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Health inequalities and social deprivation

What are health inequalities?[1]

Health inequalities are avoidable, unfair and systematic differences in health between different groups of people. There are multiple factors which influence health and well-being, including social, cultural, political, economic and environmental factors. Inequality in access to education, employment and income all contribute to health inequalities.

In England, health inequalities are often analysed and addressed across four factors:

- Social deprivation, including income.
- Geography - eg, region or whether urban or rural.
- Specific characteristics, such as gender, ethnicity or disability.
- Socially excluded groups - eg, people experiencing homelessness.

Inequalities in health related to social deprivation include:

- Adverse effects on many aspects of health, including life expectancy, healthy life expectancy, infant mortality, cancer and chronic disease outcomes, and pregnancy complications.
- Worse rates of adverse health factors such as smoking, obesity, poor diet, and drug misuse.
- Reduced access to care.

See also the articles on Different Ethnic Groups and Health Outcomes and Diseases and Different Ethnic Groups.

What is social class?

'Social class' has long been used to define a group of people within a society who possess the same socio-economic status. However the use of the word 'class' conceals the multifactorial nature of social deprivation and inequality, as well as the increasing diversity of society.

Social deprivation may be the outcome of a combination of many different factors such as ethnicity, unemployment, poor education and skills, low incomes, poor housing, social exclusion, crime and family breakdown.

Historically, social class has been defined by simplified categories such as:

- **Working class**: often low levels of educational achievement. The classic, traditional working class jobs include heavy labouring and factory-based work.
- **Middle class**: often higher levels of educational achievement. Classic middle class jobs include everything from doctors and lawyers to clerical workers.
- **Upper class**: the elite class that controls the majority of wealth and power in society.

Alternatively class has been defined by occupation:

1. Professional and managerial - eg, accountant, doctor.
2. Intermediate - eg, teacher, farmer.
3. Skilled occupations: non-manual (eg, police officer, sales representative), or manual (eg, electrician, bus driver).
4. Semi-skilled manual - eg, farm worker, postal worker.
5. Unskilled manual - eg, labourer, cleaner.

Manual and non-manual occupations have been considered as:

- **Manual occupations**: involve more physical effort. Also known as blue collar occupations and seen as working class.

- **Non-manual occupations**: involve more mental effort, such as professions and office work. Also known as white collar occupations and are seen as middle class.

Measurements of health inequality

The relative index of inequality and the slope index of inequality are now the two major indices used in epidemiological studies for the measurement of socio-economic inequalities in health[2] [3] :

- **Relative index of inequality**: a measure of the social gradient in an indicator and shows how much the indicator varies with deprivation. It takes account of inequalities across the whole range of deprivation and summarises this into a single number.
- **Slope index of inequality**: represents the absolute difference in the indicator across the social gradient from most to least deprived. It assumes a linear relationship between the indicator and deprivation.

The index of multiple deprivation is the official measure of relative deprivation in England and is based on a set of factors that includes income, employment, education and local levels of crime[4] .

Life expectancy[5]

Life expectancy is closely related to people's socio-economic circumstances. In England, there is a relationship between social deprivation and life expectancy, which is known as the social gradient in health.

- In 2021, the gap in male life expectancy between the most and least deprived areas in England was 10.3 years in 2020, 1 year larger than in 2019.
- For females, the gap was 8.3 years in 2020, 0.6 years larger than in 2019.

This demonstrates that the pandemic has exacerbated existing inequalities in life expectancy by social deprivation. COVID-19 was the cause of death that contributed most to the gap in 2020. However, higher mortality from heart disease, lung cancer, and chronic lower respiratory diseases in deprived areas remained important contributors.

Healthy life expectancy[6]

Another key measure of health inequality is how much time people spend in good health over the course of their lives. Two important measures of the amount of time that people spend in good health are:

- **Healthy life expectancy**: estimates time spent in 'good' or 'very good' health, based on how people perceive their general health.
- **Disability-free life expectancy**: estimates, again based on self-reported assessment, time spent without conditions or illnesses that limit people's ability to carry out day-to-day activities.

Inequalities in both healthy life expectancy and disability-free life expectancy are even wider than inequalities in life expectancy. People in more deprived areas spend, on average, a far greater part of their lives in poor health.

- Healthy life expectancy at birth among males living in the most deprived areas was 52.3 years in 2017 to 2019, compared with 70.7 years among those living in the least deprived areas.
- Only males living in the more advantaged areas in England were expected to live more than 65 years of their life in good health.
- Those living in the more disadvantaged areas were expected to live fewer than 60 years in good health.

In 2017 to 2019, females living in the more advantaged areas were expected to live more than 65 years in good health, while those living in the most deprived areas were expected to live fewer than 60 years in good health.

For females, the years spent in poorer health states were clearly linked to the level of exposure to area deprivation, falling from 27.3 years among females living in the most deprived areas to 15.3 years among the least deprived areas.

The Office for National Statistics analyses deaths that could be averted or delayed through timely, effective healthcare ('amenable mortality') or wider public health interventions ('preventable mortality'):

- In 2017, almost one in four deaths were considered avoidable. Cancers were the leading cause, followed by cardiovascular diseases, injuries, respiratory diseases and drug misuse.
- In England, in 2017, males in the most deprived areas were 4.5 times more likely to die from an avoidable cause than males in the least deprived areas.
- Females in the most deprived areas were 3.9 times more likely to die from an avoidable cause than those in the least deprived areas.

Long-term health conditions

Long-term conditions are one of the major causes of poor quality of life in England. In addition to their direct impact on health status, long-term conditions also have an indirect impact on health because of the importance of being in good-quality work for physical and mental health.

People in lower socio-economic groups are more likely to have long-term health conditions, and these conditions tend to be more severe than those experienced by people in higher socio-economic groups.

Social deprivation also increases the likelihood of having more than one long-term condition at the same time, and on average people in the most deprived fifth of the population develop multiple long-term conditions 10 years earlier than those in the least deprived fifth.

Mental ill health

Assessing differences in the prevalence of mental illness between social groups is complex because rates of recognition, reporting and diagnosis are likely to vary between groups.

Several socially excluded groups have been shown to experience higher rates of mental ill health than the general population. More than 80% of people experiencing homelessness report having a mental health difficulty, and people in this group are 14 times more likely than those in the general population to die by suicide. Asylum seekers and refugees are also at increased risk of experiencing depression, PTSD and other anxiety disorders.

See also the article on Poverty and Mental Health.

Addressing health inequalities[1]

Tackling health inequalities is complex and challenging, but achievable. The wider determinants of health are the social, economic and environmental conditions in which people live that have an impact on health. These include income, education, access to green space and healthy food, the work people do and the homes they live in. Inequalities in these factors are a fundamental cause of health inequalities.

Addressing these wider socio-economic inequalities is therefore essential for reducing health inequalities.

Interventions to tackle health inequalities need to reflect the complexity of how health inequalities are created and perpetuated. Otherwise they could be ineffective or even counterproductive. For example, efforts to tackle inequalities of health status associated with behavioural risks (such as poor diets) should address the wider network of factors that influence these behaviours (such as access to affordable healthy food, marketing and advertising regulations) and the impact that these behaviours have on health outcomes (such as access to clinical services).

Core20PLUS5[7]

Core20PLUS5 is a national NHS England and NHS Improvement approach to support the reduction of health inequalities. The identifies '5' focus clinical areas requiring accelerated improvement:

- **Maternity**: ensuring continuity of care for 75% of women from Black, Asian and minority ethnic communities and from the most deprived groups.
- **Severe mental illness**: ensuring annual health checks for 60% of those living with severe mental illness.
- **Chronic respiratory disease**: a clear focus on chronic obstructive pulmonary disease, seeking to increase uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.
- **Early cancer diagnosis**: 75% of cases diagnosed at stage 1 or 2 by 2028.

- **Hypertension case-finding**: to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.

The target groups include ethnic minority communities, coastal communities, people with multi-morbidities, protected characteristic groups, people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery, and other socially excluded groups.

Behavioural change [1]

People's behaviour is a major factor for health. In addition to the need for funding at both national and local government level, there is a need for education and behavioural change as there are differences in the likelihood of engaging in healthy or unhealthy behaviours.

Health-related behaviours are shaped by cultural, social and material circumstances. Interventions and services aimed at helping to change behaviours need to be able to adapt to the reality of people's lives, address the wider circumstances in which behaviours take place, and recognise the difficulty of achieving and maintaining behavioural change under conditions of stress.

The Public Health England Strategy for 2020 to 2025 identifies smoking, poor diet, physical inactivity and high alcohol consumption as the four principal behavioural risks to people's health in England today [8] . The distribution of these behaviours correlates with levels of deprivation, income, gender and ethnicity, with risks concentrated in the most disadvantaged groups. For example, 28% of the most deprived fifth of the population are smokers, compared to 10% in the least deprived fifth.

Risky health behaviours also tend to cluster together in certain population groups, with individuals in disadvantaged groups more likely to engage in more than one risky behaviour. The prevalence of multiple risky behaviours varies significantly by deprivation. In 2017, the proportion of adults with three or more behavioural risk factors was 27% in the most deprived fifth, compared with 14% in the least deprived fifth.

Evidence suggests that some people's circumstances make it harder for them to move away from unhealthy behaviours, particularly if they are worse off in terms of a range of wider socio-economic factors such as debt, housing or poverty. This is compounded by differences in the environments in which people live. For example, deprived areas have, on average, nine times less access to green space, higher concentrations of fast food outlets, and more limited availability of affordable healthy food. Recent estimates suggest that, after housing costs, households in the bottom fifth of income distribution may need to spend 42% of their remaining income on food in order to follow Public Health England's recommended diet.

Further reading

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