Section 2: The causes of preventable illness and health inequity

In recent years, there has been a trend towards more people in the UK getting more ill, physically and mentally, at an earlier age. Much of this is preventable and it is on top of the increased burden of ill health simply due to an ageing population.

Health inequalities, health equity and preventable illness

Health 'inqualities' are defined by the Office for Health Improvement and Disparities (OHID) as avoidable differences in health outcomes between groups or populations – such as differences in how long we live, or the age at which we get preventable diseases or health conditions. They reflect the distribution of preventable illness across the population; they are linked to the injustices experienced by different communities. There are big differences both in longevity and in years spent in good health across different communities of geography and identity in the UK.

Equity is defined by the World Health Organisation (WHO) as the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, geographically or by other dimensions of inequality (e.g. sex, gender, ethnicity, disability or sexual orientation). Health is a fundamental human right. Health equity is achieved when everyone can attain their full potential for health and well-being.[7]

Dominant narratives about the causes of health inequity/inequalities

The complex multi-factorial drivers of health inequity – that include causal and consequential factors – makes consensus around the causes hard to reach. What you see depends on the perspective you are looking from.

The Health Foundation's Evidence hub: What drives health inequalities? articulates the issue principally through the lenses of money, work, transport, housing, family, friends and communities. Rethink Mental Illness talks about serious mental illness (SMI). Some adopt a somewhat judgmental 'lifestyle and behaviours' explanation while Sir Michael Marmot identifies low social status within a social gradient and a lack of control over life events as being two key causes of stress which leads to life problems and then to ill health, both physical and mental. This variance, coupled with the NHS' to tendency to interpret the issue principally as inequality in access to healthcare, is partly why success in reducing health inequity has been modest at best.

Looking through the community lens to understand the causes of the causes

The Health Creation Alliance looks at this issue through the lens of the day-to-day experience of people and communities with the poorest health outcomes. We dig deep and really listen to the stories people tell us and a fairly consistent picture emerges; rather than divergence, we start to see coherence in the real drivers that lie behind the published evidence.

A common thread is a felt lack of control or influence due to an imbalance in, or abuse of, power that has an exclusionary and isolating effect on people. Research too has shown that lacking a sense of control and influence over our lives and immediate environments is a major cause of health inequity, damaging health and social behaviours and leading to costly management of chronic illness and community breakdown.[8] Social isolation negatively impacts health through psychosocial, physiological and behavioural processes and over time, results in psychological and physical disintegration.[9]

When this imbalance of power happens at an organised society level and results in policies or decisions that systematically disempower people, we call this 'social injustice'. It is often rooted in historical and cultural factors that create and maintain social divisions and hierarchies.

Familiar examples of injustices that reduce people's control over their lives include:

- **Injustices in the distribution of resources:** including resources for infrastructure projects, investment in economic development, provision of healthcare, such as lower numbers of GPs in poorer areas.

- **Poverty, a steep social gradient, unfair access** to health (not just healthcare), education and suitable housing, inadequate income to live on, chronic stress, challenges achieving potential or ambitions for the future.[10]

- **Structural discrimination:** such as systemic racism, sexism, classism, culturally insensitive and hostile environments in which stereotyping, stigmatisation, bullying and more nuanced or personal forms of discrimination are accepted causing damage to people and communities and resulting in unequal access to health and to healthcare.

- **Trauma in childhood or adulthood:** which can be experienced at a moment in time, or after a long period, and can be caused or exacerbated by poverty or discrimination or separately from them. Either way, it can lead to many of the same issues, for example poverty due to difficulty accessing and sustaining suitable employment.

Health implications of three types of social injustice based on geography, race, disability

Geography: People who live in 'left behind' neighbourhoods face discrimination due to not having received their fair share of available investment, sometimes over many decades. These places are largely concentrated in housing estates on the edges of post-industrial towns and cities and in coastal areas. While they often have a rich heritage and committed people with skills, they lack social infrastructure – services and facilities that enable people to live well, develop and prosper – compared to other areas. Their residents have markedly worse socio-economic outcomes than residents of other equally deprived areas. Recent work by Local Trust identified 225 such neighbourhoods concentrated in the North and Midlands and with pockets elsewhere.[11]

Race: Race discrimination is negatively associated with health outcomes including hypertension,[12,13,14] risky health behaviours,[15] poor mental health outcomes, such as psychological distress or depressive symptoms[16,17,18] and self-reported health.[19] The effects of racism on health operate directly, through stress pathways, and indirectly, through socio-economic inequalities.[20,21,22] Racist and classist ideologies activate biological processes that wear out the physical and mental health of people of colour across all economic classes, if to different degrees; a process called ´Weathering´ by Arline Geronimus.[23] Black people who have achieved a measure of socioeconomic security or upward mobility face unique assaults on their health. Fighting your way up the ladder adds stress and can shorten life.[24]

Disability: People with disabilities are often marginalised by not being given equal opportunities to participate in society. This frequently leads to social exclusion and limits access to education, employment, and healthcare, all fundamental to leading a fulfilling life. The psychological effects of discrimination can also be significant, leading to feelings of worthlessness, reduced self-esteem, and isolation and the societal perception that individuals with disabilities are less capable can create barriers that prevent them from achieving their potential. All this can result in 'entrenched invisibility', where disabled people's needs and voices are overlooked in policy-making and social discourse perpetuating a cycle of neglect and inadequate support and exacerbating the challenges they face.

People are not getting access to their human social rights

Everyone in the UK has economic and social legal rights enshrined in the European Convention on Human Rights (ECHR), the European Social Charter (ESC) and the Human Rights Act. This includes *'the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable'* as well as *'the right to protection against poverty and social exclusion'* and *'the right to housing'* among others.

The word 'rights' quite often conjures up ideas of protest, antagonistic debate and judicial process. But it doesn't have to be that way. It is both possible and desirable to find a purposeful path to giving more people access to their right to the best possible health.

"Everyone (in the UK) has the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable."

European Social Charter,
Part 1 (11) to which UK is a signatory

"Every human being has the right to the highest possible attainable standards of physical and mental health. Countries have a legal obligation to develop and implement legislation and policies that guarantee universal access to quality health services and address the root causes of health disparities, including poverty, stigma and discrimination."

World Health Organization

EXAMPLE: Children accessing the best possible health attainable, through dance leadership

Example from a THCA member

TR14ers Community Dance Charity Limited gives disadvantaged children the space to calm their anxieties, do something they love and have the confidence to be ambitious.

Founded in 2005, free weekly dance workshops mean there are no barriers to access for children in the highly disadvantaged town of Camborne, Cornwall. Connecting with others in a shared interest helped build their confidence and it was also a factor in them becoming stakeholders and assuming ownership of the organisation. Taking control in this way means they are starting to access their human social right to the best possible health.

Jess left us in 2016 to improve her dance skills and appeared on The Brits 2019 dancing on Stormzy's set. The children spoke with the Trustees (who are appointed from age 16) explaining that they wanted the same opportunities as Jess without leaving the TR14ers. Trustees' response was to offer intermediate and advanced dance lessons at a nearby dance school, Studio4Dance C.I.C founded by a former TR14er. We saw an immediate improvement in the children's dance skills, which they brought back to the charity and shared with younger members.

In 2019 a group of young people presented the findings from research by the University of Exeter Medical School at the European Youth Centre in the Council of Europe in Strasbourg; they show that the physical and emotional health of the children at TR14ers is above the national average and way above what would be expected in a town as deprived as Camborne.

These children are accessing their human social right to the best possible health through developing as leaders doing something they love. It created opportunities for the children to compete and win at a national dance competition in 2023, perform at Move It Excel London 2024, the biggest dance show in the world, and to work with professional dancers from the West End. Very high-profile dance teachers now visit us.

The health and Social Care system is not set up for prevention or to address the causes of the causes

A focus on healthcare rather than on health

There is an over-focus on treatment-based healthcare (that accounts for only around 20% of our health outcomes) compared with relationships and the social processes that can enhance health and wellbeing. Resources available for treatments to meet the growing burden of preventable illness are hugely insufficient; yet very little of what goes on in the NHS (and even public health), is geared to dealing with the conditions that make people sick.

Some system processes are adopted with insufficient challenge or assessment as to whether they positively contribute to population health before they become inextricably embedded. For example, increasing numbers of GP surgeries have now adopted total triage, whereby appointments are offered according to information that the patient submits within a template, by email or text. The impact of this change on health inequality has not been assessed, despite a known link between poverty and digital exclusion, yet it is nevertheless becoming normal practice.

The idea of 'proportionate universalism' – where actions or interventions are implemented with a scale and intensity proportionate to need – is starting to be recognised as important. But on its own it is not sufficient. Delivering the same service at a higher level of intensity is not always what is required; in some instances, a whole different service is required, delivered differently with communities as equal partners. This is what a commitment to Health Creation can achieve.

Social Care: a deficit-model, rather than asset-based model[25]

The core purpose of adult care and support is to help people to achieve the outcomes that matter to them in their life.[26] While there are individuals and organisation care providers that adopt this 'asset-based' approach, seeing people as capable and creating the conditions for them to achieve things that matter to them is not most people's experience.

Social Care is driven by a deficit paradigm based on a combination of a medical model of treating and fixing 'vulnerable people', a charity model of rescuing and looking after people and a welfare model of providing a safety net. Social Care has become largely a process of managing demand from 'service users' with an infrastructure that includes eligibility criteria, assessments, review and performance management that reflects this. The purposes of social workers have become to gatekeep, judge, prescribe. The Care Act 2014 has failed to bring about the necessary reforms, leaving many without the help they need; individuals with disabilities and unpaid carers continue to struggle, with the latter often facing the question "When is the help coming?"

This is dehumanising, both to the people who Social Care is for and to the people working in Social Care. The original purpose has become opaque at best. Without significant changes and a commitment to reform, the risks of maintaining the status quo are high, and the well-being of a vulnerable segment of the population remains at stake.

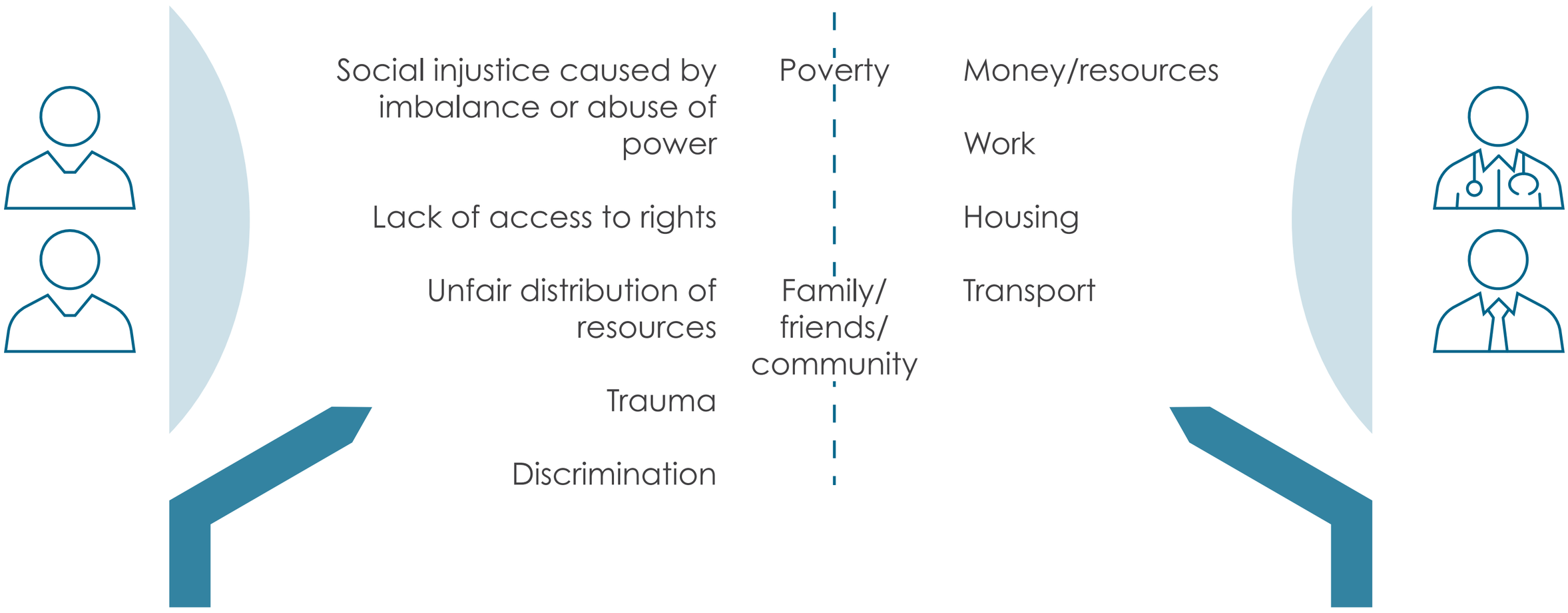
Insufficient focus on clinical and 'wider determinants' prevention

Prevention is usually interpreted as 'clinical prevention' in which conditions are diagnosed early and worsening attenuated. Screening, vaccination and better self-management of long-term conditions are a critical part of disease management.

Prevention of illness where the causes lie in the wider determinants of health is not currently systematically addressed. This of course, requires strategic-level relationships between Healthcare Professionals and other parts of the statutory and voluntary sector such as housing, Citizens Advice, police and many local agencies to redesign pathways and services so that issues can be addressed at a higher level than the case-by-case basis that social prescribing offers.

'Health inequalities' continues to be understood by many as an activity or programme that can be run alongside the NHS's main priority of treating illness. The small budget of £200m overall recently devolved to ICBs to address health inequalities was equivalent to around 0.25% of the entire health budget. These tiny sums will hardly scratch the surface of the dual problem of increasing health inequity – in some places over 50% of the population are in the Core20 or lower quintile of the Index of Multiple Deprivation (IMD) – and decreasing sustainability of the NHS and Social Care system. In a recent NHS Confederation report and accompanying blog,[27] Prof Mark Gamsu makes the case for ICBs to take a strategic system level approach to address health inequalities so that the entire NHS budget is stress tested to take account of its impact on reducing inequality.

What causes health inequity?



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