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for Nursing Associates

LM Learning Matters

Chapter 3

Understanding health inequalities

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NMC STANDARDS OF PROFICIENCY FOR NURSING ASSOCIATES

This chapter will address the following platforms and proficiencies:

Platform 2 Promoting health and preventing ill health

2.4 understand the factors that may lead to inequalities in health outcomes
2.6 understand and explain the contribution of social influences, health literacy, individual circumstances, behaviours, and lifestyle choices to mental, physical, and behavioural health outcomes.

Chapter aims

After reading this chapter you will be able to:

1. understand the factors that lead to health inequalities;
2. examine how inequalities are measured and reported within society;
3. identify and discuss how unequal differences within society can influence the health and wellbeing of individuals;
4. use the above knowledge to explain how inequality affects communities and populations.

Introduction

Why is there such a difference in life expectancy between people living just a few miles apart? For instance, people born in the London areas of Knightsbridge and Belgravia have a life expectancy of 93 years, but a few stops on the tube to Hammersmith and life expectancy drops to 79 years (life.mappinglondon.co.uk, 2021). In 2008, the London Health Observatory showed

that if travelling east on the tube from Westminster, every two tube stops represented more than a year of life expectancy lost. These startling facts capture how health equalities can vary within small geographical areas. The differing dates of these studies also show that health inequalities persist in areas of deprivation. We will explore rural and urban deprivation further in the chapter.

Health inequalities are often defined as the unfair and avoidable differences in health across the population and between different groups in society. It is also suggested that health inequalities arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health, and how we think, feel and act and this shapes our mental health, physical health and wellbeing (NHS, 2020).

The broad social and economic circumstances which together influence the quality of the health of the population are known as the 'social determinants of health', which we were introduced to in Chapter 1. Work by Williams et al. (2020) highlights that the social determinants of health are often outside an individual's control. People living in the United Kingdom often experience systematic, unfair and avoidable differences in their health and the care they receive. All of which impacts upon their ability to live a healthy life across the lifespan. This chapter will discuss health inequalities, how health inequality is measured and the impact of inequality on marginalised groups. You are also asked to use your knowledge to undertake activities that reflect real life scenarios to check your understanding.

Understanding health inequalities

Within the context of healthcare, the term 'health inequalities' is often used to refer to differences that arise from socio-economic factors. These include income, work, housing and residence (other types of living accommodation, such as caravans and boats) with the inference that some people from a lower socio-economic group may deliberately choose more unhealthy ways of living (Naidoo and Wills, 2016). There are multiple interrelated causes of health inequalities, and, while the ability to access traditional health and care services play an important part in determining the health of a population, work by Marmot et al. (2010, 2020) and the WHO (2018a) suggests that access to traditional healthcare is not as important as the wider determinants. These would include the local environment, in addition to the conditions in which people are born, live and work.

Over the past few decades there have been a series of publications that have emphasised health inequalities and have made recommendations to support health and social care practitioners to manage the health of the population. These recommendations acknowledge the work of the NHS in the delivery of traditional healthcare services. In addition, the work emphasises that there should also be a co-ordinated delivery of a range of interventions, which are designed to tackle the underlying social, economic and environmental determinants across populations.

In 1977, the Labour government commissioned a report to investigate why there had been no reduction in the inequalities in health being experienced in society. In August 1980, the findings of the Inequalities in Health working group chaired by Sir Douglas Black, president of the Royal College of Physicians were published by the Department of Health and Social Security. This report provided detail to the extent of which ill health and death were unequally distributed among the population of the United Kingdom. The main findings made clear links between those living with unemployment, low income, poor education and substandard housing, and their health outcomes. Having concluded that these inequalities had been widening rather than diminishing since the establishment of the National Health Service in 1948, the report offered

37 recommendations which focused upon two main areas. The report recommended that the government should have policies aimed at reducing poverty and should increase spending on health education and prevention of illness.

By the time of its publication, the Labour government was no longer in power, having lost the general election to Margaret Thatcher's Conservative government in 1979. The Black Report was criticised and supressed (it was never printed) at the time. The Conservative government took no immediate actions to tackle the identified inequalities as suggested. This was due to a projected £2 billion cost of implementing the recommended health goals, tax changes and benefit increases.

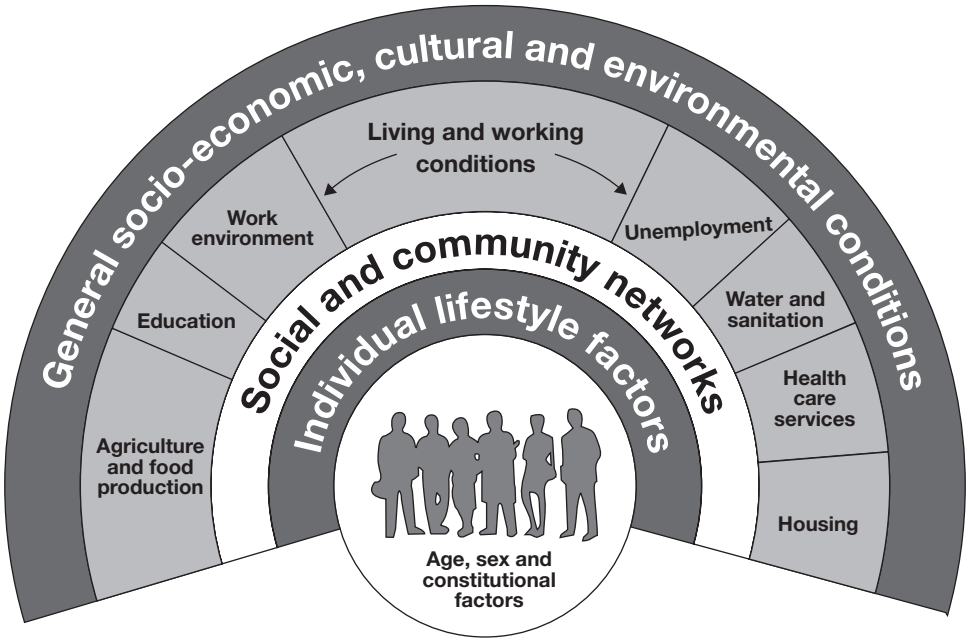

Figure 3.1 The determinants of health © WHO

The Health Divide Report (1987) was commissioned and produced by a group of professionals working independently to the government and led by Margaret Whitehead. The findings of the Health Divide Report concluded that the gap between health standards and social class had widened since the Black Report (1980). The Whitehead Report restated there was a direct link between health standards and social class. The Health Education Council campaigned on modifiable behaviours that are linked to health inequality such as alcohol, tobacco and food products. Unfortunately, the Conservative government dissolved the Health Education Council before it could formally publish its findings. The Acheson Enquiry (1988) also identified key areas of concern between social class and mortality rates. Margaret Whitehead and Göran Dahlgren produced the rainbow of inequalities in 1991 (see Figure 3.1), called the determinants of health, which maps the relationship between the individual, their environment and health. These reports collaboratively identified the causes of health inequalities as social, economic, cultural and political, thus actions to tackle these should also involve actions that take into account the social, economic, cultural and political factors.

Case study 3.1: George

George is aged 67 years old, and lives in Northeast England with his wife Sarah. George and Sarah have been married for 45 years and have two children. George worked in the shipbuilding industry for approximately 35 years until he was made redundant at the age of 52. George went on to have a series of temporary positions with other employers. Redundancy has had a huge impact upon his life and George has struggled for many years with his mental health.

In his early 60s, George developed Type 2 diabetes, this is currently managed with oral medications. Recently, George has been finding it increasingly difficult to manage his blood glucose levels. He walks with a walking stick and has known mobility issues due to his arthritic knees and spine.

George has been attending his GP surgery for his regular diabetes review and is noted to be significantly overweight. Blood tests have revealed he has raised cholesterol levels. George's GP has given him another medication to take, but it makes George feels nauseous and he does not take it.

Activity 3.1 now asks you to consider George's case study and some of the possible underlying medical and social reasons for his health problems.

Activity 3.1 Critical thinking

Using the case study, identify the health needs currently being experienced by George. Once you have identified these, can you make links to health determinants shown in Dahlgren and Whitehead's rainbow map that impact upon George's ability to live a healthy life.

An outline answer is given at the end of this chapter.

Thinking about George and his life over the last 40 years, there have been many significant changes in society. In the 1970s and 1980s, work was mainly heavy industry, mining, ship building, steelmaking, car manufacturing and factory production work. Although the hours were long, the work was secure and paid a reasonable wage. Usually, earnings were enough to buy a house, especially if someone was living in council accommodation and had the right to buy. House prices have risen exponentially, and home ownership is beyond the reach of many, leaving individuals and families at risk of high rent, poor-quality accommodation and the fear of eviction.

The report 'Tackling Health Inequalities' (2009) acknowledged that although the health of the worst off in England had improved since the 1988 Acheson Enquiry, the gap between the average and the worst off has not narrowed. The data presented showed persistent inequalities in income, educational achievement, literacy, child poverty, crime and unemployment. Even with some political commitment to improvement across these areas, it is clear that inequalities are deep-seated structures within society.

The Marmot Review (2010) went onto raise the profile of the wider determinants of health by emphasising the strong and persistent link between social inequalities and disparities in health outcomes. This review outlined a range of policy recommendations, some of which have been adapted and used as indicators of social determinants of health, health outcomes and social inequality.

These are the six priority objectives listed in the 2010 Marmot Review are:

1. *Give every child the best start in life.*
2. *Enable all children, young people and adults to maximise their capabilities and have control over their lives.*
3. *Create fair employment and good work for all.*
4. *Ensure a healthy standard of living for all.*
5. *Create and develop healthy and sustainable places and communities.*
6. *Strengthen the role and impact of ill health prevention.*

Many studies describe how it is not just access to healthcare provision that influences the health of individuals. They conclude that the social and economic factors often have a more significant impact on the health of the individuals, communities and populations. There have been repeated calls following the publication of the Marmot Review (2010) that government should tackle these issues as a matter of priority. To successfully address persistent health inequalities across society would require the political will to embark upon one of the most comprehensive and multifaceted programmes to tackle the underlying social determinants of health. In 2010, the Labour government did agree to make tackling health, social and educational inequalities a priority, and set a series of public health service agreement targets. However, with the change in government in May 2010 to the Conservative–Liberal Democrat coalition, this approach came to an end. The introduction of significant austerity measures, intended to reduce the national deficit, meant substantial cuts to funding for local authorities, reductions to the NHS budget (the Nicholson challenge) and the education sector, in addition to various restrictions being placed upon the welfare system.

Measuring inequalities

Although NHS England acknowledge the need for meaningful data as essential to providing the evidence base for effective healthcare delivery, there is also a need consider any implications of inequality.

Public Health inequalities are measured in different ways, however, the main broad measure of inequality is life expectancy. This is the difference in life expectancy between the most and least deprived areas of the UK. We looked at this at the beginning of the chapter using the London underground tube stations. Data findings published in 2020, show that the gap in life expectancy is widening, with average life expectancy for males and females living in the most deprived areas being 73.9 and 78.6 years, respectively. Whereas in the least deprived areas, the life expectancy for males is 83.4 years and for females it is 86.3 years. This most recent published data shows that the male life expectancy is less in more deprived areas, with males in the least deprived areas living on average 9.5 years longer (Gov.UK, 2020). According to the King's Fund, from 2011, increases in life expectancy slowed after decades of steady improvement, prompting much debate about the causes. The data published does not account for the mortality rates occurring due to the Covid-19 pandemic (Raleigh, 2021).

It has been noticeable that Covid-19 has affected lower socio-economic status people much more than white-collar workers. Many people employed in office-based jobs were furloughed and paid 80 per cent of their salary, or they could work from home. Service sector workers such as those working in social care, security, food production lines and retail were people who could not afford to self-isolate.

Despite the inequality in life expectancy being notably variable across the UK, the data still indicates that people living in more affluent areas are living longer than those in more deprived areas. Research work led by the King's Fund (2015) acknowledges that although the data is clear, we need to also consider the quality of life being experienced by those who may be living longer.

Williams et al. (2020) note that inequalities are ultimately about the differences in the care that people receive, and the opportunities they have had to live a healthy life across the life course. Between 2011 and 2019, those living in the most deprived areas are reported to spend nearly a third of their lives in poor health, compared to those living in least deprived who spend only a sixth, hence, not only do those living in deprived areas have the shortest lifespans, they also live more years in poor health (Raleigh, 2021).

Some populations have a shorter life expectancy than the general population. Research data shows that males with learning disabilities have shorter lives by 23 years (HQIP, 2019). Those in society affected by homelessness are also at significant risk with the average age of homeless males and females living 30 and 38 fewer years respectively than males and females in the general population (ONS, 2019b).

There are many deaths that are avoidable. These fall into two categories:

1. Preventable mortality: these deaths can be avoided through effective public health and **primary prevention** interventions.
2. Treatable mortality: these deaths would be avoidable through timely and effective healthcare interventions.

This is something that is also discussed in the work of the WHO (2013, 2018b), within their reports relating to the largely preventable non-communicable diseases, such as cancers, diabetes mellitus, chronic respiratory diseases and cardiovascular disease. All of these are causally linked to health inequalities. The Office for National Statistics (2020) report that in 2019, 80 per cent of all avoidable deaths fell into four main groups: cancers, respiratory diseases, circulatory diseases and substance misuse (drugs and alcohol). Cardiovascular, respiratory disease and lung cancer are reported as the main causes of death in those living in the most deprived areas of England (Gov.UK, 2020).

The Marmot Review update 'Health Equity in England: 10 Years On' (2020) found that improvements to life expectancy have stalled and have actually declined for the poorest 10 per cent of women. The review also found that there is a strong regional variation. The poorest in the northeast of England are worse off than the poorest in London. Marmot further states that 'Over the past decade there has been a significant shift in expenditure across government, moving from spending on the services and infrastructure that help people stay healthy, towards addressing problems that could be avoided in the first place' (healthfoundation.org, 2020).

Health literacy

Health literacy is defined by the World Health Organization as a 'The personal characteristics and social resources needed for individuals and communities to access, understand, appraise and use information and services to make decisions about health' (WHO, 2021c). Recent research by Public Health England tells us that between 43 per cent and 61 per cent of English working-age adults routinely do not understand health information. In the UK, 1.7 million adults read and write at or below the level of a nine-year-old and, critically, 43 per cent of adults do not understand written health information. Jonathan Berry (2016) gave examples that included a lady who thought her 'positive' cancer diagnosis was a good thing and couldn't understand why she wasn't getting better, and another lady who sprayed her inhaler on her neck because she had been told to 'spray it on her throat'. Nobody had checked whether she knew she had to open her mouth and inhale. He went on to say, 'Our system provides oral and written information to patients of such complexity that it far exceeds people's functional skills in language, literacy and numeracy, and therefore their ability to make sense of it and act on it'. Inadequate health literacy is associated with difficulties in understanding health information. Many people have limited knowledge of their own bodies and body functions, and the diseases that afflict it. This leads to lower medication adherence, which, in turn, contributes to poor health, risk of mortality, ineffective use of healthcare resources and increased health outcome disparities.

Nutbeam (2000) created three levels of health literacy:

1. *Functional: basic reading, writing and numerical skills used in a health context.*
2. *Interactive: advanced cognitive skills which allow the individual to conduct meaningful health conversations.*
3. *Critical: the individual can critically analyse information and use this to exert greater control over life events and situations.*

Providing information that is easily understood is a key health promotion activity. This allows the patient to give informed consent, participate in planning their own care and manage long term conditions. Also, communicating in a manner the patient feels comfortable with, and simple and clear language, gives patients the confidence to ask questions without feeling uncomfortable or stupid. Health Education England offer a toolkit to support you to support your patients and this can be found at: https://healtheducationengland.sharepoint.com/

Rural deprivation

Case study 3.2: Critical thinking

Tamsyn lives in the southwest of Cornwall, she and her two children are in rented accommodation and her children attend the local school. She and her children were born in the village and have strong local roots. The house she lives in needs remedial work as it is damp and does not have central heating. She has a coal fire in the lounge as a primary form of heating, with an expensive-to-run electric radiator in the children's bedroom. The village does not have a gas supply. Both children suffer from pulmonary ailments and have inhalers for asthma. They often take time away from school when they are unwell. The nearest hospital is 30 miles and three buses rides away. It takes 2 hours to reach the hospital by public transport and the cost is expensive. Tamsyn has a part-time job in the local shop and her wage is topped up with Universal Credit, which includes housing benefit. Tamsyn suffers from stress-related ailments and takes medication for anxiety and depression. She is frightened to complain to her landlord about the damp as she thinks her landlord will evict them and turn the house into a holiday home.

Activity 3.2 Reflection

Using knowledge you have gained so far, place Tamsyn's inequality characteristics into the following factors: health, social living, work and education.

Health	
Social living	
Working	
Educational	

Compare your answer with the one given at the end of the chapter.

The rural fringes of the UK are both attractive and deprived. Employment tends to be seasonal and based in the hospitality and agricultural sectors, both of which are poorly paid. Both sectors used to offer accommodation to offset the wage and to attract employees. Now, such accommodation is turned over to holiday makers. Rural deprivation is mainly hidden. May et al. (2020) noted that austerity compounds problems of rural poverty. Tamsyn's housing problem is exacerbated by rising house rental costs and the lack of either social housing or genuinely affordable housing. Eleven per cent of Cornwall's housing stock are second homes and average house prices have risen by 300 per cent in the last five years. May et al. also noted that urban dwellers live within 2.5 miles of a GP. Many rural households travel much further. The same applies to supermarkets and banks: 44 per cent of rural dwellers travel more than three miles to shop and access banking facilities. Small local shops tend to be 10–15 per cent more expensive and carry fewer goods. Tamsyn's village does not have a gas supply, so she suffers from fuel poverty. Fuel poverty considers households whose energy costs are higher than can be sustained by their income. She must buy smokeless fuel from the local shop and use an expensive method of heating the children's room to mitigate the damp.

The problem for calculating rural deprivation indices is that wealthy incomers skew the results. For example, six out of the top ten people on the *Sunday Times Rich List* live or have homes in Cornwall. Cornwall has a residential population of approximately 565,968 but this rises by an additional 850,000 in the summer months, and this places intense strain on the single Cornish hospital.

Urban deprivation

Urban deprivation is a standard of living that falls below that of the majority in a particular locale, area or society. Places suffering from urban deprivation have visible differences in housing, high unemployment, limited access to healthy food, few community resources and limited access to health facilities. Urban decay refers to run down, badly maintained houses, shuttered shops, empty factories, vandalised buildings and high levels of air and ground pollution.

Many of the factors in urban deprivation are historical, lack of town planning in the past led to narrow streets, which causes traffic congestion, which leads to poor air quality. Many post-war houses were of dubious build quality, especially council houses which were system-built, deck access houses, which are notorious for damp.

As traditional industries declined due to lack of government support, the export of manufacturing to low-cost Asian countries or changing market conditions, those who were able to migrated to where work was available. Leaving behind an area which became progressively poorer. High unemployment and higher crime rates ensure these areas remained deprived. Houses lose their value and eventually sell as 'buy to lets', which are poorly maintained. The concentration of low-income groups in deprived areas bring many social problems. Low property rental prices attract poorer immigrants, who are least likely to be offered loans and mortgages.

The net result of urban decay is that there is low investor interest to start up new industry in the area. People feel abandoned and become depressed. Children are less future orientated and have lower aspirations (with notable exceptions), lack of scholastic achievement means low-skilled, low-paid work. This is the engine that drives the cycle of deprivation or inherited poverty.

Health impacts of deprivation on individuals and families

The cycle of deprivation is what happens when people or areas suffer from a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, crime, bad health and family breakdown. These problems are linked and mutually reinforcing, hence the cycle.

As we have discussed, poverty and ill health are closely inter-related. Poor people have little power to make changes and unequal power and opportunities play a pivotal role in creating an uneven distribution of social determinants of health. We know the causes of poverty are complex

and entwined, and include unemployment, low-paid work, inadequate state benefits and lack of affordable housing. Here, they also intersect with disability, poor physical and mental health, lone parenting, being an unpaid carer, and being older and alone.

Within the cycle of deprivation is a health deprivation cycle. The significant association between poor physical and mental health and poverty is explained by the stresses associated with poverty. Having poor physical and mental health makes it difficult to find and keep work. Very few employers offer any degree of flexibility to accommodate periods of ill health.

A child born into poverty is likely to have a low birth weight which could impact on cognitive development. S/he is less likely to be breastfed and the mother is more likely to suffer from post-natal depression. As the child grows, s/he is more likely to suffer tooth decay, malnutrition, obesity and ultimately, diabetes and cardiovascular problems. Poor children also have a higher rate of accidents and accidental death. They also are 13 times more likely to die from unintentional injury (Watson and Lloyd, 2019). Gibson and Asthana (2000) make the correlation between low household income and poor educational performance. Child poverty can have a direct negative effect on children's social, emotional, developmental and cognitive outcomes. As the child grows into adulthood they are at risk of long-term and life-limiting illnesses. This accounts for poor life expectancy.

The effects of inequalities within marginalised groups

The research work undertaken by the King's Fund (2015) is a significant contribution to understanding social inequality. Researchers highlight evidence which shows that those from lower socio-economic groups and those with lower levels of educational attainment are not actively engaging with positive lifestyle choices. They note this as a public health concern given the variety of health education approaches and health campaigns active within the UK.

Activity 3.3 Critical thinking

Who do think falls into a marginalised group and what are the protected characteristics? And how do these groups of people have inequalities in accessing healthcare?

Jot down your thoughts and then compare them with Table 3.1.

There is also a lack of positive lifestyle choices across the lifespan, which indicates that the problems are persistent, complex and multifaceted. Therefore, there is a need to adopt a more holistic approach to addressing contemporary inequalities. It is quite demonstrable that people with lower socio-economic status engage in risk taking behaviours, such as tobacco use, alcohol misuse, poor diet, a lack of exercise and street drug use. These behaviours have persisted through generations (the cycle of deprivation), but it is not clear why. There are sociological and psychological explanations, but it seems a lack of future orientation also has a role. Low lifetime earnings give people less reason to plan for the future. Poor coping strategies for stress, such as comfort eating tend to be familial. Tobacco, street drugs and alcohol are used for relaxation when other means of escape are unaffordable.

The lower lifespan statistics include those with 'protected characteristics' from populations often defined as being part of 'health inclusion' groups. As explained earlier, they are at significantly higher risk of experiencing inequalities in accessing healthcare services (see Table 3.1). Their situation is summed up by Tudor's (1971) inverse care law: those most in need of attention by health services are often the least likely to receive that care.

Table 3.1 Inequalities in accessing health services experienced by people with protected characteristics and by health inclusion groups.

Protected characteristic	Inequality of access
Young people	There is evidence of service gaps for young people reaching adulthood particularly for those with complex needs. Young people with ADHD and autism can find it especially difficult to transition to adult mental health services that often do not offer specific services for their conditions.
Disabled people	Transport costs and long waiting lists can be barriers to equal access for disabled people. Breast screening, and contraceptive advice, smear tests are significantly lower for people with learning disabilities than in the general population.
Black and minority ethnic (BME) groups, including Gypsy, Roma, and Traveller (GRT) communities	Some Black and minority ethnic groups can have less access to healthcare services. Gypsy, Roma, and traveller communities face substantial barriers and have some of the lowest rates of healthcare access. Discrimination, lack of cultural awareness, literacy and language barriers can also create problems with access.
Religion and belief	Healthcare can be influenced by a person's religion and belief towards things such as abortion, contraception, and neonatal care. Specific views on dying, death and the afterlife are often influenced by religion. The religious beliefs of people are not always considered during care planning or when people attend healthcare settings. This can be considered a form of indirect discrimination and can have a negative impact on diagnosis and treatment, in addition to causing distress for patients and their families.
Lesbian, bisexual, gay and transgender (LBGTQ+) communities	Barriers to accessing services can be because of a lack of understanding of LGBTQ+ health concerns. Equality and diversity training for staff around the health needs of LGBTQ+ people can be lacking, often resulting in unsympathetic approaches to care.
People with alcohol and substance misuse needs	Stigmatisation and discrimination experienced by people who are dependent on alcohol or other substances have resulted in individuals not being accepted on to practice lists, and an inability to access medical care for conditions not related to their substance misuse.
Asylum seekers and refugees	Difficulty in accessing healthcare by these groups has been reported due to lack of awareness of entitlement, difficulties registering and accessing primary and community healthcare services, and language and literacy issues.
Carers	Evidence suggests that there is a lack of recognition of the caring role and the needs and issues related to caring within the health service. Failure to provide flexible appointment times, in addition to costs, waiting times, and transport and car parking difficulties, prevent carers from attending to their own health needs.

Information adapted from Institute of Health Equity (2018)

From examining this table and the activity you undertook (Activity 3.3) you will realise that stigma and discrimination pays a large role in barriers to access. As a nursing associate, you will understand how your non-judgemental attitude can have a positive influence in helping marginalised patients to feel accepted and respected. Supporting a marginalised individual will ripple through their community and encourage other to engage with health services.

New ways of working

In 2012, the Health and Social Care Act introduced the first legal duties for health bodies such as the Department of Health, Public Health England, Clinical Commissioning Groups and NHS England (the devolved nations of Scotland, Wales and Northern Ireland were required to introduce many of the provision of the act) which stated the need for such bodies to have due regard to reducing health inequalities between the various populations of England. The introduction of the Health and Social Care Act (2012) also brought about changes for the local authorities on Public Health Functions.

In response, Public Health England published 'Towards a Public Health Surveillance strategy for England' (2012). Public Health England suggested that effective **surveillance** and collection of data would be key in determining the needs of the population, stating that their vision was to offer world-leading surveillance services which provide a robust evidence base for decision making, and action-taking in respect of both acute and chronic diseases and health determinants. PHE stated that 'Surveillance will underpin the protection and improvement of health and service delivery, through outputs that are timely, accurate, accessible and meaningful to users of this information at the local, national and international level'. The systematic collection, analysis, interpretation and dissemination of data for a given population can help in ensuring that responses to specific identified areas of need are delivered at the right time, and in the most effective and equitable way. Essentially, if the various organisations that make up the NHS and individual staff members were to work effectively to reduce the health inequalities, this would ensure that everyone was given the same opportunities to lead a healthy life, no matter where they live or who they are.

NHS England acknowledges that there needs to be a significant improvement in the way healthcare professionals help people to live healthier lifestyles. A preventative approach was the starting point for the work that was carried out in the 'NHS Five Year Forward View' in 2014. That report addressed the need for a review of the structure primary and acute care services. It proposed an increased workforce with strong leaders to ensure that all NHS processes can meet the demand of the population with effective utilisation of the resources available.

This five-year forward view provided consensus relating to why change was required to make improvements and how to address the persistent inequalities within society. Acknowledgment of the need for change is echoed throughout and although there is a clear expression that it is within the power of the NHS to change, strong leadership is required to facilitate this change. It was noted that fragmented service provision could further disenfranchise the marginalised. There is also appreciation that success would be dependent upon a well-functioning social care system too. The current long-term plan (NHS, 2019a) builds on the need for integrated care, focusing on GP provision and strategies for mental health, maternity services and cancer care. The government have increased the NHS budget by three per cent for the next five years (approximately £20 billion). It should be noted that this plan is exclusively for the NHS. It does not include funding for social care.

The financial burden due to health inequalities in England also remain of concern. It is estimated that the increased use of NHS hospital and healthcare services from those in the most deprived areas is around an extra £4.8 billion each year. Health inequalities are also estimated to cost the UK between £31 billion and £33 billion a year in lost productivity and between £20 billion and £32 billion a year in lost tax revenue and higher benefit payments (PHE, 2021).

During the spring of 2021, the Conservative government published plans for the introduction of the Office for Health Promotion, which will be situated within the Department of Health and Social Care. The focus of the office is to lead work across government to promote good health and prevent illness, which impacts upon an individual's ability to live a healthy life across the lifespan. This will have the hopeful addition of reducing some of the financial burden placed upon the NHS.

Approximately 80 per cent of an individual's health outcomes are not connected to the healthcare they receive but are a direct consequence of the preventable risk factors such as diets, smoking and exercise. The Office for Health Promotion aims to build upon the work of Public Health England, leading on national efforts to improve the health of the nation by tackling public health issues, including obesity and nutrition, mental health across all ages, physical activity, sexual health, alcohol, and tobacco use (Gov.UK, 2021a).

The role of the nursing associate

Across the health and social care sector, there are staff shortages of approximately 220,000 workers and this is why the role of the registered nursing associate was created. You will become a trained and skilled healthcare professional with the opportunity to provide holistic care across all four fields of nursing: adult, child, mental health and learning disability. As a qualified nursing

associate within health and social care, you will actively engage with public health issues and tackling some of the inequalities experienced by individuals, populations and communities. Your role will be supporting and empowering people and communities to exercise choice and take control of their own health decisions and behaviours by encouraging people to manage their own care where possible.

Promoting holistic health

Health promotion interventions are seen as a way of facilitating active engagement in order to safeguard the health and wellbeing of individuals in need. Historically, any interventions suggested by nurses or healthcare professionals were often undertaken without question. Patients would do as they were told and adopt what has been referred to as the 'sick role' (Parsons, 1951). More recently this relationship has become much more balanced with all nurses and healthcare professionals being required to work in partnership with individuals accessing healthcare. People are now more likely to want to be actively involved in all decisions about care.

Involving people in their care is complex, empowering them to take responsibility and manage their own health, and to encourage patients to making positive lifestyle choices can be challenging. As a qualified nursing associate, you should be able to effectively listen to and address the health concerns, and give informed advice to help patients make changes in their behaviours.

Health and healthcare practice is a holistic process. There is an expectation that all nursing associates working within healthcare practice will be able to address the healthcare needs of an individual using a biopsychosocial approach (Chapter 7). Holistic practice is the ability to consider the individual's needs in a variety of circumstances, and to include involvement of the person's family and wider social and community network.

Within healthcare practice, the essence of true holistic nursing is to tailor care to meet the needs of the patient. However, in order to meet the needs of others, there is an expectation that, as nursing associates, we are fully aware of ourselves. When addressing the issue of health inequalities, there is an expectation that we can distinguish between what is desirable and what is unacceptable practice.

Case Study 3.3 highlights the variations of opinion in why people from low-income families are more likely to have poor health and asks you to use your knowledge to decide which opinion you support.

Case study 3.3: Ruth

You are visiting a friend, Ruth. She is quite upset as she has had a disagreement with her mother. Ruth explains that she has been to visit her uncle George (Activity 3.1) and told her mother that George's diabetes was getting worse, but that George didn't like the new tablets he had to take. Ruth's mother said he was a silly old fool and only had himself to blame, if he ate better food, he wouldn't be so fat and he wouldn't have diabetes. Ruth told her mother that George couldn't afford better food.

Ruth knows you are a trainee nursing associate and asks you to tell her mother that people from low-income families struggle to adopt a healthy lifestyle.

Activity 3.4 now asks you to consider how you as a nursing associate would answer Ruth, who is right? Ruth or her mother?

Activity 3.4 Critical thinking

Give consideration to what you have learned so far about health inequalities, how would you advise both Ruth and her mother

An outline answer is given at the end of this chapter.

Activity 3.4 asks you to reflect upon Ruth and her mother's argument and to think about the knowledge you have gained by reading this chapter, the answer given at the end of the chapter highlights the complexity of social inequality and the varying perspectives that influence your work.

Chapter summary

This chapter has provided you with an overview of health inequalities. You have been introduced to some of the avoidable and unjust differences experienced by individuals, communities and populations when accessing healthcare. As far back as the publication of the Black Report in 1980, the unequal distribution of ill health, morbidity and mortality amongst society has been evident. The key links between those living with low income, limited education and poor housing and poor health outcomes is startling. Despite any number of commissioned reviews and reports, the persistent link remains. Marmot (2020) makes clear that there is still much work to be done. From the plethora of publications, the evidence is clear that potential solutions are available, however, there needs to a focused and sustained approach to implementing them.

Activities: brief outline answers

Activity 3.1 Critical thinking (page 52)

Reflecting upon the health inequalities George may have experienced across his life course, some of the issues you may have been able to identify could include the following:

- Exploration of data regarding mortality rates as a measure of the population health. You may have been able to identify that George has lived in northeast England which has a history of higher levels of deprivation. The links between those most deprived and health issues have specific links as made by Marmot et al. (2010, 2020).
- Links between George's educational attainment, employment and financial stability would also impact upon his ability to live a healthy life across the life course.
- The health issues noted include his mental health problems. It is reported that George has experienced poor mental health since his redundancy, which continued as he was unable to find secure work. The impact of mental health and the ability to live a healthy life across the life course for both George and his family are well documented.

- Obesity, raised cholesterol, mobility issues and Type 2 diabetes are all conditions that can have an impact upon a person's ability to live a healthy life. The detailed pathophysiology (see Chapter 6) of diabetes is well understood, with the evidence explaining that a large proportion of those experiencing Type 2 diabetes could reverse this with appropriate engagement with positive lifestyle choices, which includes diet and exercise.

Activity 3.2 Reflection (page 55)

Table 3.2

Health	Both children and Tamsyn have health related ailments predicated on their living conditions, but Tamsyn's fear of eviction prevents any improvements to the house and maintains her anxiety.
Social living	Tamsyn wants to stay in her home village and ensure the children have strong social roots in the community. The isolated rural community has barriers to access to healthcare due to distance to the local health facility and the cost of public transport.
Working	Tamsyn's access to employment is reduced with very little employment opportunities available without personal transport/childcare. Tamsyn could be no better off financially in low waged full-time employment if she had vehicle and child care costs, she would lose her benefits and still be trapped in poverty.
Educational	The children have reduced life chances due to poor health and frequent absences from education.

Activity 3.4 Critical thinking (page 61)

There is an ongoing academic discourse relating to this scenario and no simple either/or explanation. Explanations for health inequalities often focus upon the cultural/behavioural versus materialist/structural, and psychosocial explanations, which in turn suggests that the adverse environmental conditions across the life course can lead to ill health. As you have learned from reading this chapter, poverty and poor health education has a lifelong impact on people's abilities to make good choices. You might argue that people in lower socio-economic groups do not choose to be poor but they are poor as a result of structural barriers, or you might argue that poor people should take a more active approach to modifiable risks to health.

Further reading

To deepen your understanding of health inequality, read these reports:

1. Institute of Health Equity (2018) *Reducing Health Inequalities Through New Models of Care: A Resource for New Care Models*. London: University College London.
2. *Health Foundation/Marmot Review Ten Years On*, found at www.health.org.uk/publications/reports/the-marmot-review-10-years-on
3. Public Health England (2021b) *Inclusive and Sustainable Economies: Leaving No-one behind Supporting Place-based Action to Reduce Health Inequalities and Build Back Better*. London: PHE.

Useful websites

The following websites are useful to aid your research and understanding.

The King's Fund: www.kingsfund.org.uk

This is an independent organisation working to improve health and care in England, the website is rich in health information.

Public Health England: www.gov.uk/government/organisations/public-health-england

Currently provides information relating to the reduction in health inequalities and protection and improvement of the health and wellbeing of the nation. This function moves later in 2021 to the new Office for Health Promotion. The website is not currently functional, but you can read about it here: www.gov.uk/government/news/new-office-for-health-promotion-to-drive-improvement-of-nations-health