Health inequality and health seeking behaviour

Dr Malav Bhimpuria and Zishan Jiwa

Cases for discussion in groups

Questions

1. What patient factors (bio/psycho/social/cultural) contribute to the state of this individual's health? (demand side factors)

2. What healthcare factors contribute to or obstruct this individual from receiving optimal healthcare? (supply side factors)

What patient factors (bio/psycho/social/cultural) contribute to the state of this individual's health? (demand side factors)

- age
- gender
- genetic
- education
- income
- living conditions
- work environment
- unemployment
- diet
- ethnic/cultural background

What healthcare factors contribute to or obstruct this individual from receiving optimal healthcare? (supply side factors)

- ease of access to services
- awareness
- language
- culture
- geography/location
- education level
- time
- employment
- money
- community/networks
- knowledge/access to information

RCGP Curriculum Statement 3.02

Summary

- **The optimal approach to the public's health requires coordination of the three domains of public health: health improvement, health protection and healthcare services**
- **As a general practitioner (GP), you have a crucial role to play in promoting health, preventing disease and delivering brief advice and interventions where appropriate**
- **Factors predisposing to poor health operate across the whole life course from pre birth to old age *(life course model)***
- **Health inequalities are important determinants of health**
- Screening and immunisation have risks as well as benefits
- Work offers an opportunity to promote health and well-being

Inequality

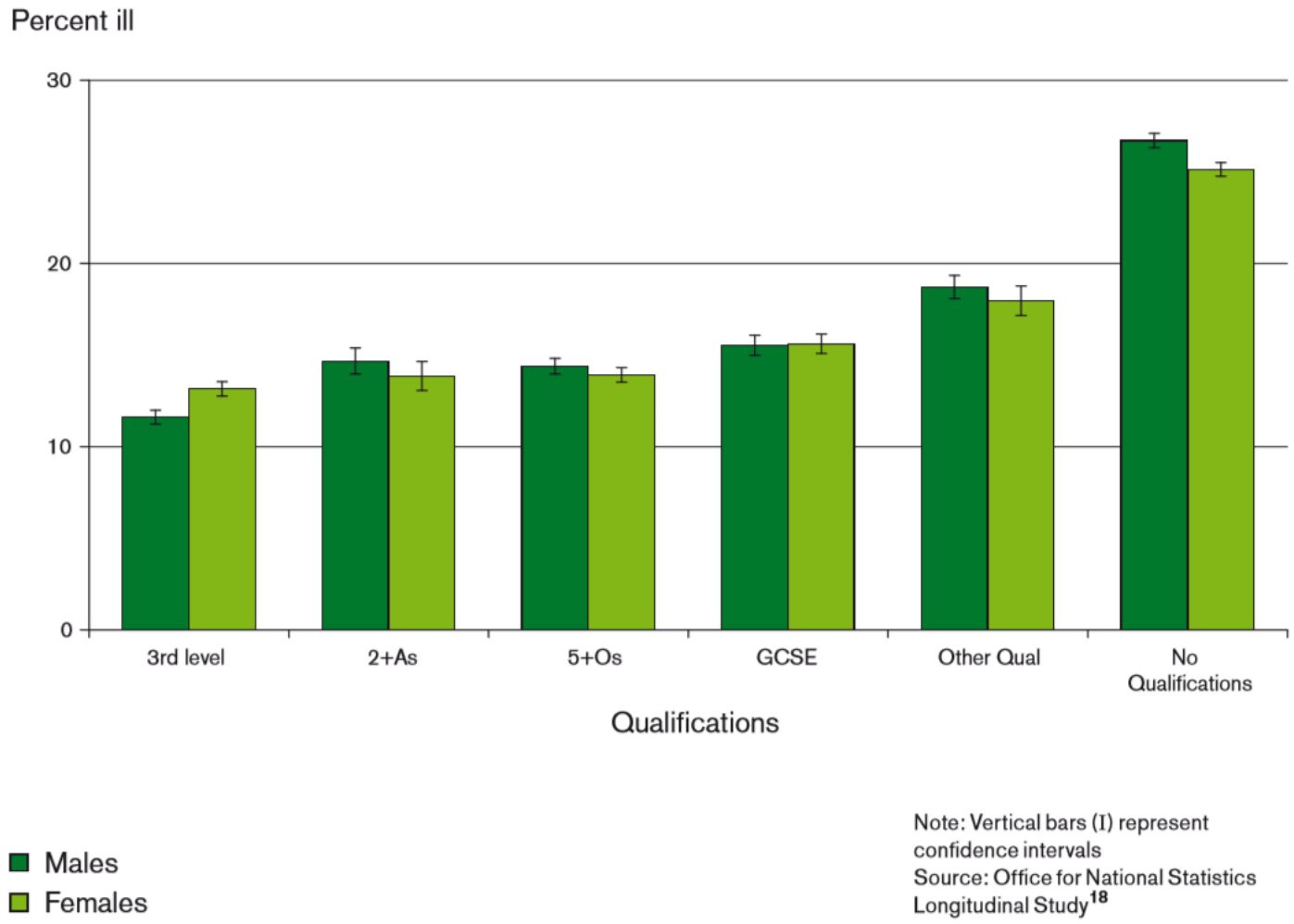
1. Inequality in disease distribution

2. Inequality in healthcare distribution

Inequality in disease distribution

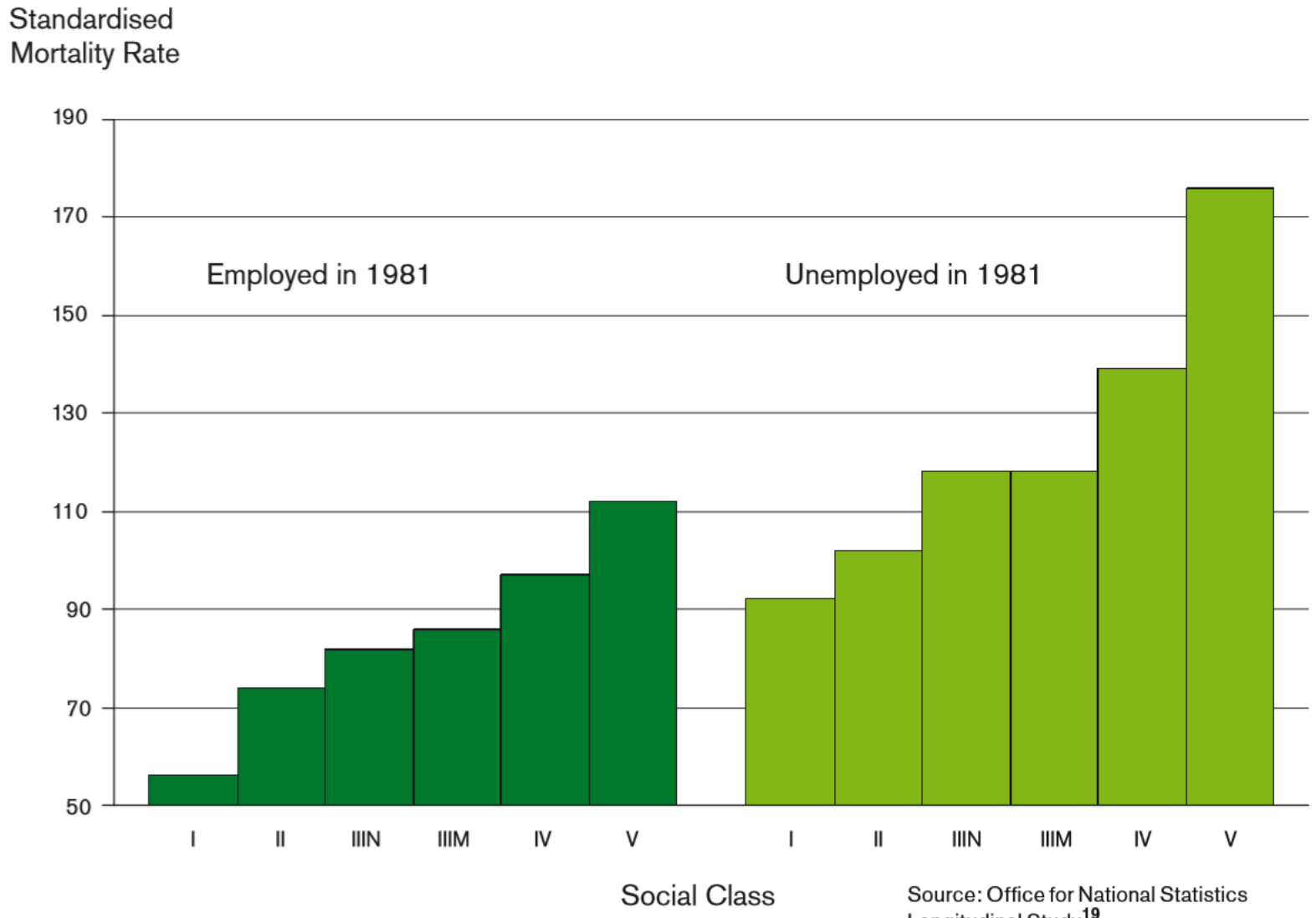
1. Inequality clusters by:
    1. Income via cost of housing
    2. Ethnic/cultural clustering
    3. Employment/industry
2. Inequality magnified by:
    1. Quality of local services
        1. Schools/libraries
        2. GP surgeries/hospitals
        3. Children's centres
        4. Sports facilities
    2. Environmental factors i.e. pollution, road traffic accidents, litter/detritus, green spaces, housing conditions
    3. Commercial/local government investment
    4. Crime

Education level



Note: Vertical bars (I) represent confidence intervals
Source: Office for National Statistics Longitudinal Study[18]

Employment status



Environmental conditions

Environmental conditions: river water quality, air quality, green space, habitat favourable to bio-diversity, flood risk, litter, detritus, housing conditions, road accidents, regulated sites (e.g. landfill)

Source: Department for Environment, Food and Rural Affairs[23]

DOH: Living well for longer (2013) – reduce avoidable premature mortality

Figure 8 – Mortality rate from the big killers across deprivation quintile[13]

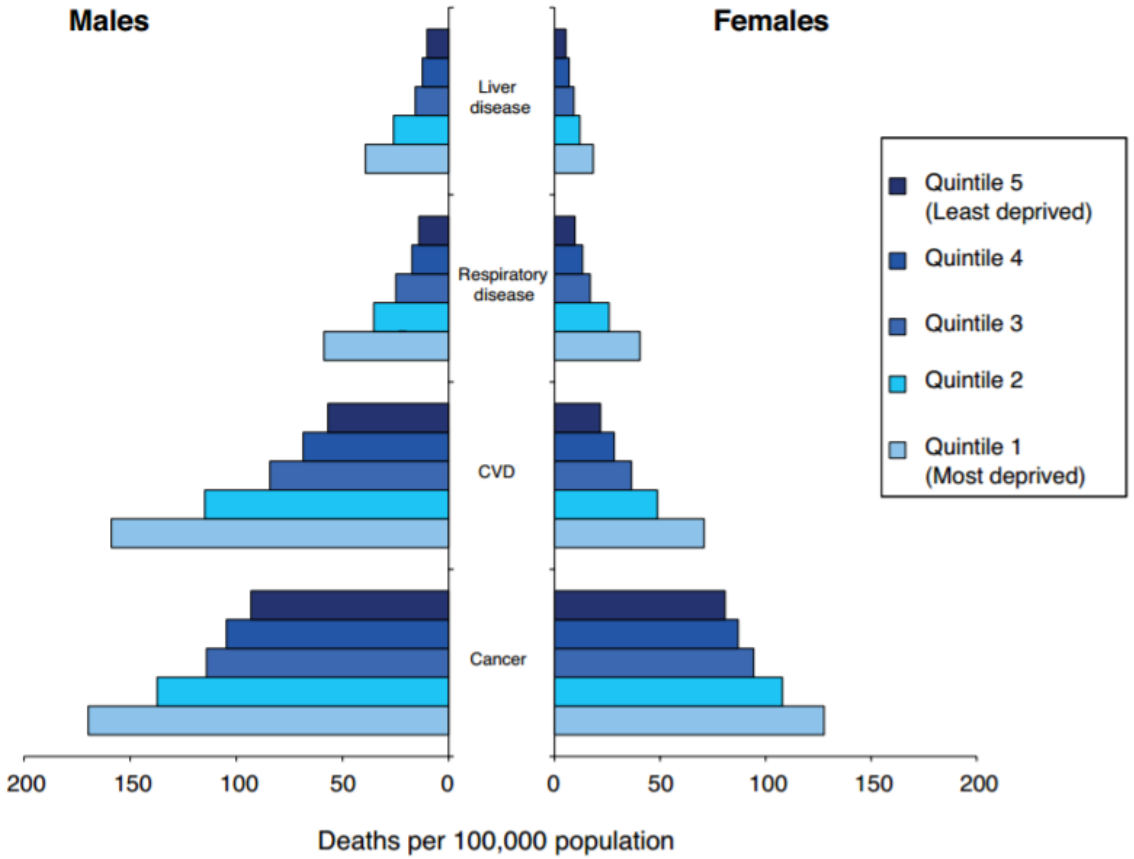
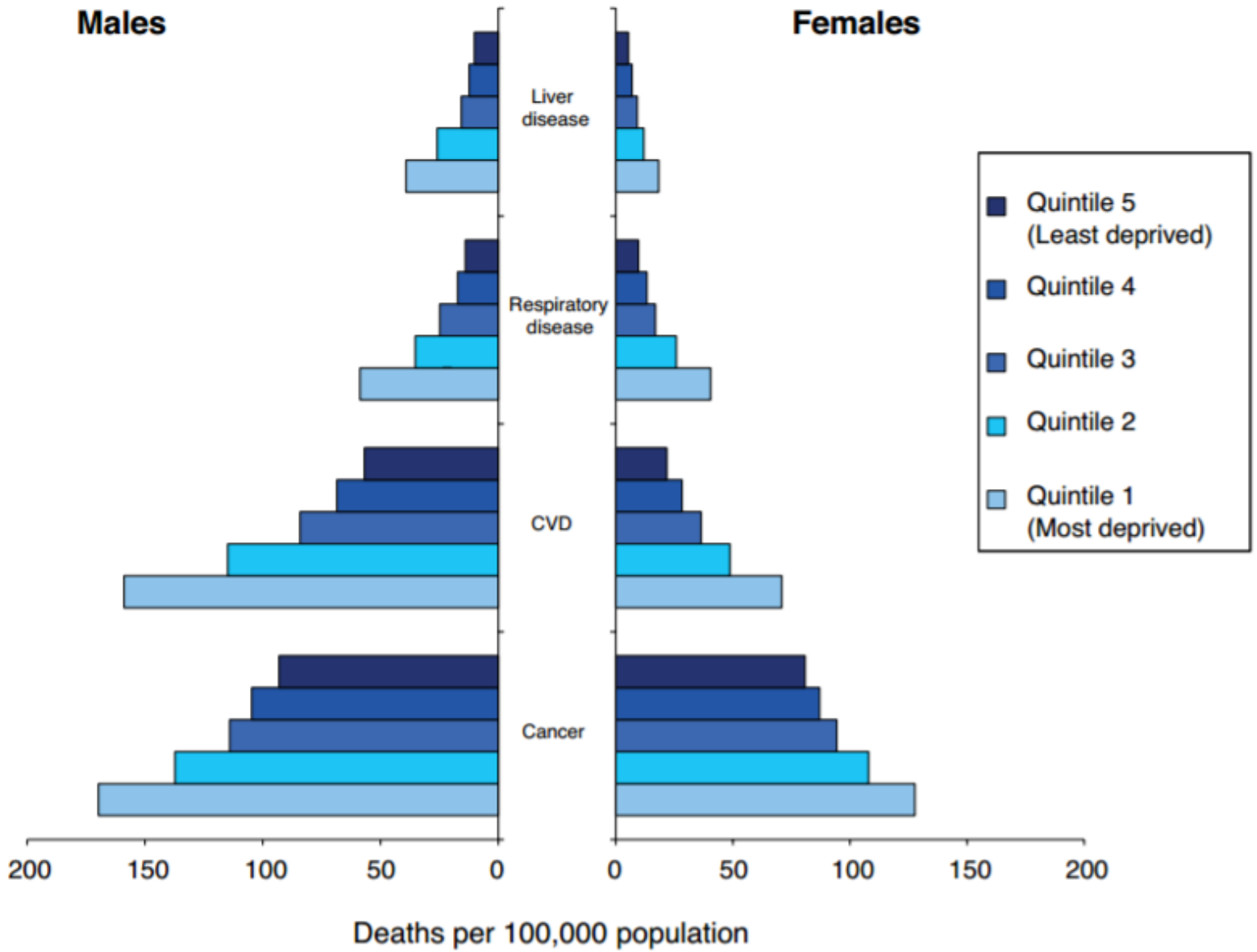


Figure 8 – Mortality rate from the big killers across deprivation quintile[13]



Inequality in healthcare distribution

"We have learnt from 15 years' experience of the Health Service that the higher income groups know how to make better use of the service; they tend to receive more specialist attention; occupy more of the beds in better equipped and staffed hospitals; receive more elective surgery; have better maternal care, and are more likely to get psychiatric help and psychotherapy than low-income groups particularly the unskilled.“

Richard Titmuss 1968

Inequality in healthcare distribution

The Lancet · Saturday 27 February 1971

THE INVERSE CARE LAW

JULIAN TUDOR HART
Glyncorrwg Health Centre, Port Talbot, Glamorgan, Wales

Summary The availability of good medical care tends to vary inversely with the need for it in the population served. This inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced. The market distribution of medical care is a primitive and historically outdated social form, and any return to it would further exaggerate the maldistribution of medical resources.

Interpreting the Evidence

THE existence of large social and geographical inequalities in mortality and morbidity in Britain is known, and not all of them are diminishing. Between 1934 and 1968, weighted mean standardised mortality from all causes in the Glamorgan and Monmouthshire valleys rose from 128% of England and Wales rates interpreted either as evidence of high morbidity among high users, or of disproportionate benefit drawn by them from the National Health Service. By piling up the valid evidence that poor people in Britain have higher consultation and referral rates at all levels of the N.H.S., and by denying that these reflect actual differences in morbidity, Rein [3,4] has tried to show that Titmuss's opinion is incorrect, and that there are no significant gradients in the quality or accessibility of medical care in the N.H.S. between social classes.

Class gradients in mortality are an obvious obstacle to this view. Of these Rein says:

"One conclusion reached . . . is that since the lower classes have higher death rates, then they must be both sicker or less likely to secure treatment than other classes . . . it is useful to examine selected diseases in which there is a clear mortality class gradient and then compare these rates with the proportion of patients in each class that consulted their physician for treatment of these diseases. . . ."

He cites figures to show that high death-rates may be associated with low consultation-rates for some

Inequality in healthcare distribution

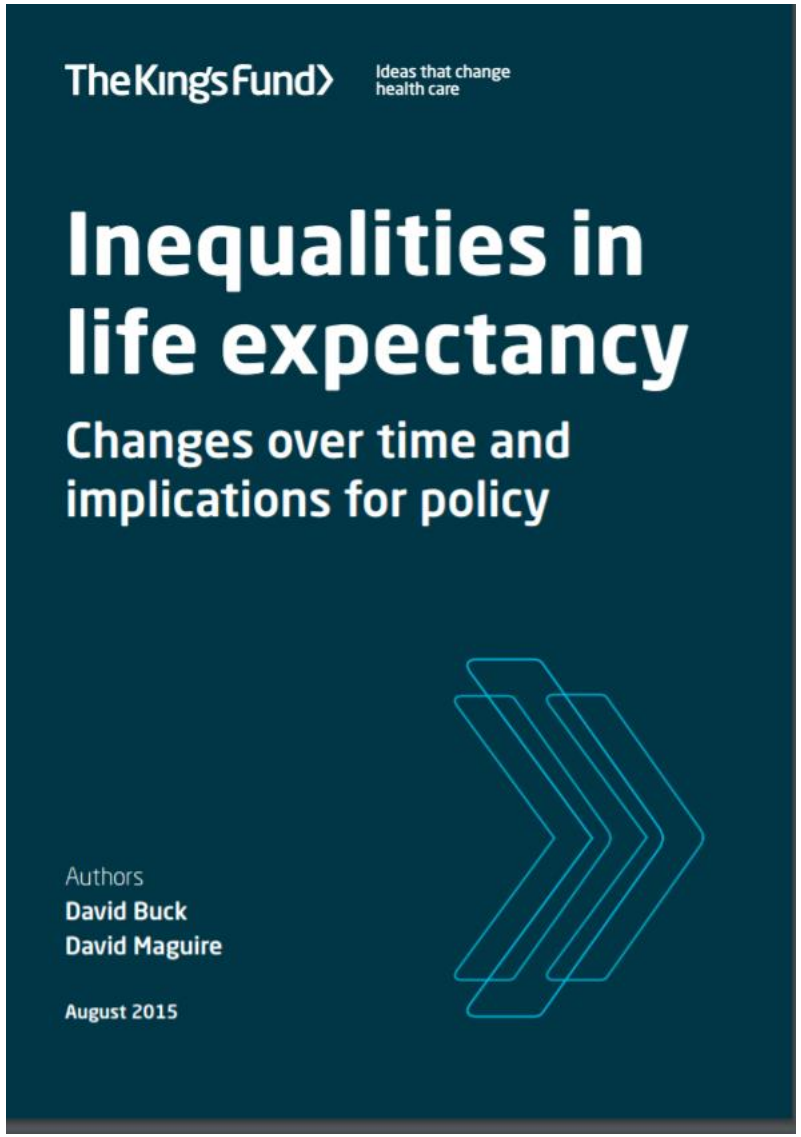
"The availability of good medical care tends to vary inversely with the need for it in the population served."

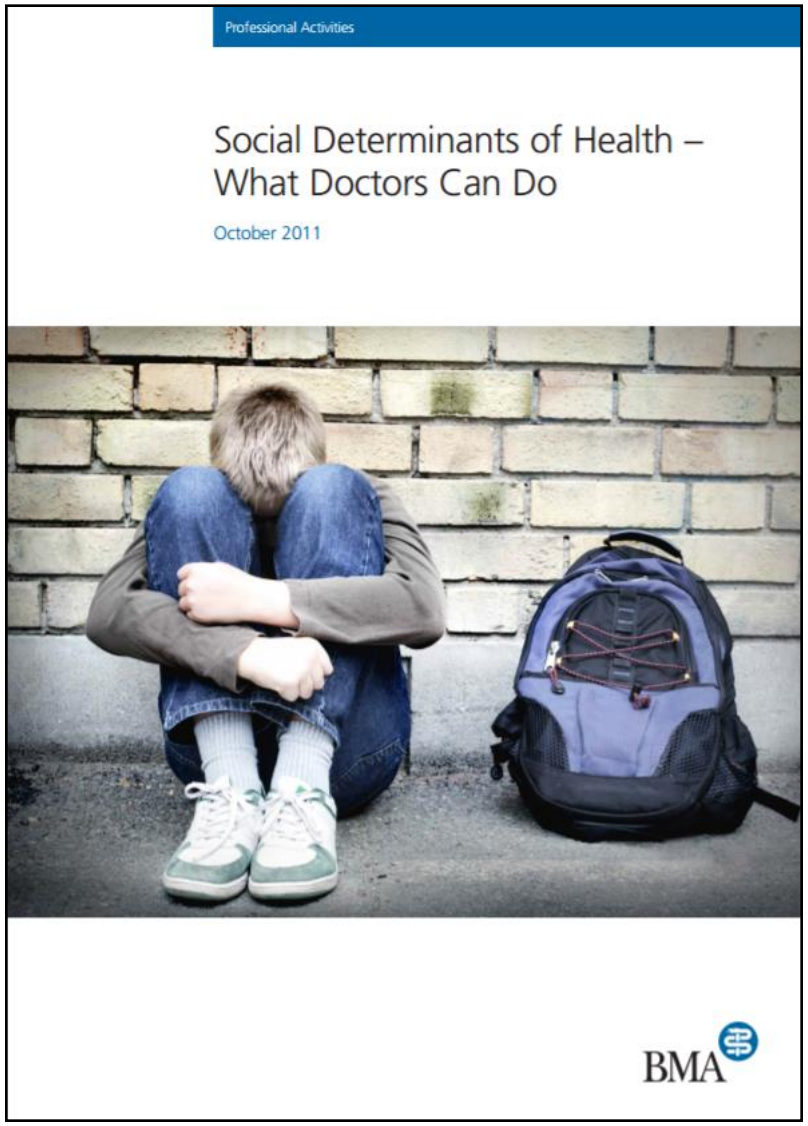
- Equity in access to health care has been a central objective of the NHS since its inception

Landmark studies

- The Black Report 1980
  - Confirmed health inequality by social class in overall mortality
  - Showed that these health inequalities were widening
- The Archeson Report 1988
  - Overall mortality decreased over last 50 years
  - However, inequalities between social classes had continued to widen
- Whitehall Study of British Civil Servants
  - Ongoing cohort study
  - Individual risk factors (weight, cholesterol, BP, smoking, etc) only accounted for up to 1/3 of the observed health inequality by employment grade

Key publications





Fair society, healthy lives (2010)

"In England, the many people who are currently dying prematurely each year as a result of health inequalities would otherwise have enjoyed, in total, between 1.3 and 2.5 million extra years of life."

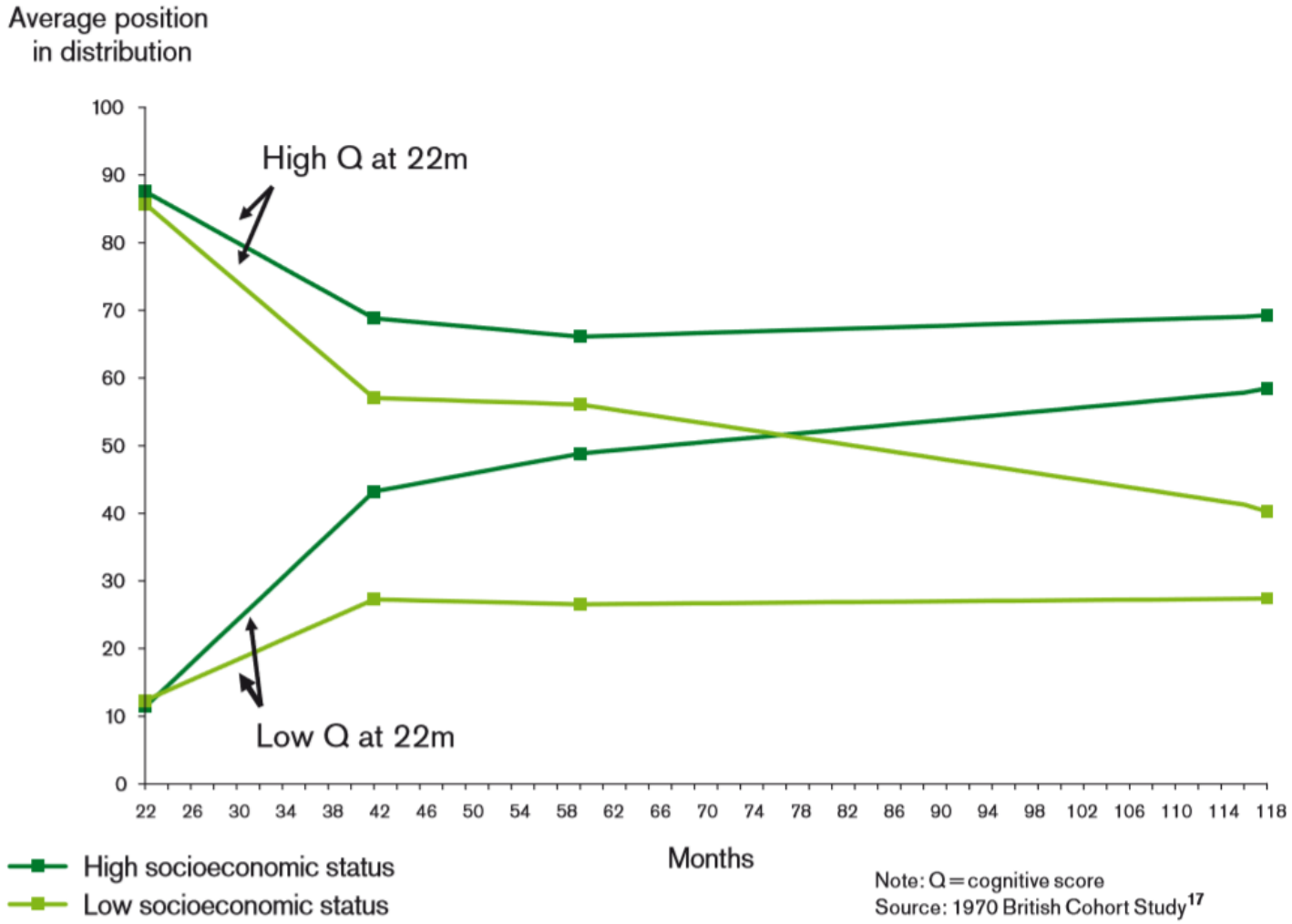
"In England, people living in the poorest neighbourhoods will, on average, die seven years younger than those living in the richest neighbourhoods. Even more disturbing, the average difference in disability free life expectancy is 17 years"

Fair society, healthy lives (2010)

- Why is health across the UK so unequal?
  - Health inequalities arise from a complex interaction of many factors - housing, income, education, social isolation, disability - all of which are strongly affected by one's economic and social status

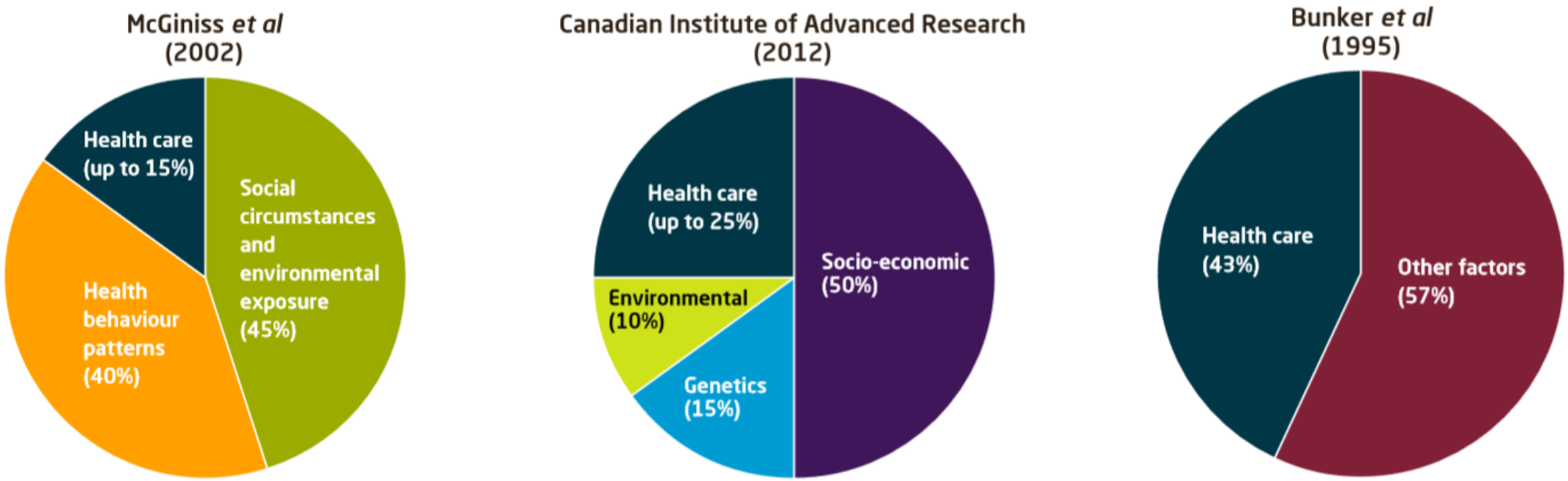
- Should we be concerned about the inequalities in health?
  - Health inequalities are largely preventable. Not only is there a strong social justice case for addressing health inequalities, there is also a pressing economic case. **It is estimated that the annual cost of health inequalities is between £36 billion to £40 billion through lost taxes, welfare payments and costs to the NHS**

The impact is cumulative so earlier intervention is more effective



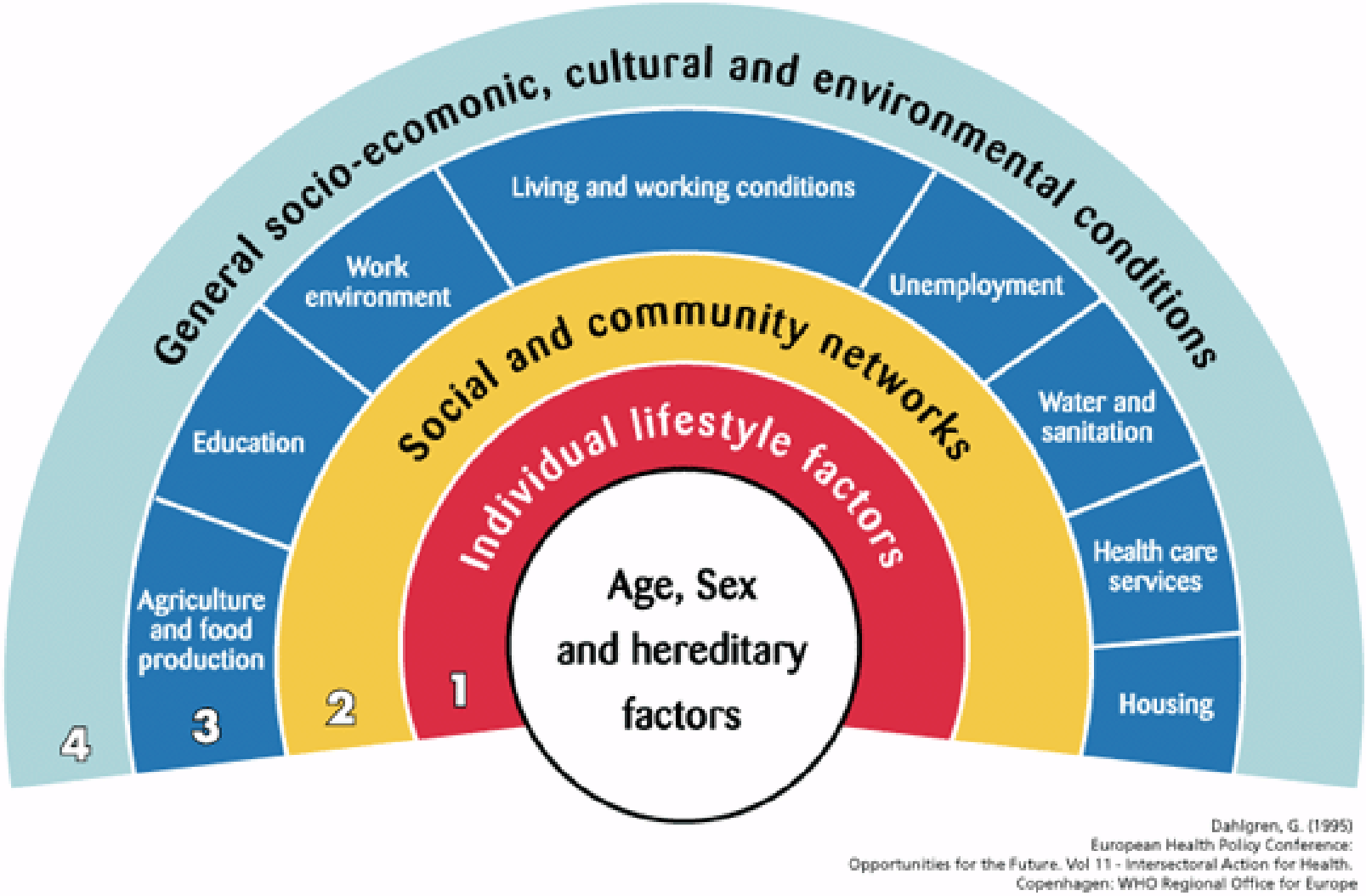
What determines the health of an individual?

Figure 1 Estimates of the relative contribution of factors to our health



Source: The Kings Fund 2013

Wider determinants of health



Dahlgren, G. (1995)
European Health Policy Conference:
Opportunities for the Future. Vol 11 - Intersectoral Action for Health.
Copenhagen: WHO Regional Office for Europe

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Final exercise

What interventions/actions can you think of that could change the course of this individuals health or their community's health?

- Within the consultation
- As a partner in a practice
- As a commissioner/part of a local CCG

Professional Activities

Social Determinants of Health – What Doctors Can Do

October 2011

BMA

Final exercise

What interventions/actions can you think of that could change the course of this individuals health or their community's health?

- Within the consultation
- As a partner in a practice
- As a commissioner/part of a local CCG