# Socio-economic influences on health

*Scenario*

You are employed by the Public Health England as an assistant to the regional Public health officer in UK. Your manager has asked you to produce a report on why the life expectancy of individuals in the Midlands is lower than the London. Your report should cover AC 1. 1, 1. 2 and 1. 3 (Evidence type-Report)

AC 1. 1Explain the effects of socio-economic influences on health. Your report should highlight the reasons for the difference in life expectancy for the two regionsM1.

The term ‘ socio-economic’ has been developed from the sociology and economic disciplines which, respectively, explore and examine people which comprise society and the economy which encapsulates finance. Together, social and economic factors, their interaction is examined to identify its impact and/influence on outcomes such as health. Socio-economic factors include income/low or no income, employment/unemployment, the environment, access to information, and citizenship status.

The availability of jobs, and the type of jobs, is, in the main, the factor which impacts on life expectancy. Income is derived from employment, whether self or external, and with income housing can either be purchased or rented, food can be bought and citizenship issues can be resolved; albeit across a range such as the quality of food and housing stock. However, it is quite often the case that without income acquiring food, clothing and shelter is problematic. Over many years the main industries, which allowed families to manage their lives, have been either reduced or eliminated across the UK,

and more so in some areas than in others. In the Midlands many of the textile industries no longer exist, as too the car manufacturing industries, and training in new technologies, available in other areas of the UK such as London, has either not been made available or is available in specific areas as opposed to all areas. Hence, without investment in other technologies by both the private and public sector jobs in areas such as the Midlands are limited; educated Midland's people whose voice may have been heard in demanding better civic services, such as in regular weekly bin collection, are no longer heard as many migrate to London for employment, and/or better employment opportunities.

High socio-economic factors almost guarantees good health in that the quality of food is most likely to be nutritious and with ' ready' access to health information, whether in text or through networking such as having a neighbour who is a doctor or a medical researcher, high socio-economic individuals will manage and monitor their health with regular visit to alternative practitioners and gyms as they practise a preventative health lifestyle to avoid negative socio-economic health conditions. Obviously, some health conditions cannot be prevented if they are hereditary but, conditions linked to obesity for example, are more likely to be avoided with the assistance of a physical fitness trainer for example. In so doing, obesity is avoided and linked lifestyle conditions such as Type 2 diabetes and hypertension can either be avoided or delayed. This may not be the case with those living with low incomes, either owing to poorly paid employment positions or unemployment. Such people would not be able to afford a personal trainer who may also assist them in constructing a menu conducive

to a healthy lifestyle; notably not all vegetables are of the same nutritious quality so even if low income families are eating healthily they may not be eating quality health food when compared with those with a high income (Fowajuh, 2007; Joseph Rowntree Foundation, 2011). Based on available employment opportunities, it would be ‘ safe’ to claim that high income individuals/families are more likely to be found in London than in the Midlands, with the observation that life expectancy being greater in London than in the Midlands.

Along with the quality of food purchased, and opportunities to purchase help to support a healthy physical regime, is the issue of housing. Low income individuals may have to content themselves with having ‘ a roof over their heads’, irrespective of damp which brings on mould, poor heating and a generally ‘ unpleasant’ environment. Conditions, as stated in previous sentence, impacts on respiratory health, and if a child grows up in such conditions, these conditions can either exacerbate asthma or increase the chances of developing it, with long-term effects into adulthood and quite limiting life expectancy. A child from a high income family may have asthma but the chances of his or her home environment aggravating the condition is quite minimal, if at all. In addition, those with high disposable incomes are more likely to live in hospital trust areas which are well resourced and well-funded, and if not they are more likely to ‘ make a fuss’ to try and force a change or have the ‘ know how’ to demand a second opinion or go to the private sector; Low income individuals are unlikely to do the same and most certainly will not have the finance ‘ to go private’

Quite, unfortunately, socio-economic factors, which are greatly affected by income leave certain regions in the UK at the mercy of those ‘ dispensing’ healthcare, whether it is adequate and fit for purpose or not, hence the discrepancy in life expectancy in regions such as London and the Midlands. In essence, the central socio-economic factor, ‘ Money buys goods and services that improve health. The money families have, the better the goods and services they can buy. [and] For various reasons, people on low incomes are more likely to adopt unhealthy behaviours – smoking and drinking, for example – while those on higher incomes are more able to afford healthier lifestyles’ (Joseph Rowntree Foundation, 2014).

AC 1. 2 Assess the relevance of government sources in reporting on inequalities in health in England

There are many various government sources reporting on the levels of health experienced by public service users across England. These sources include Health Survey for England (HSFE), Acheson Report ‘ Independent Inquiry in Inequalities in Health’ (1998), Census Data and Health and Lifestyle Surveys (HALS). These sources, with the exception of the Census Data, provide a ‘ snapshot’ of health of public health service users in England. The information acquired from these different sources assist the government in its decision making when allocating health related funding to the various regions in England, recognising that the variation in health needs, or to be precise health inequalities, within one particular region may be as great, or greater than, the variation in needs between regions.

In a blog, on the Guardian website in 2010, the following statement partly explains the relevance of government sources in reporting on inequalities in health in England in that ‘ It has been said that each stop on the District line to east London cuts life expectancy by a year’ (Guardian, 2010). The District line runs through some of the most expensive areas in London through to some of the most deprived. Drawing on statistics produced by the Office of National Statistics (ONS), this same blog highlighted the following: the average life expectancy age of a man in London is 78. 6; however along the District Line, from west to east, the following boroughs showed variants around this average age, as follows:

- Ealing 78. 9
- Hammersmith & Fulham 78. 1
- Kensington & Chelsea 84. 4
- Westminster 83. 4
- Tower Hamlets 76. 0
- Newham 76. 2
- Barking and Dagenham 76. 5

(Guardian, 2010).

In an NHS study on life expectancy it was observed that ‘ Money may not buy you happiness, but it is linked to good health’ (NHS, 2015). Notably, this report considered the ‘ North-South’ divide in England, but this observation is very much applicable to the findings included in the Guardian blog above. Either side of the two richest boroughs in England, Kensington & Chelsea and Westminster, the link between money and health, in London, is clear. At the west end of the District line male life expectancy differs from the London

average by tenths of a percentage point; Ealing being six tenths of a percentage point higher, while Hammersmith and Fulham is five tenths of a percentage point lower. Overall family income levels are not as high in these two boroughs when compared with Kensington & Chelsea and Westminster, however, family income levels are higher than those in Tower Hamlets, Newham and Barking & Dagenham which have all been classed, at various times, as deprived boroughs (Hill, 2015).

Although, the examples of life expectancy above are for men in London, the point should not be missed that money, or to be precise the lack of money, does play a part in health inequalities. Thus, it is undoubtedly necessary for the government to be fully conversant with the varying conditions of wealth, which impact health outcomes, across England. In this way, funding and resources should be deployed to areas experiencing inequalities in health, and in so doing health inequalities should be address for the benefit of the population most in need of public funded health care.

AC 1. 3 Discuss reasons for barriers to accessing healthcare.

There are many reasons why there are barriers to accessing healthcare. These reasons include a lack of education, information, funding for staff and facilities and mobility, plus limited or no access to GPs and other health professionals.

In detail, there is a somewhat convoluted cycle of ‘ lack’ which may results in those with the most health needs not receiving the necessary medical attention. A lack of education may prevent a potential public service user from accessing and/or receiving the relevant information even if it is

available, which may assist them in making an informed decision as to which health professional could be seen first. In England, now, a pharmacist could be the first point of call, avoiding possible long waits to see a GP. Therefore, ‘ simple and treatable’ conditions could get worst while awaiting a GP appointment.

Without the appropriate information a public service user may not know that a certain question should be asked; it is difficult to ask a question if one is ignorant of the fact that a question should be asked. Lack of information, along with restricted numbers in staffing contributes to ignorance in health related conditions, since the staff which could possibly mitigate the outcomes, arising from no written information by sharing that information in discussion, may have been cut owing to limited and/or reduced funding. Funding, or the lack of it, reduces staffing levels and the appropriate facilities to address public health issues. Funding also impacts on GP availability if a health trust decides to cut funding per patient to a GP; in this way GPs may be reluctant to accept new patients, or reduce surgery cover which may impact on the services provided by other health professionals linked to a surgery. Without a nearby and accessible surgery, those service users with mobility issues may find it a struggle to attend the ‘ nearest’ surgery which requires a journey involving two or more changes using public transport.

Whatever the reason, or combination of reasons, for being unable to access healthcare, most negative outcomes are probably quite preventable, and as such more costly to the public health providers when corrective action must be taken.

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