Health inequalities in England: A complex case of *sticking plasters* and *category errors*

Jonathan Wistow, Department of Sociology

Durham University

Introduction

- Political economy, policy, and methodology are all significant for understanding and reducing health inequalities.
- In England each of these strands are broadly complementary:
  - Individualism; treatment and behaviour; and linearity
- However, the ontological and epistemological coherence that cuts across these is negatively reinforcing and goes a long way towards explaining the persistence of health inequalities in England

Political economy

- General shift, since the late 1970s to neoliberalism and successive governments viewing the market as the optimal or default form of economic organisation (Sayer, 2016):
  - Key instruments of the welfare state, including local government, were seen as placing constraints on the central state's marketization project (Crouch, 2011).
- Inequality no longer necessarily seen as problematic, allowing for less progressive taxation, privatisation of public assets and runaway salaries at the top of the labour market (Marmot, 2015).
- The UK witnessed a 'phase shift' in income inequality in the 1980s

(Unequal spatial) Political economy

- It would be ‘stretching credulity’ to suggest that the concentration of finance, corporate and political power and institutions in London had no role in the growth or persistence in the spatial economic imbalance between the north and south of the country (Martin, 2015).
- National political economy spatially concentrated in, and controlled from, London contributes to:
    - The extent and nature of social problems; and
    - The extent and types of social policy response to these
- As a consequence of the huge loss in manufacturing and industrial jobs Beatty and Forthergill (2016) – Treasury has ‘misdiagnosed’ high welfare spending as the result of inadequate work incentives rather than resulting from job destruction extending back decades.
- North East of England provides ‘an almost limiting case’ of post-industrial society within one of the most post-industrialised societies in the world (Byrne, 2019).
    - Between 2011-12 and 2015-16 London has nearly twice as much spent per head on ‘economic affairs’ than the NE.
    - North East lowest household income and wealth of any English region

Health inequalities in England

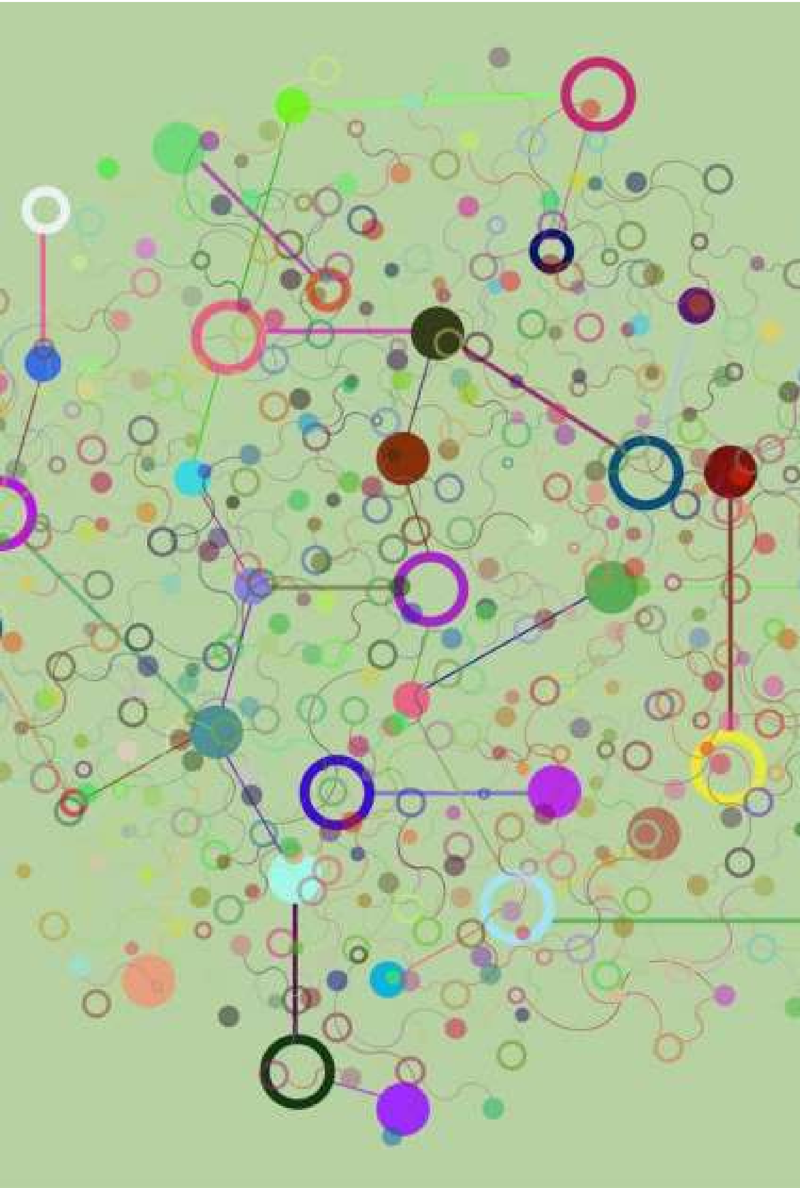
- Over 20 years difference in healthy life expectancy (HLE) and 6.5 years in life expectancy (LE) for females and 16 years HLE and 7.5 years LE for males between best and worst local authorities.
- Health inequalities have remained remarkably persistent despite:
  - 'Endlessly repeated statistical associations linking socio-economic classification to health' (Scambler and Scambler, 2015: 343); and
  - Agreement that population health is more a function of the characteristics of society than of healthcare (e.g., Lynch, 2017; and Scambler 2011) and that HIs will persist alongside unequal social structures (e.g., Mackenbach, 2010; Sassi, 2005).
- Therefore, we need to question the structural and class forces that are key causal factors in producing health inequalities (see, for example, Coburn, 2009; Lynch, 2017; Scambler and Scambler, 2015; Schrecker, 2017; Wistow et al., 2015).
- Large parts of northern England have been left-behind in terms of health inequalities – as they have in the spatial economy

Without addressing and understanding the causal processes produced through the political economy; policy designed to tackle health inequalities is likely to be no more than a 'sticking plaster' for the deep cut that these represent within society.

Health policy

- What is the role and scope of state/policy to modify inequalities?
- *If*, health inequalities are a major priority then the NHS has been based on a 'category error', i.e., medical model's concern to treat symptoms more than causes of ill health
  - Despite longstanding challenges (e.g., McKeown, 1976 and Doyal with Pennell, 1979) and evidence-base (Black Report, 1980 onwards) pointing to the material and structural causes of health inequalities
- Implications for:
  - Resourcing - only four per cent of NHS spending in the first decade of the 21st century was on health promotion and preventing illness (NAO: 2013) + local government much harder hit during austerity than NHS; and
  - Understanding e.g., within health promotion and prevention tendency to focus on knowledge and skills to empower people to take more responsibility
- Doyal with Pennell (1979) the, 'emphasis on the individual origin of disease is of considerable social significance, since it effectively obscures the social and economic causes of ill health.'
  - The medical emphasis on individual causation is one means of defusing the political significance of the 'destruction of health'.

The NHS compounds the category error at the level of the political economy of using sticking plasters when stitches are required and, to extend the metaphor, does so by producing a plaster that is both too small and the wrong shape for the cut. Under these circumstances methodology should help us to understand and frame the problem better but the dominant approaches here are lacking.



Methodology

- Despite public health researchers and professionals generally understanding that the causes of ill health are complex and structural Salway and Green (2017: 523) conclude that both health promotion campaigns and journal evidence, 'suggest we remain deeply wedded to linear models and individualistic interventions.'
- RCTs remain the gold standard in medical research and increasingly influence public health and social research:
  - Questions have to be asked about the extent to which an RCT is capable of understanding the dynamic and relational factors that operate at levels above and beyond individuals (see, for example, Kelly, 2010)
- Reductionist approach – simplifying and dividing problems, losing sight of embeddedness and interconnections (Chapman, 2004)
- Complexity theory helps to respond to these limitations:
  - In framing research problems; and
  - Advocating mixed-methods approaches

Health inequalities are complex and no one methodological approach should take precedence in understanding these. By opening up the methodological toolbox and using a variety of methods we can develop a much fuller understanding of how these exist within complex systems, which, in turn, directs our attention much more fully to the constraints in the political economy and the limitations of policy as presently configured.

References

- Chapman, J. (2004) System failure: Why governments must learn to think differently, London: Demos.
- Coburn, D. (2009) Income inequality and health. In Panitch, L. and Leys, C. (eds) Morbid Symptoms: Health under capitalism. Pontypool: The Merlin Press.
- Crouch, C. (2011) The strange non-death of neoliberalism, Cambridge: Polity.
- Department of Health (1998) Independent Inquiry into Inequalities in Health – Report. London: HMSO.
- Doyal, L., with Pennell, I. (1979) The political economy of health, London, Pluto Press Limited.
- Harvey, D. (2005) A brief history of neoliberalism, Oxford: Oxford University Press.
- Kelly, M. (2010) The axes of social differentiation and the evidence base on health equity, Journal of the Royal Society of Medicine, 103(7), 266-272.
- Lynch, J. (2017) Reframing inequality? The health inequalities turn as a dangerous frame shift, Journal of Public Health, 39: 4, 653-660.
- Marmot Review (2010) Fair Society, Healthy Lives: Strategic review of health inequalities in England post-2010, London: The Marmot Review.
- McKeown, T. (1976) The role of medicine: Dream, mirage or nemesis? London: Nuffield Provincial Hospitals Trust.
- NAO (2013) Early action: Landscape review: https://www.nao.org.uk/report/early-action-landscape-review/
- Salway and Green (2017) Towards a critical complex systems approach to public health, Critical Public Heealth, 27:5, 523-524.
- Sayer, A. (2016) Why we can't afford the rich, Bristol: Policy Press.
- Scambler and Scambler (2015) Theorizing health inequalities: The untapped potential of dialectical critical realism, Social Theory and Health, pp 340-354, 13: 3/4
- Schrecker, T. (2017) Was Mackenbach right? Towards a practical political science of redistribution and health inequalities, Health and Place, 46, 293-299.
- Wistow, J., with, Blackman, T., Byrne, D., and Wistow, G. Studying health inequalities: An applied approach, Bristol: Policy Press