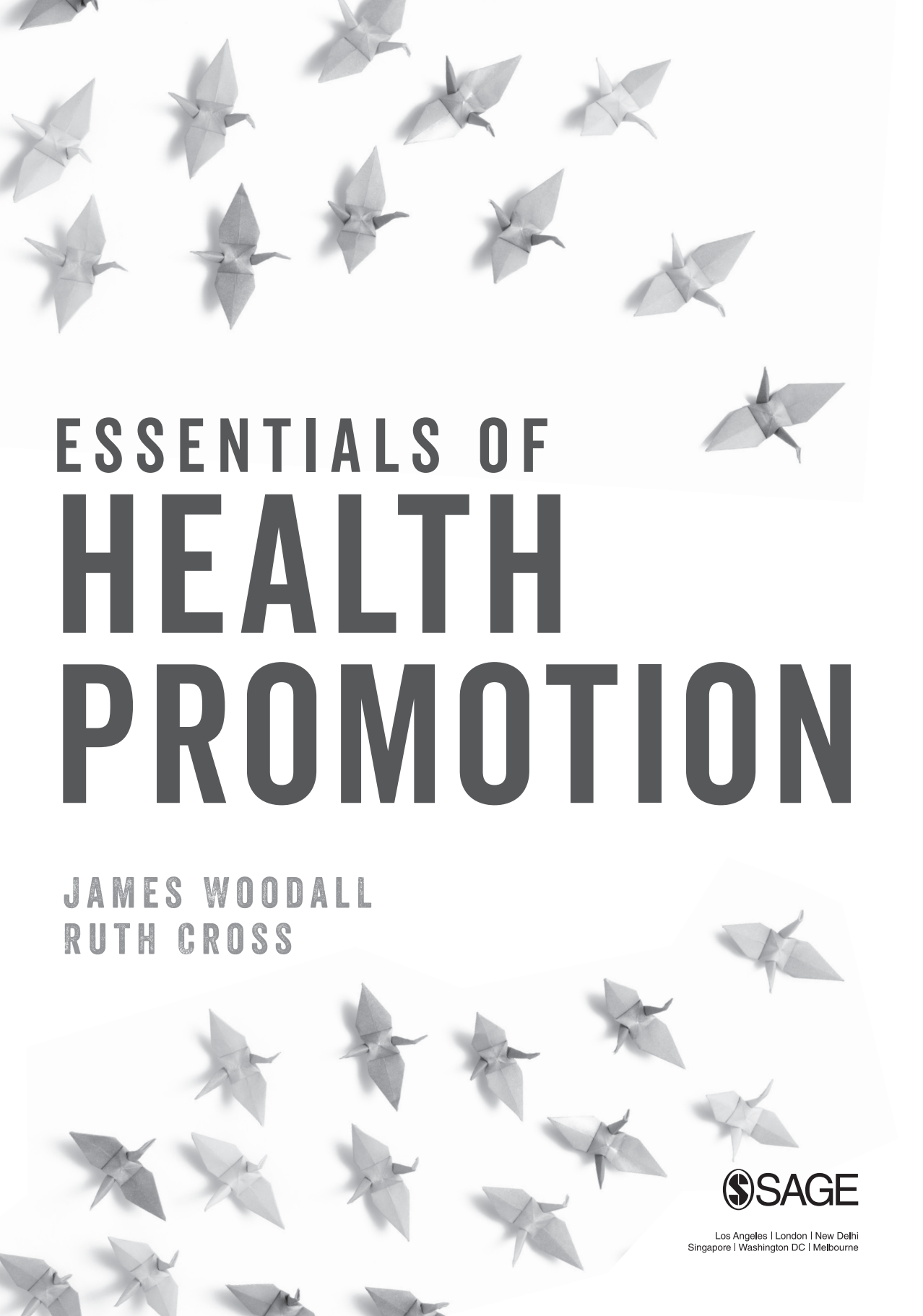

ESSENTIALS OF HEALTH PROMOTION

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INEQUALITIES IN HEALTH

5

INTRODUCTION

A commitment to addressing inequalities in health has been a key concern for health promotion and is a common strand running through this book. This chapter, however, will specifically show how health inequalities exist between individuals and communities, examining this from a global and national perspective. The chapter explores why communities have different health experiences and why, ultimately, some people die sooner than others – not based on their genetic profile necessarily, but on their living and working conditions or, by virtue of where they were born and raised. Explanations for these inequalities are provided using sociology and psychology to provide theoretical insight. The chapter will suggest that one of the key reasons for health promotion practice is to reduce health inequalities in society, but why, in some cases, inequalities in health have widened rather than reduced.

WHAT ARE INEQUALITIES?

Inequalities relate to differences in people's health as a result of a range of social or economic factors. Differences in people's health could relate to how long they live (their life expectancy) or the likelihood of facing a particular condition (e.g. cancer or obesity). Differences in health based on social and economic factors are avoidable and unfair, but manifest consistently in many ways – physical health, mental health, social connectiveness and, of course, many others. Recognising that health inequalities exist suggest we need to reallocate resources not equally but equitably to balance up this unfairness. Some people may argue that in most societies we treat everyone with equal worth and are equitable with resources so that everyone can lead a full and healthy life, but this cannot be the case. Children would not be dying in the 'developing' world due to preventable diseases such as diarrhoea, respiratory infections or measles, whilst others live in some luxury if we readdressed health inequalities (Dixey, Cross, Foster and Woodall, 2013).

There are several ways in which health inequalities have been described and explained. Health inequalities have been documented between population groups across at least four dimensions:

- socio-economic status and deprivation: e.g. unemployed, low income, people living in deprived areas (e.g. poor housing, poor education and/or unemployment);
- protected characteristics: e.g. age, sex, race, sexual orientation, disability;
- vulnerable groups of society, or 'inclusion health' groups: e.g. migrants, Gypsy, Roma and Traveller communities, rough sleepers and homeless people and sex workers;
- geography: e.g. urban, rural.

This is perhaps summed up most effectively by Graham (2007) who suggests three meanings of health inequalities:

1. health differences between individuals;
2. health differences between population groups;
3. health differences between different groups based on the social position they occupy.

Health inequalities are evident between population groups at a global level as well as within countries and within communities. As an example, average global life expectancy at birth in 2016 was 72.0 years ranging from 61.2 years in the WHO African Region to 77.5 years in the WHO European Region (WHO, 2020b). Data on inequalities in health is abundant, whether this is within rich countries such as the UK, between richer countries, such as the USA and Japan, or in poorer countries of the global South (Cross, Rowlands and Foster, 2021). Within countries differences exist yet further – as an example in England's most deprived areas, life expectancy was 74.0 years in the years 2015 to 2017, whereas it was 83.3 years in the least deprived, a gap of 9.3 years. Women in the least deprived areas of England were expected to live 78.7 years in 2015–17, while those in the most affluent were expected to live 86.2 years, a gap of 7.5 years (Iacobucci, 2019). Some differences in life expectancy can literally be seen between two communities in very close proximity, but, as shown, health inequalities manifest also at global and national levels for a range of health indicators and outcomes.

REFLECTIVE EXERCISE 5.1

A version of the London Underground map has been produced to show how life expectancy varies from station to station. Travelling east on the Tube from Westminster, every two Tube stops represented more than a year of life expectancy lost. For example, if you travel eastbound between Lancaster Gate and Mile End – 20 minutes on the Central line – life expectancy decreases by 12 years (Cheshire, 2012). What explanations do you propose cause this inequality in life expectancy? What factors may be at play in creating these differences in life expectancy?

BOX 5.1 INFANT MORTALITY AS AN INDICATOR OF HEALTH INEQUALITIES

Using the example of infant mortality as a crude indicator of health we can map clear health inequalities at local, regional and global levels. If we start with Leeds, which is where the authors are based, we can see differences within the city itself:

- In 2016 in Leeds there were 4.8 infant deaths for every 1000 live births compared with 3.9 for the rest of the country. The most deprived parts of the city had a higher rate (above 5) and the least deprived had a lower rate (below 4).

Moving to the regional level, we can see differences between Yorkshire and Humber (the region where Leeds is located) and the rest of England:

- In 2014–2016, the average infant mortality rate for the whole of England was 3.9 deaths per 1000 live births and 4.1 deaths per 1000 for Yorkshire and Humber. Within the Yorkshire and Humber region, there were variations from 2 (East Riding) to 5.7 (City of Bradford).

There are differences between England and the rest of Europe:

- In 2014–2016, the average infant mortality rate was 3.9 in England per 1000 live births. Compare this with, for example, the highest rates – 6.7 in Malta and Romania – and the lowest – 1.3 in Cyprus or 2 in Finland – whilst the average in Europe in 2017 was 3.6 deaths per 1000 live births.

There are differences between Europe and the rest of the world:

- In 2018, the average infant mortality rate in the countries comprising Latin America and the Caribbean was 14 per 1000 live births compared with the average infant mortality rate in the countries of the European Union, which was 3 per 1000 live births. There is a clear difference here between 'developed' and 'developing' countries.

There are also differences within continents:

- Within the continent of Asia for example, in 2018, the infant mortality rate was 48 per 1000 live births in Afghanistan, compared with 2 per 1000 live births in Japan in the same year. In Africa for the same year South Sudan's IMR was 62 whilst South Africa's was 29.

Source: adapted from Cross, Rowlands and Foster (2021)

SOCIAL CLASS AND HEALTH INEQUALITIES

People's social class has been consistently used by researchers, politicians and health practitioners as a way to examine health differences across groups in society (see Box 5.2). In short, people in the 'higher' socio-economic groups do better on many health indicators compared to people in poorer circumstances working in routine and manual occupations.

Social class is a way of producing a classification or hierarchy of people (Sayani, 2019). Social class can be determined by several factors, but often relates to economic, social and cultural capital – or, in other words, how much wealth, networks and knowledge someone has. Identifying and measuring social class is very difficult and there have been several attempts throughout history to do this. Reports on inequalities in health in the United Kingdom make heavy use of the concept of social class and a five-point social-class classification was the principal classification of socio-economic status used in the UK when it first appeared in the Registrar General's Annual Report for 1911. Analysis using this classification has consistently shown social gradients for a wide range of health indicators, with social classes IV and V having a disproportionate amount of ill health (Hubley et al., 2021). The Registrar General's class schema was one example of how social class was defined – it classified people based on their job role:

I. Professional
II. Intermediate
IIIN. Skilled non-manual
IIIM. Skilled manual
IV. Semi-skilled manual
V. Unskilled manual

While this classification was, and remains, popular, it has faced some strong critique. It is based, fundamentally, on employment relations and therefore is quite narrow in its focus – social class is made up of far more than occupation (Savage et al., 2013). More recently, researchers have developed a more sophisticated way of approaching class, looking at cultural, social and economic capitals (using different measures of economic capital, including household income, but also savings and the value of owner-occupied housing) which provides seven classes (Savage et al., 2013):

1. Elite (e.g. barristers and judges)
2. Established middle class (e.g. police officers)
3. Technical middle class (e.g. pharmacists)
4. New affluent workers (e.g. sales and retail assistants)
5. Traditional working class (e.g. electrical and electronic technicians)
6. Emergent service workers (e.g. chefs)
7. Precariat (e.g. cleaners).

BOX 5.2 BLACK REPORT TO THE MARMOT REVIEW

Social class has been used throughout as a variable to see how disease patterns vary based on these classifications. The Black Report of 1980 was the first major report in the UK to highlight how health is systematically related to social class (Cross, Warwick-Booth and Foster, 2021). Later work has continued to look closely at health inequalities – perhaps the most significant being the Marmot review of the social determinants of health that highlights the role of psychosocial factors in explaining the differences in health between social groups. Professor Sir Michael Marmot in his report *Fair Society, Healthy Lives* (Marmot, 2010) emphasised the link between health and social groups, showing that the lower a person's social position, the worse his or her health. Marmot argues that a reduction in health inequalities requires the following action:

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

Health Equity in England: The Marmot Review 10 Years On (Marmot et al., 2020) examined the decade that had passed since the publication of the original Marmot Review in 2010 (Marmot, 2010). Despite the set of recommendations that were made to government in the original review there has been a slowing in improvements in life expectancy, and in some areas it even went down (Marmot et al., 2020).

As noted, social class impacts on health. You are more likely to die sooner if you are in a lower social class position (Green et al., 2019). People of lower socio-economic status are more likely to experience mental health problems – those who are unemployed or economically inactive have higher rates of common mental health problems than those who are employed (Mental Health Foundation, 2020). Moreover, obesity is linked to social class and socio-economic status; however, these differ according to whether they are measured in lower- or higher-income countries. In higher-income countries, levels of obesity are greater in the lower social classes, and this is associated with a poorer diet (Warwick-Booth and Cross, 2018b). Box 5.4 in the chapter shows some of the explanations for why health inequalities occur. In relation to social class, there is little

doubt that a materialist or structuralist explanation is very persuasive. Being materially deprived in terms of income and employment can reduce people's access to important health resources – as an example people on lower social class groups may not have a car and may be more likely to not attend important cancer-screening programmes (Sayani, 2019). There may also be implications for accessing fresh produce and food for those on lower incomes. This can result in people feeling a lack of control over their health and their social circumstance which can be highly stressful which in turn affects biological pathways that impact negatively on health (known as a psycho-social impact) (Warwick-Booth et al., 2012).

REFLECTIVE EXERCISE 5.2

Could a consensus be formed whereby we *accept* that some people will predictably have healthier lives than others and live longer and happier? Similarly, people will also experience differences based on whether they are in a highly industrialised economy or from developing nations? Put simply, isn't inequality a natural by-product of the economically prosperous lives that most of us wish to lead?

As a health promoter, why would you argue against this statement? How would you potentially challenge this view of inequalities? What counter-arguments would you develop and how would you articulate or communicate the necessity for more equal societies? Can you hold capitalist viewpoints and also be committed to reductions in health inequalities and improvements in health equity?

ETHNICITY AND HEALTH INEQUALITIES

Ethnicity is a term defined by some as: 'a form of collective identity that draws on notions of shared ancestry, cultural commonality, geographical origins and shared biological features' (Salway et al., 2014: 4–5). The data is unequivocal in demonstrating that people, based on their ethnicity, face disproportionate health challenges. These relate to several outcomes; for example, experiences of discrimination and exclusion (including the fear of such negative incidents) have been shown to impact on health (Toleikyte and Salway, 2018). To equate poor health with differences based on biology is therefore incorrect (Bartley, 2017).

There are some challenges to recording people's ethnicity. Terminology does vary (see Box 5.3) and, in many countries, data is collected via a national census where individuals can self-declare their ethnicity (Bartley, 2017). Often when analyses are done on data based on ethnicity, the categorisation can be extremely broad. So, for example, 'Black African' or 'White British' is a very broad classification and somewhat unhelpful for understanding the data or in designing appropriate and culturally tailored interventions, programmes and policy.

BOX 5.3 TERMINOLOGY

Terminology relating to ethnicity varies. Terms such as: 'ethnic group' and 'minority ethnic' are seen in the literature. Other common terms used in English health publications include 'Black, Asian and minority ethnic' (BAME), 'Black and minority ethnic' (BME) and 'ethnic minority groups'.

While it is not possible to report all health outcomes for all ethnicities, a brief list of some of the health inequalities faced by some groups includes:

- Individuals identifying as Gypsy or Irish Traveller, and to a lesser extent those identifying as Bangladeshi, Pakistani or Irish, stand out as having poor health across a range of indicators.
- Black men have higher reported rates of psychotic disorder than men in other ethnic groups.
- Prostate cancer makes up over 40 per cent of Black men's cancer compared with around 15 per cent among Chinese men and 25 per cent among all men.
- The National Child Measurement Programme in England indicates that among children most minority ethnic groups have higher levels of overweight or obesity at age 10–11 than the White majority. Those in Black groups have the highest levels.

(Data from Toleikyte and Salway, 2018)

Inequalities in health as a result of ethnicity reflects other inequalities in terms of socio-economic position and social class. Therefore, it is a complicated and complex web of interacting factors and issues. A recent example of this was COVID-19 and how people's living conditions could have a detrimental impact (see Box 5.4).

BOX 5.4 COVID-19 SHOWS HEALTH INEQUALITIES IN SOCIETY

COVID-19 has exposed deep inequalities in society. Data has shown that deaths and people experiencing COVID-19 were disproportionately Black or from another minority ethnic background. People from Black, Asian and minority ethnic communities are more likely to live in densely populated urban areas and are often overly represented in high-risk key worker jobs (The Health Foundation, 2020).

There is also evidence that shows how people from some ethnicities are less likely to seek healthcare services or advice. The lack of accessible information, language barriers, poorer knowledge about services, inadequate surgery premises and longer waits for appointments all contribute to difficulties in terms of healthcare access (Evandrou et al., 2016). Imagine walking into primary care services and feeling that they in no way reflect your background, cultural identification, language or rituals? This can have significant consequences in terms of delayed treatment and management of conditions (Marlow et al., 2015).

CASE STUDY 5.1: BARRIERS TO CERVICAL CANCER SCREENING AMONG ETHNIC MINORITY WOMEN: A QUALITATIVE STUDY

Background Ethnic minority women are less likely to attend cervical screening.

Aim To explore self-perceived barriers to cervical screening attendance among ethnic minority women compared to white British women.

Design Qualitative interview study.

Setting Community groups in ethnically diverse London boroughs.

Methods Interviews were carried out with 43 women from a range of ethnic minority backgrounds (Indian, Pakistani, Bangladeshi, Caribbean, African, Black British, Black other, White other) and 11 White British women. Interviews were recorded, transcribed verbatim and analysed using Framework analysis.

Results Fifteen women had delayed screening/had never been screened. Ethnic minority women felt that there was a lack of awareness about cervical cancer in their community, and several did not recognise the terms 'cervical screening' or 'smear test'. Barriers to cervical screening raised by all women were emotional (fear, embarrassment, shame), practical (lack of time) and cognitive (low perceived risk, absence of symptoms). Emotional barriers seemed to be more prominent among Asian women. Low perceived risk of cervical cancer was influenced by beliefs about having sex outside of marriage and some women felt a diagnosis of cervical cancer might be considered shameful. Negative experiences were well remembered by all women and could be a barrier to repeat attendance.

Conclusions Emotional barriers (fear, embarrassment and anticipated shame) and low perceived risk might contribute to explaining lower cervical screening coverage for some ethnic groups. Interventions to improve knowledge and understanding of cervical cancer are needed in ethnic minority communities, and investment in training for health professionals may improve experiences and encourage repeat attendance for all women.

Source: Marlow et al. (2015)

GENDER AND HEALTH INEQUALITIES

Data shows that women live longer than men, but spend fewer years in good health (EuroHealthNet, n.d.). Like other sections in this book, the relationship is complex but we know that social structures do not, and continue to not, favour women. That could relate to progression in workplaces; pay and salary; expectations for childcare and family responsibility; sexism and many, many others. Patriarchy – a social system where men hold power and political authority – is a major obstacle to women achieving their full potential and it remains difficult to maintain issues in the political spotlight, such as: gender-based violence, traditions harmful to women (such as genital cutting), sexual harassment and forced marriage (Cross, Warwick-Booth and Foster, 2021). Patriarchy is apparent in many situations and contexts – in Zambia, for example, men hold the power over money within most family contexts (Warwick-Booth et al., 2012).

CASE STUDY 5.2: THE STATE OF WOMEN'S HEALTH IN LEEDS

- Twice as many women as men are recorded as having a common mental health disorder. Black women, asylum seekers, refugees, and Gypsy and Traveller women have higher rates of common mental health issues and are less likely to receive mental health treatment.
- Women are more likely than men to become addicted to smoking, alcohol and drugs and find it harder to stop.
- 30% of women accessing support for drug/alcohol treatment have a mental health condition, compared to 21% of men.
- Problem gambling – predominately seen in men – is now increasing for women.
- More women than men are diagnosed as underweight.
- Women over 65 years have twice as many emergency admissions due to a fall as men.

Source: Thomas and Warwick-Booth (2019)

REFLECTIVE EXERCISE 5.3

Take one of the statements presented in the case study above and try to explain why there is a difference in the health issues between men and women. Discuss why these inequalities are happening in a large city in the UK with good access to healthcare services?

MARGINALISED POPULATIONS AND HEALTH INEQUALITIES

Data on many sources of inequalities go uncollected, particularly certain populations – information on the health of refugees, asylum seekers, prisoners, the homeless, and a range of other marginalised groups is not available (Cross, Rowlands and Foster, 2021). In many cases, albeit, not all, many marginalised populations face complex challenges. It is difficult to ascertain the number of people faced with severe and multiple disadvantage (Rankin and Regan, 2004), although the estimated figures are not inconsequential. Over 250,000 people in England have contact with at least two out of three of the homelessness, substance misuse and/or criminal justice systems and at least 58,000 people have contact with all three (Bramley et al., 2015). Evidence suggests that severe and multiple disadvantage results from myriad factors including structural, systemic, family and personal influences (Bramley et al., 2015) – resonating strongly with ecological views of health promotion which seek to intervene at macro, meso and micro levels (McLeroy et al., 1988). The lack of affordable, available or suitable accommodation is a tangible illustration of a structural factor that impedes intervention with people with multiple and complex need (Macias Balda, 2016). Other systemic challenges include poor management sharing and a lack of collective recording processes across agencies working toward supporting those with severe and multiple disadvantage (CLES, 2016). This can mean that individuals 'fall through the gaps' of service provision (Bringewatt and Gershoff, 2010, Warwick-Booth and Cross, 2018a). Finally, unsupportive interpersonal relationships, irregular contact with care services and fractured family dynamics may also characterise the experiences of people facing severe and multiple disadvantage (Social Exclusion Unit, 2002).

We will focus briefly on inequalities facing people in prison specifically. People in prison undoubtedly face significant health challenges to a greater extent to those in the wider community. This relates to almost all health outcomes, but particularly in regard to mental health. De Viggiani (2006) has argued that both 'deprivation' and 'importation factors' are significant health determinants within prison. This suggests that there are factors caused by imprisonment that contribute to ill health and those which are a result of circumstances which pre-dated someone's prison sentence. For example, deprivation factors are based on the premise that imprisonment deprives individuals and renders them powerless. Prison from this perspective is viewed as being counterproductive and harmful to prisoners' health. In contrast, importation factors focus on prisoners' past experiences, biographies and demographic characteristics that influence their negotiation of prison life (Gover et al., 2000).

Prisons are settings in which the health needs of those from marginalised and disempowered groups can be addressed (Woodall, 2020). This has the potential to improve individual health outcomes and lessen health inequalities and improve health equity. There have been some promising signs of individual countries developing their own approaches to delivering a healthy settings approach in prison – England and Wales (Department of Health, 2002) and Scotland (Scottish Prison Service, 2002), for example, have led the way by adopting clear strategies for health promotion in prison. In other countries there has been far less activity – in Norway and in Ireland, for instance, there are no dedicated policies for health promotion in prison (MacNamara and Mannix-McNamara, 2014; Santora et al., 2014) and in several Eastern European regions there is no resource for health promotion in prison (MacDonald et al., 2013). In extreme cases, some countries in sub-Saharan Africa are reported to run prisons that are

unjust, unhealthy and sites of human rights abuses (Dixey et al., 2015). These differences often relate to resource allocation and, in some instances, ideological views on who is deserving or not in regard to health intervention.

WHY DO HEALTH INEQUALITIES EXIST?

There are several theories concerning why health inequalities exist in societies. We have grouped these in Box 5.5.

BOX 5.5 EXPLAINING HEALTH INEQUALITIES

ARTEFACT EXPLANATION

This position suggests that the differences seen in health (life expectancy, illness, etc.) between groups is a result of the way variables, like social class, are measured and due to challenges in gathering accurate data. The relationship between class and health is not real, but is instead artificial or statistical anomaly. Overwhelmingly, however, this explanation has been discounted as a way of understanding and explaining health inequalities as evidence clearly shows differences between social class and health. Some groups still argue that this is not the case.

SOCIAL SELECTION

This theory suggest that people with better health tend to occupy higher social class positions. Health therefore has consequences for social life and success or failure in the labour market and class structure. Good health provides upward social mobility, whereas poor health has a downward impact on social mobility.

CULTURAL/BEHAVIOURAL EXPLANATION

This theory suggests that health behaviours are associated with cultural influences and therefore causes increases in disease. In short certain social groups 'choose' an unhealthy lifestyle because of either fatalism, recklessness of ignorance and therefore at higher risk of poor health. Lower social classes experience poorer health because they choose to smoke more, drink more, eat sugary foods, etc. This position, however, has been viewed as victim blaming and having an overly individualistic view on how health and disease patterns occur in society – failing to fully consider wider social influences.

MATERIALIST OR STRUCTURALIST EXPLANATION

The inequalities that are presented in society are due to material differences in people's lives such as unemployment or poor living conditions. This can lead to chronic stress and impact negatively on health. This, for many, is the most plausible theory for health inequalities.

WHY ARE HEALTH INEQUALITIES WIDENING?

There have been significant interventions to try to rebalance health inequalities operating at individual and state (government) levels (see Chapters 10 and 11). In many cases, there has been an expectation that in many countries life expectancy and quality of life will increase for us all. There is a long-held assumption that your generation will live longer than the previous generation as a result of improved healthcare and eradication of diseases and conditions through prevention activities. Throughout the twentieth century, the UK saw significant increases in life expectancy. Of people born in 1905, only 62 per cent lived to 60 compared with 89 per cent of those born in 1955. For people born today, 96 per cent can be expected to live to 60 (Marshall et al., 2019).

This improving historical picture is not now the case: 'The UK has been seen as a world leader in identifying and addressing health inequalities but something dramatic is happening' (Marmot et al., 2020: 5).

GO FURTHER 5.1

Advances in public health and healthcare in the last century drove big improvements in life expectancy: the eradication of many infectious diseases in the 1950s and 1960s, reductions in smoking rates from the mid-1970s, advances in treatment of heart disease in the 1990s and, more recently, better diagnosis and treatment of cancer (Marshall et al., 2019).

Societies have already made significant gains in life expectancy, so is it becoming increasingly difficult to achieve further big improvements? Discuss this statement and try to consider how life expectancy and quality of life can continue to improve further. Where or what would you prioritise to achieve these gains?

We have seen a stalling in life expectancy as a result of a wide range of factors which broadly relate to social and economic determinants (see Box 5.5). Some of these have been political decisions by governments not to invest substantially in improving people's living and social conditions. This is indeed an ideological position and relates back to whose responsibility poor health is and whether health inequalities are in themselves seen as a statistical artefact or a matter of individual choice.

BOX 5.6 STALLING LIFE EXPECTANCY IN ENGLAND

The evidence we compile in this 'ten years on' report, commissioned by the Health Foundation, explores what has happened since the Marmot Review of 2010. Austerity has taken its toll in all the domains set out in the Marmot Review.

> From rising child poverty and the closure of children's centres, to declines in education funding, an increase in precarious work and zero hours contracts, to a housing affordability crisis and a rise in homelessness, to people with insufficient money to lead a healthy life and resorting to foodbanks in large numbers, to ignored communities with poor conditions and little reason for hope. And these outcomes, on the whole, are even worse for minority ethnic population groups and people with disabilities. We cannot say with certainty which of these adverse trends might be responsible for the worsening health picture in England. Some, such as the increase in child poverty, will mostly show their effects in the long term. We can say, though, that austerity has adversely affected the social determinants that impact on health in the short, medium and long term. Austerity will cast a long shadow over the lives of the children born and growing up under its effects.
>
> (Marmot et al., 2020: 5)

Health promoters, whose remit leans heavily on reducing inequalities, should be concerned by the current picture of widening health inequalities. Epidemiological data showing the life expectancy of the poorest and wealthiest widening is troubling. This is happening in many countries across the world. Indeed, it may be time for an increased focus on 'big picture health promotion' (Cross, Warwick-Booth and Foster, 2021) which looks at important, but complex, factors concerning our health and well-being. Yet, even the most optimistic health promoter will be aware that such a call to action is difficult and such rhetoric for 'big picture health promotion' has been around for many decades now (St Leger, 1997). Climate change and globalisation are just two examples where health promoters can work towards making change through activism, lobbying and raising health consciousness. Developing countries are ill-equipped to cope with the forces of globalisation and furthermore have seen a decline in their independent policy-making capacity, whilst having to accept the policies made by outside agencies (Cross, Warwick-Booth and Foster, 2021). The fact that Coca-Cola can be purchased in even the most remote parts of the world suggests the forces of globalised marketing. Health promotion, as a global profession, needs to question whether as a community we are doing enough to challenge this.

SUMMARY

Health inequalities are differences in outcomes – like how long we live and the chances of becoming unwell – as a result of a range of social and environmental factors. While this chapter has only just touched upon some of the main issues, it is clear that factors such as someone's gender, their ethnicity and their social position have significant impacts on their health. There are several explanations for why this happens, but most commonly material disadvantage plays a huge role. The role of health promotion is to undoubtedly

tackle health inequalities and yet there are indications that current efforts are not enough. Life expectancy is not continuing to rise as it once was and the health gap between the wealthiest and poorest in many countries is widening. The impact of forces such as climate change and globalisation cannot be underplayed here and requires health promoters to adopt new ways of working to reverse the trend of growing health inequalities in society.

SUGGESTED READING

Bartley, M. (2017) *Health inequality: an introduction to concepts, theories and methods*. Cambridge, Polity Press.

Marmot, M., Allen, J., Boyce, T., Goldblatt, P. and Morrison, J. (2020) *Health equity in England: the Marmot Review 10 years on*. London, Institute of Health Equity.

Warwick-Booth, L. and Cross, R. (2018) *Global health studies: a social determinants perspective*. Cambridge, Polity Press.