradient

Pathways

The social determinants of health approach uses the language of association, even causation and causal pathways.

Please read more about the pathways and four types of theories explaining inequities.

Don't forget to check all the links before turning the page to study about health inequalities within countries...

Health gradient

The **most influential studies on the social gradient on health are the Whitehall studies by Michael Marmot and his group**. The studies established the health gradient in the UK. Also in countries like Finland, which is among the countries with least inequities, healt gradient is clearly visible.

The first Whitehall study, set up in 1967, by Professor Sir Michael Marmot (pictured), included 18,000 men in the British Civil Service. It showed that **men in the lowest employment grades were much more likely to die prematurely than men in the highest grades**. Furthermore, these socio-economic inequalities in health did not appear to be fully accounted for by differences in well-known risk factors, such as smoking.

Between 1985 and 1988 the same research group investigated the degree and causes of the social gradient in morbidity in a new cohort of 10,314 civil servants (6900 men, 3414 women) aged 35-55 (the Whitehall II study). Participants were asked to answer a self-administered questionnaire and attend a screening examination.

In the 20 years separating the two studies there has been no diminution in social class difference in morbidity: we found an **inverse association between employment grade and prevalence of angina, electrocardiogram evidence of ischaemia, and symptoms of chronic bronchitis**. Self-perceived **health status and symptoms were worse in subjects in lower status jobs.** There were clear employment-grade differences in health-risk behaviours including smoking, diet, and exercise, in economic circumstances, in possible effects of early-life environment as reflected by height, in social circumstances at work (eg, monotonous work characterised by low control and low satisfaction), and in social supports.

ADD PPT Whitehall Twenty-Five-Year Mortality (British Civil Servants), By Employment Grade

ADD Finn slide

Braveman and Tarimo (2002) discuss the importance of studying health inequalities and the social gradient within low and middle-income countries, where two thirds of the world's population lives, rather than focusing solely on between-country health inequalities. They point to certain countries as case studies and show many large and growing disparities in health and health care for example along gender, between different races and ethnicities, regionally, between urban and rural residents.

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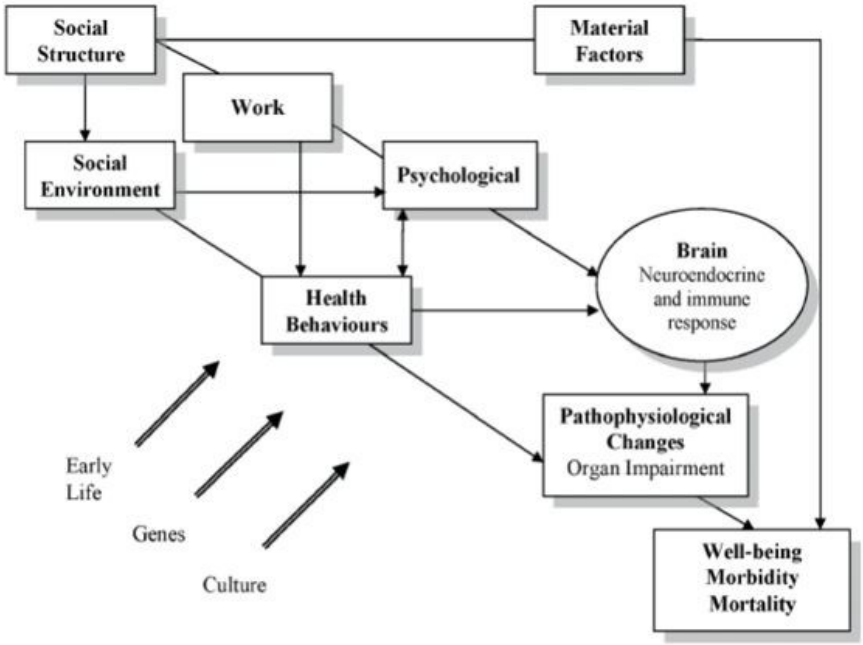
Pathways

Typically, **four types of theories have been proposed to explain inequities** in health and its relation to socioeconomic position.

1) **Materialist/ structuralist theory** proposes that inadequacy in individual income levels leads to a lack of resources to cope with stressors of life and thus produces ill health.
2) **Psycho-social mode**l proposes that discrimination based on one's place in the social hierarchy causes stressors of various kinds which lead to a neuroendocrine response that produces disease.
3) **Social production of health model** is based on the premise that capitalist priorities for accumulating wealth, power, prestige and material assets are achieved at the cost of the disadvantaged.
4) **Ecosocial theory** brings together psycho-social and social production of health models, and looks at how social and physical environments interact with biology and how individuals 'embody' aspects of the contexts in which they live and work. It builds on the 'collective lifestyles' approach and the theory that lifestyle choices are influenced life chances defined by the environment in by life chances defined by the environment in which people livewhich people live.

The below model is an example of attempt to **illustrate pathways to health and illness through life course using social SDH approach.**



Source: Modified from Brunner, E. and Marmot, M. G. (2006) 'Social Organisation, stress and health'.

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