5 Addressing Sources of Inequality and Health Disparities: Socioeconomic Status

Learning Objectives

- Summarize the evidence examining the relationship between income, education and health
- Describe why marginalization is a social determinant of health
- Theorize as to why the social gradient in health exists
- Explain how the demand–control model and the effort–reward imbalance model theorize the relationship between work and health outcomes
- Propose mechanisms to reduce social inequities in health
- Discuss why income inequality is often associated with poorer health outcomes at the population level

Summary

In Chapter 5, the reader is introduced to condition Z59.5, more commonly known as extreme poverty. Extreme poverty, often due to structural inequalities (social class, race, gender) is viewed as the greatest cause of ill health. Being poor leads to social exclusion where individuals are marginalized, which has a negative impact on health and wellness. Groups at risk for social exclusion include: women, new immigrants, racial minorities, and First Nations people. Social exclusion presents itself in four different ways: social exclusion from civil society, social goods, social production, and adequate material conditions.

Research has consistently shown that there is a strong positive relationship between income and good health. This relationship exists for many different health status indicators, including self-reported health, mortality rates, life expectancy and measures of functioning such as the Health Utility Index. For example, Quebec women living in the highest socioeconomic households have fewer preterm births, stillbirths, neonatal deaths, and post-neonatal deaths.

The relationship between employment and good health is not straightforward. Although it is believed that work generally has a positive effect on health, this is not always the case. There are many factors that contribute to work and good health such as working conditions, meaningful employment, and income. The demand–control model looks at how the psychological demands working people experience and the degree of control they have in their jobs influences their health. Workers who have high demands with little control have poor health outcomes. A second model, the effort–reward imbalance model, highlights the need for balance between work effort and the fiscal and

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non-monetary benefits associate with that employment (income, career advancement and security and work enjoyment).

Education also has a positive effect on health. That said, education is interrelated with higher income and better jobs, so it is not straightforward which effect is being measured. The authors call for an intersectional model that, in addition to socioeconomic status, takes into account structural factors (gender and age) and contextual factors (employment and labour force participation rates) in understanding health and wellness.

The Whitehall studies of civil servants in England, led by Michael Marmot demonstrated that there is a social gradient in health. That is, health status is linked to location in the social hierarchy; differences in population health are explained by the width of the gap between the wealthiest and the poorest persons within a society.

There are three main explanations of the social gradient in health. Materialist explanations focus on the effects of harmful environments on health; cultural behavioural explanations focus on the poorer coping skills and behaviours associated with being lower on the socioeconomic ladder; and psychosocial explanations emphasize that people's perceptions of hierarchy shape patterns of health across populations.

The relationship between income inequality and population health is complex. Earlier research showed that there was a significant negative effect in that populations, and communities that had wide disparity in income had poorer health outcomes than those that were more equitable. The findings of Canadian-based research examining income inequality have been inconsistent. Comparisons between studies are also hindered by a range of factors including different types of income data being used, varying levels of aggregation and which control variables are included. What is needed is a more comprehensive research strategy that draws on multiple theoretical approaches to unravel the connection between income inequality and population health.

Key Concepts/Terms

Cultural capital: Symbolic and information resources for action such as values, normative beliefs, knowledge and skills that acquired through socialization in particular socio-cultural contexts (p. 150).

Demand–control model: Model that focuses on how the dimensions of control over work conditions and schedules and the psychological demands associated with work can shape patterns of health (p. 139).

Differential exposure hypothesis: Explanation that sees higher number of health problems in low-socioeconomic-status groups as a result of greater exposure to psychosocial stressors such as financial insecurity, neighbourhood crime and social isolation (p. 148).

Differential vulnerability hypothesis: Explanation that sees higher number of health problems in low-socioeconomic-status groups as a result of harmful behavioural practices and coping skills used to cope with environmental stressors (p. 148).

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Effort–reward imbalance model: Model that focuses on how the dimensions of time and effort put into work must be matched by adequate monetary and other rewards in order to ensure work contributes in a positive way to health outcomes (p. 139).

Gini coefficient: A statistical measure of income inequality that ranges from 0 to 1, with lower scores representing more equitable societies (p. 155).

Health inequities: A term used to describe avoidable health inequalities that are unnecessary and unjust (p. 166).

Income adequacy: A calculation based on total household income and the number of people in the family, measuring financial capacity to meet needs (p. 155).

Income inequality: The uneven distribution of income within a society of community, which is linked to disparities in population health (p. 153).

Income inequality hypothesis: The hypothesis originated by Richard Wilkinson that greater inequality in income distribution within a population increases social problems, including a social gradient in health (p. 155).

Political economy perspective: A framework that focused on the socio-political causes of inequality, or the causes of the causes (p. 160).

Social class: A social grouping based on a combination of socioeconomic factors such as income, occupation and education (p. 133).

Social exclusion: A process of marginalization reflecting unequal power relationships between groups in society that involve unequal access to social, cultural, political and economic resource and have adverse health effects (p. 132).

Social gradient: The graded association between socioeconomic status and population health (p. 142).

Social inequality: Relatively stable differences between individuals and groups of people in the distribution of power and privilege that exist because opportunities are differentially distributed in society (p. 131).

Socioeconomic status: An individual's relative social and economic position in society based on personal factors such as income, occupation and education (p. 133).

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Structural amplification: A life course perspective that emphasizes the process by which parental education, occupation, and income structure many of our life experiences including health (p. 140).

Structures of inequality: Factors, such as social class, gender, ethnicity and age, that are associated with enduring patterns of advantage and disadvantage and shape health outcomes (p. 131)

Study Questions

1. Which groups of people are at a high risk for social exclusion?
2. How is social class measured?
3. What is the relationship between socioeconomic status and health?
4. Compare the two conceptual models that have been developed to account for how stressful job characteristics influence health.
5. What does the work model of social reciprocity describe?
6. What is structural amplification?
7. What did the Whitehall studies demonstrate?
8. Describe three frameworks that have been used to explain the social gradient in health.
9. What is the Gini coefficient?
10. What factors need to be considered when comparing research examining the relationship between income inequality and health?
11. What was the World Health Organization's Commission on the Social Determinants of Health?

Explore and Discuss Questions

1. What are the four components to social exclusion, and how do they affect health and wellness?
2. Why is finding a good job so important to your health?
3. How do people assess their position in the social hierarchy?
4. Why is income inequality increasing? What strategies might we use to reduce income inequality?
5. Guaranteed annual income policies should be implemented in Canada. Debate.

Further Exploration

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Recommended Websites

1. **Canadian Council on Social Development**
   CCSD is a not-for-profit organization that partners and collaborates with all sectors (not-for-profit, philanthropic, government and business) and communities to advance solutions to today's toughest social challenges.
   www.ccsd.ca

2. **A Mother's Risk, Washington Post**
   In Sierra Leone, one in eight women die in childbirth, a problem that gets little attention from international donors who are far more focused on global health threats such as malaria, tuberculosis, and HIV/AIDS.
   www.washingtonpost.com/wp-srv/photo/galleries/mothersrisk

3. **Work, Stress and Health Program, CAMH**
   The WSH Program is a non-OHIP funded interprofessional program that provides comprehensive Psychiatric and Psychological consultations, assessments, and treatments in Pain Management, Medication Misuse, Addictions, and Relapse Prevention.
   www.camh.net/About_CAMH/Guide_to_CAMH/Mental_Health_Programs/Mood_and_Anxiety_Program/guide_work_stress_health.html

4. **Shift Work and Health, Statistics Canada**
   This article describes the characteristics of shift workers and compares stress factors and health behaviours of shift and regular daytime workers.
   www.statcan.gc.ca/studies-etudes/82-003/archive/2002/6315-eng.pdf

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