TECH2503 Community Media Production

Lecture Fourteen – Community Media and Social Policy

Contents

1 Introduction - The Spirit Level

"It is a remarkable paradox that, at the pinnacle of human material and technical achievement, we find ourselves anxiety-ridden, prone to depression, worried about how others see us, unsure of our friendships, driven to consume and with little or no community life. Lacking the relaxed social contact and emotional satisfaction we all need, we seek comfort in over-eating, obsessive shopping and spending, or become prey to excessive alcohol, psychoactive medicines and illegal drugs" (Pickett & Wilkinson, 2010, p. 3).

The Spirit Level: Professor Richard Wilkinson | The Chartered Society of Physiotherapy: Speaking at Physiotherapy UK in Birmingham, author of The Spirit Level Professor Richard Wilkinson explains how income inequality and chronic stress creates white-coat hypertension, impacts on healthcare and diminishes wellbeing. https://youtu.be/pqH8rE_c8vk

"Health is immediately related to our sense of well-being and the quality of our lives" (Jones, 2001, p. 149).

1.1 Health Priorities

"Policies to reduce inequalities in health should, therefore, be a high priority. In order to develop appropriate and effective policies the cause of health inequalities need to be clearly identified" (Jones, 2001, p. 149).

- "Class-related inequalities in health;
- Gender inequalities;
- Ethnic inequalities;
- Spatial inequalities;
- The problematic and contested nature of much of the evidence on which debates about inequalities in health are based;
- The policy implications of health inequalities;
- The current government's strategy for combatting health inequalities" (Jones, 2001, p. 149).

1.2 Health Inequality

The Spirit Level authors: why society is more unequal than ever

The truth is that human beings have deep-seated psychological responses to inequality and social hierarchy. The tendency to equate outward wealth with inner worth means that inequality colours our social perceptions. It invokes feelings of superiority and inferiority, dominance and subordination – which affect the way we relate to and treat each other. As we looked at the data, it became clear that, as well as health and violence, almost all the problems that are more common at the bottom of the social ladder are more common in more unequal societies – including mental illness, drug addiction, obesity, loss of community life, imprisonment, unequal opportunities and poorer wellbeing for children. The effects of inequality are not confined to the poor. A growing body of research shows that inequality damages the social fabric of the whole society. When he found how far up the income scale the health effects of inequality went, Harvard professor Ichiro Kawachi, one of the foremost researchers in this field, described inequality as a social pollutant. The health and social problems we looked at are between twice and 10 times as common in more unequal societies. The differences are so large because inequality affects such a large proportion of the population. https://www.theguardian.com/commentisfree/2014/mar/09/society-unequal-the-spirit-level

1.3 Economic Disadvantage

The Spirit Level: Why More Equal Societies Almost Always Do Better was published in 2009. Written by Kate Pickett and Richard Wilkinson, the book highlights the "pernicious effects that inequality has on societies: eroding trust, increasing anxiety and illness, (and) encouraging excessive consumption". It shows that for each of eleven different health and social problems: physical health, mental health, drug abuse, education, imprisonment, obesity, social mobility, trust and community life, violence, teenage pregnancies, and child well-being, outcomes are significantly worse in more unequal rich countries. As of September 2012, the book had sold more than 150,000 copies in English. It is available in 23 foreign editions. A collection of Powerpoint slides regarding The Spirit Level can be downloaded here. https://www.equalitytrust.org.uk/sites/default/files/files/Spirit-Level%20slides.pptx https://www.equalitytrust.org.uk/resources/the-spirit-level

Taking 'The Spirit Level' to a New Level: Imagine if we compared the world's major developed nations on most all the yardsticks that define social health and decency, everything from average life expectancy and levels of trust to the incidence of teenage pregnancies and drug addiction. Suppose we also ranked these same nations by their level of income inequality. What would we see? We would see, the British epidemiologists Richard Wilkinson and Kate Pickett have helped the world realize, that relatively equal nations far outperform — on nearly every measure that matters — nations where income and wealth concentrate at the top. http://inequality.org/spirit-level-level/

2 Social and Health Inequalities

"In Western societies, there are growing concerns around obesity, the aging population and mental health problems, especially for young people. Increasing demand is placed on over-stretched health provision with high expectations for expensive treatments and emergency care" (Gilchrist & Taylor, 2016, p. 119).

"Since the mid-nineteenth century an accumulation of evidence has pointed to a relationship between death rates on the one hand and male occupations, overcrowding, poor areas and insanitary conditions on the other. Evidence has also grown of a link between high illness rates, high death rates and poverty" (Jones, 2001, p. 149).

"Complicated, chronic health problems are associated with low incomes, poor housing and stress" (Gilchrist & Taylor, 2016, p. 118) .

2.1 Limited Access

"Communities that have limited access to opportunities for exercise and who live in impoverished environments experience higher than average rates of heart and respiratory disease, sometimes exacerbated by obesity and stress. This holds true across many countries and is attributed to, among other things, the pressures of living in an unfair economic system, where rewards and opportunities are unevenly distributed with little prospect of change" (Gilchrist & Taylor, 2016, p. 118).

"Like many earlier studies the Acheson report also pointed to other long-established inequalities in health standards" (Jones, 2001, p. 151).

Independent Inquiry into Inequalities in Health Report: From: Department of Health, First published: 26 November 1998 https://www.gov.uk/government/publications/independent-inquiry-into-inequalities-in-health-report

The Acheson report up close: A government-commissioned report on health inequalities will provide "a key influence" on future public health policy in the UK, according to Health Secretary Frank

Dobson. Sir Donald Acheson's report highlights a range of areas where health inequalities can be reduced. News Online details four of these. The report calls for an increase in benefit levels for women of childbearing age, expectant mothers, young children and older people. It says poverty has a disproportionate effect on children. In the mid 1990s, around a quarter of people in the UK were living below the poverty level. http://news.bbc.co.uk/1/hi/health/222649.stm

2.2 Political Objectives

Tackling health inequalities since the Acheson Inquiry: In recent years, tackling health inequalities has become a key political objective in the UK and other countries. However, few studies have examined the formulation and implementation of policies designed to address inequalities in health care or health status. This study examined the impact of the recommendations proposed in the report of the Independent Inquiry into Inequalities in Health (the 'Acheson Inquiry', chaired by Sir Donald Acheson and published by The Stationery Office, November 1998). The study also looked at the subsequent development of policies across central government in the UK. https://www.jrf.org.uk/report/tackling-health-inequalities-acheson-inquiry

Acheson Report: Like earlier reports on health disparities in the United Kingdom including the Black Report and the Whitehall Study, the Acheson report demonstrates the existence of health disparities and their relationship to social class. Among the report's findings are that despite an overall downward trend in mortality from 1970–1990, the upper social classes experienced a more rapid mortality decline. The report contains 39 policy suggestions in areas ranging from taxation to agriculture, for ameliorating health disparities.] It had some influence on the 1998 government green paper Our Healthier Nation: A Contract for Health which had a stated aim of reducing health inequalities;[4] and the 1999 white paper Saving Lives: Our Healthier Nation. https://en.wikipedia.org/wiki/Acheson_Report

3 Gender Related Inequalities

“There is also evidence, going back many years, that women and men experience socio-economic circumstances and poverty differently. Studies since the 1930s have demonstrated that women bear the brunt of poverty, and that this in turn affects their health. Even within the same family, women – by prioritising the needs of other family members, undertaking the day-to-day unpaid household tasks (including shopping on a low budget) and caring (including looking after others when they are ill), as well as, in some cases, paid work – enduring the worst health” (Jones, 2001, p. 151).

3.1 Hidden Experiences

“Hiding women in the male statistics, however, is misleading became it undervalues gender differences and, as we know that women’s and men’s experiences of health are not the same, it is important to measure them both as accurately as possible” (Jones, 2001, p. 152).

“Gender differences in life expectancy, so consistent throughout the century, are now plummeting” (Jones, 2001, p. 153).

Gender Differences in Health Care, Status, and Use: Spotlight on Men’s Health: Women and men face different health concerns and also have different levels of connections to health providers. This slideshow presents findings from the 2013 Kaiser Men’s Health Survey and the 2013 Kaiser Women’s Health Survey contrasting gender-based differences in health, access, and utilization of care. The data presented highlights the health care challenges facing low-income and uninsured men.

http://kff.org/womens-health-policy/fact-sheet/gender-differences-in-health-care-status-and-use-spotlight-on-mens-health/

Do men consult less than women? An analysis of routinely collected UK general practice data: Overall gender differences in consulting are most marked between the ages of 16 and 60 years; these differences are only partially accounted for by consultations for reproductive reasons. Differences in consultation rates between men and women were largely eradicated when comparing men and women in receipt of medication for similar underlying morbidities. http://bmjopen.bmj.com/content/3/8/e003320.full

4 Class-Related Inequalities

"The definition of 'class,' however, is complex and a matter of dispute. It can be defined according to a number of yardsticks, which may include occupation, income, level of education, type of home and now even car ownership. For the purposes of health analysis, class has traditionally been defined according to one indicator alone, that used by the Register-General – occupation" (Jones, 2001, p. 150).

"Defining class by occupation is a crude way of conveying a complex set of social and economic circumstances, and the inadequacy of the definition is made worse by the fact that over the year's certain occupations have been moved from one class to another" (Jones, 2001, p. 150).

The REAL health map of Britain: From the lowest life expectancy to the fattiest diet, how are you likely to fare? Where we live really does have an impact on our health, as this unique map reveals. Drawn from a variety of sources, including the Healthcare Commission, the Office of National Statistics and charities such as the British Heart Foundation, it paints a fascinating real-life portrait of the health of the nation. Some of the findings are predictable - but others are highly surprising. For as this map shows, it's not as simple as a North/South divide, with some areas in the South, where you'd expect people to be healthier, faring worse than other parts of the country.http://www.dailymail.co.uk/health/article-1037116/The-REAL-health-map-Britain-From-lowest-life-expectancy-fattiest-diet-likely-fare.html

4.1 Life Chances

"The limitations of this classification notwithstanding, it is still widely used as a means of exploring differences in people's life chances and the incidences of ill-health" (Jones, 2001, p. 150).

"Acheson reported a steep class-related health gradient. In nearly every disease from stroke to lung cancer, including mental health, differences between individuals from the highest and lowest social groups were significant" (Jones, 2001, p. 150).

"Illness and infirmity are often regarded as an individual, private or 'lifestyle' matter and therefore addressed through attempts to change everyday behaviour or to improve people's access to health care provision. Health professionals trained in the medical model tend to focus on diagnosis, treatment and prevention at this level rather than listening to community views on how residents would like to see things improving or trying to address neighbourhood harms or even social-economic issues such as income inequalities" (Gilchrist & Taylor, 2016, p. 121).

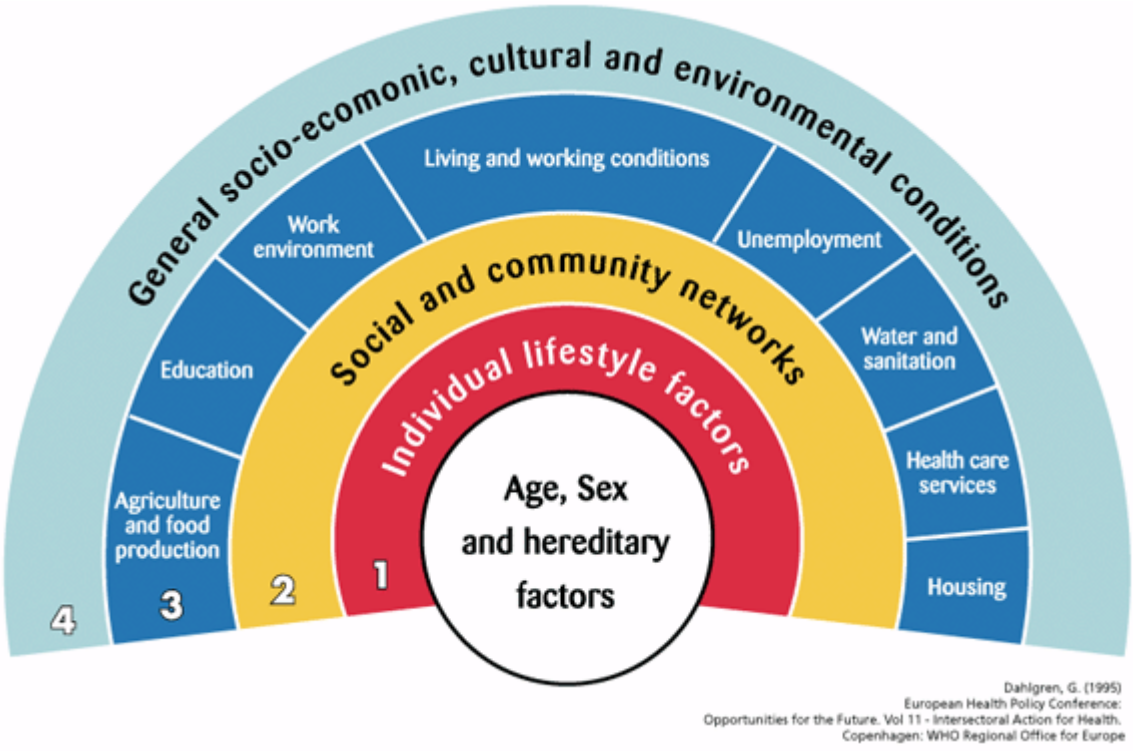
4.2 Atomisation & Fragmentation

"All that's left of society are atomised, lonely, fragmented individuals with impaired powers of association: their only problem is with themselves and their impending death and extinction. A living culture creates its own and life's forms; a dying culture no longer creates anything but only interprets itself" (Bauman & Donskis, 2013, p. 203).

"Freedom of choice comes together with uncounted and uncountable risks of failure; many people may consider such risks unbearable, finding out or suspecting that they may exceed their personal ability to cope. For most people, freedom of choice will remain an elusive phantom and an idle dream, unless the fear of defeat is mitigated by an insurance policy they can trust and rely on in case of misfortune. As long as it remains a phantom, the pain of hopelessness will be topped by the humiliation of haplessness; the ability to cope with life challenges, tested daily, is after all that very workshop in which confidence in oneself is cast or melted" (Bauman, 2007, p. 65).

4.3 Distribution

Inequalities in the distribution of health and health care and its access: The distribution of health is determined by a wide variety of individual, community, and national factors (See Figure 1). There is a growing body of evidence documenting inequalities in both the distribution of health (i.e. health outcomes) and access to health care both internationally and in the UK. Access to health care is a supply side issue indicating the level of service which the health care system offers the individual.



http://www.healthknowledge.org.uk/public-health-textbook/medical-sociology-policy-economics/4c-equality-equity-policy/inequalities-distribution

5 Ethnicity and Inequalities

"Even more problematic than class or gender differences are ethnic inequalities. There is no agreed definition of ethnicity, but it is commonly seen as composed of one's cultural identity, place of origin and, for some people, skin colour" (Jones, 2001, p. 153).

“Yet the evidence suggests that death rates from almost all causes, for all groups of immigrants with the exception of those from the Caribbean, is higher than average. It would be interesting to know whether those whose parents and grandparents emigrated to Britain continue to die younger than the average ethnic Briton. Overall, ethnic minority groups are more likely to describe their health as fair or poor than the majority of the population” (Jones, 2001, p. 154).

5.1 Higher Mortality

“Why do ethnic minority groups, including immigrants, have higher mortality and morbidity rates than white people and the indigenous population? The oldest explanation blames the genes of particular ethnic groups for poor health. This assumes that genetic diseases are the cause of the differences between ethnic groups, but there is no evidence to support this assumption, and while in highly specific and unusual cases there is a link between ethnicity and disease, it is too rare to act as an adequate explanation” (Jones, 2001, p. 154).

“A second explanation assumes that the cultures of ethnic groups, for instance, their diet, are the cause of differences. This assumes that if members of different ethnic groups changed their lifestyles to the lifestyles of the majority, then their standard of health would improve: the explanation and blame rest with the members of the ethnic minority groups themselves. Again, there is no strong evidence to support this view” (Jones, 2001, p. 154).

5.2 Diabetes

Leicester diabetes prevalence rate set for major increase: New diabetes prevalence figures show Leicester to have one of the highest prevalence rates in the country… Professor Kamlesh Khunti, Co-Director of the University's Leicester Diabetes Centre, said "These figures highlight the threat that diabetes poses for the people of Leicester. The people of this city, for a number of reasons including the higher risk of diabetes for people from a South Asian background, face severe challenges in reducing their risk of diabetes and the long term complications such as blindness and heart disease that accompany it. I am proud that the work of the Leicester Diabetes Centre is at the forefront of both national and international initiatives to tackle the condition."
http://www2.le.ac.uk/offices/press/press-releases/2012/december/leicester-diabetes-prevalence-rate-set-for-major-increase

Diabetes in South Asians: Type 2 diabetes is growing problem for people from South Asia. The chance of developing type 2 diabetes is 6 times higher in South Asians than in Europeans
https://youtu.be/AMv2O14YsDU

5.3 Racism

“Third, it has been argued that the society in which ethnic minorities live makes them more prone to illness. This operates in two related ways. Racism exists throughout society, including in the NHS, where it manifests itself in conscious and unconscious discrimination. Discrimination interacts with wider socio-economic inequalities. Many ethnic minorities have poorer health because they are among the poorer sections of society, in terms of income, education and total resources; discrimination and racism aggravate their poorer health. In addition… the experience of immigration can also affect people’s health” (Jones, 2001, p. 154).

6 Spatial Inequalities

“In Britain, people in the poorest areas have death rates which are – age for age – three times as high as those for people in the richest areas!” (Wilkinson 1998 quoted in Jones, 2001, p. 154).

“Class and ethnic inequalities, poverty and deprivation are reflected in inequalities in health between different areas: wealthier areas are healthier than poorer areas” (Jones, 2001, p. 155).

“Comparing inequalities in Britain over time and in different areas as well as with other Western countries demonstrates that existing patterns of socio-economic inequalities in health and illness are not inevitable. Also, by looking at other countries, Britain can pick up useful tips about the successes and failures of policies in tackling inequalities” (Jones, 2001, p. 155).

Sir Michael Marmot: Social Determinants of Health (2014 WORLD.MINDS) Prof. Sir Michael Marmot, from the University College London, on the Social Determinants of Health. Talk delivered at the 2014 WORLD.MINDS Annual Symposium. Health Inequalities. Symposium Curated by Rolf Dobelli https://youtu.be/h-2bf205upQ

6.1 Socio-Economic Circumstances

“It is clear that inequalities in standards of health, linked to socio-economic circumstances, exist in all industrialised countries” (Jones, 2001, p. 155).

“Standards of health in affluent societies are influenced less by people’s absolute standards of living than by their standards of living relative to those of others in their society. Inequalities and hierarchies create psychosocial pressures which undermine rather than enhance standards of health. Improvements in health will not therefore come from tinkering with a country’s health-care system, but from reducing relative deprivation and promoting more equitable distribution of resources” (Jones, 2001, p. 155).

The Political Economy of Health Inequalities - Dennis Raphael,York University https://youtu.be/-NCTYqAub8g

6.2 How Economic Inequality Harms Societies

We feel instinctively that societies with huge income gaps are somehow going wrong. Richard Wilkinson charts the hard data on economic inequality, and shows what gets worse when rich and poor are too far apart: real effects on health, lifespan, even such basic values as trust. https://www.ted.com/talks/richard_wilkinson

"The opposite to poverty is not wealth, it is justice," was his opening line as he shared the panel with a collection of wise heads who didn't always agree with him. http://www.smh.com.au/entertainment/tv-and-radio/qa-recap-sir-michael-marmots-plans-to-address-inequality-tagged-fantasy-by-warren-mundine-20160829-gr44fp.html

6.3 Health Equity ‘Really About Democracy’

Next week, Sir Michael, director of the UCL Institute of Health Equity, returns to Sydney to -deliver the Boyer Lecture Series, broadcast on ABC Radio Nat-ional, and argue for governments to focus on health inequality. He wants to highlight the -social determinants of health — such as access to education, housing and employment — and the long-term suffering of Aboriginal Australians, in particular, that he says cannot be addressed by medicine alone. “Why treat people and send them back to the conditions that make them sick?” His idea has gained momentum in the health sector and some jurisdictions but has yet to break down the “silos” in government. He expects government ministers to take responsibility, and share blame, for the social determinants of health and realise the long-

term benefits of longer, healthier lives, with less crime, more balanced budgets, improved productivity and sustained economic growth. http://www.theaustralian.com.au/national-affairs/health/health-equity-really-about-democracy/news-story/cd9be661311a49af3b591ddfa1546895

6.4 Stress of Modern Living

More than 200,000 people a year are dying due to the stress and bad health caused by inequality - with the top-paid living eight years longer than the middle classes: Expert has warned middle class are losing out on eight years of healthy life. Sir Michael Marmot said inequality in UK is killing people 'on grand scale'. Said 500 people dying daily from poor health caused by limited education http://www.dailymail.co.uk/news/article-3228874/200-000-people-year-dying-stress-caused-inequality.html

"There is also evidence that suggests that people's networks of social capital – the strength and diversity of their informal networks – affects individual resistance to infection, contributes to speed of recovery and generally supports a sense of mental wellbeing" (Gilchrist & Taylor, 2016, p. 119).

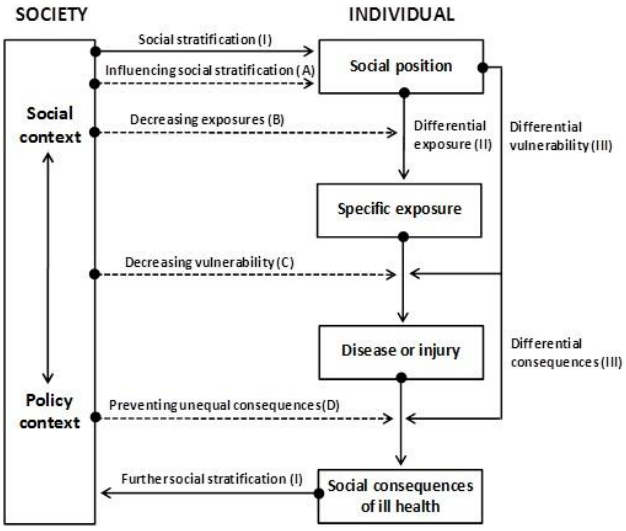
6.5 Social Determinants of Obesity

https://youtu.be/uITjuufdLuI

Community Development Interview Series: S. Leonard Syme, University of California, Berkeley: Guest: S. Leonard Syme, Professor Emeritus, School of Public Health, University of California, Berkeley. Host: David Erickson, Center for Community Development Investments, Federal Reserve Bank of San Francisco https://youtu.be/eU8xTOumoQc

7 Contested Evidence

"The reasons why health inequalities exist within countries, however, are contested. Six possible explanations are set out… followed by their policy implications" (Jones, 2001, p. 156).



https://www.hhrjournal.org/2013/08/social-conditions-health-equity-and-human-rights/

7.1 Artefact

"The methods employed to occupational class differences are unsound and have misleadingly inflated the extent of health inequalities" (Jones, 2001, p. 156).

"There is a good deal of cumulative evidence that death rates, and indeed illness rates, are closely related to socio-economic circumstances, and that class position is still a potent indicator of life chances" (Jones, 2001, p. 156).

7.2 Natural/Social Selection

"Unhealthy people fall down the socio-economic ladder, thus their health determines their socio-economic position, not vice versa" (Jones, 2001, p. 156).

"Following a BBC survey of more than 160,000 people, academics established that Britons can no longer be boxed in to the traditional "upper", "middle" and "working" classes. Instead, you could be a home-owning "elite" with highbrow cultural interests and savings of £140,000. Their "sheer economic advantage" sets them apart from the other classes, according to Professor Mike Savage of the LSE, and they make up just six per cent of the population. The findings, presented at a British Sociological Association convention, show that at the very bottom lies the "precariat". Typically shopkeepers, drivers and cleaners, they represent 15 per cent of people in the UK and lack "any significant amount of economic, cultural or social capital" http://www.independent.co.uk/news/uk/home-news/britain-now-has-7-social-classes-and-working-class-is-a-dwindling-breed-8557894.html

7.3 Health Services

"When the NHS was created in the UK it was assumed that a comprehensive service free at the point of use would improve the standard of health of the whole population, and especially that of the least well off. When this was found not to be the case research focussed on the different uses made of the health service, the quality of treatment received and the attention health workers paid to patients of different social classes" (Jones, 2001, p. 156).

"The number of variables we need to take into account when we explain these different rates, however, means that the use of health care is only one factor among many, and cannot on its own explain the differences in illness and death rates" (Jones, 2001, p. 157).

7.4 Behavioural/Cultural

"Culture, the attitudes and behaviour of individuals, families and groups, is often held to be responsible for inequalities in standards of health. Those who eat a healthy diet, take physical exercise and do not live risky lifestyles are healthier than those who eat unhealthily, fail to take enough exercise and run risks with their health" (Jones, 2001, p. 157).

"There are, however, various problems with this argument. First, it is not entirely clear what constitutes a 'healthy diet', as new food risks and scares continue to appear, and experts argue over the definition" (Jones, 2001, p. 157).

"Those who already live the most materially privileged lives will benefit from a healthy lifestyle far more than those with the fewest material resources" (Jones, 2001, p. 157).

7.5 Materialist/Structuralist

"Some writers argue that inequalities in standards of health are the result of broader socio-economic divisions. Those lower down the class scale are exposed to worse hazards at work and have less control over their work; they are more subject to irregular employment and unemployment. They live in worse housing and in environments that are more polluted and physically unsafe. They have fewer personal resources to draw on to help them over periods of crisis. Daily life is more difficult and stressful and leads to poorer health" (Jones, 2001, p. 157).

7.6 The Interplay Between Different Factors

"Health inequalities are not the result of a single cause but reflect the interaction of different influences… Poorer people have fewer material resources and suffer more health hazards, which affect their physical health, and in turn their emotional health and behaviour. They experience more stressful life events, and a lack of physical resources makes them harder to resolve. Money brings choice and the means to resolve such pressures; people without the financial and emotional resources to deal with them are more likely to resort to unhealthy behaviour, such as smoking, alcohol and comfort food in order to cope" (Jones, 2001, p. 157).

"Behaviour does not take place in a social vacuum, and health differences require a multi-dimensional explanation" (Jones, 2001, p. 158).

8 Policy Implications

Explanations for Health Inequalities and Policy Implications

Explanation	Policy Implications
1. Artefact	Do Nothing
2. Natural/Social Selection	Improve the employment opportunities and resources of those with long-standing illnesses.
3. Health Services	Allocate more resources to the NHS; provide services more sensitive to the needs of the least healthy.
4. Behavioural/Cultural	Establish targeted health education programmes to change the attitudes and behaviour of the least healthy; clamp down on unhealthy advertising campaigns of food, drink and tobacco companies.
5. Materialist/Structuralist	At its most extreme, overthrow the capitalist system; short of that, institute policies (education, housing, income maintenance, transport, environment and employment) to modify the economy and society, in order to promote the health of the most socially and economically disadvantaged.
6. The Interplay Between Different Factors	Enable individuals, families and communities to adopt more healthy lifestyles, supported by the policies under 3, 4 and 5.

8.1 Community Ideas

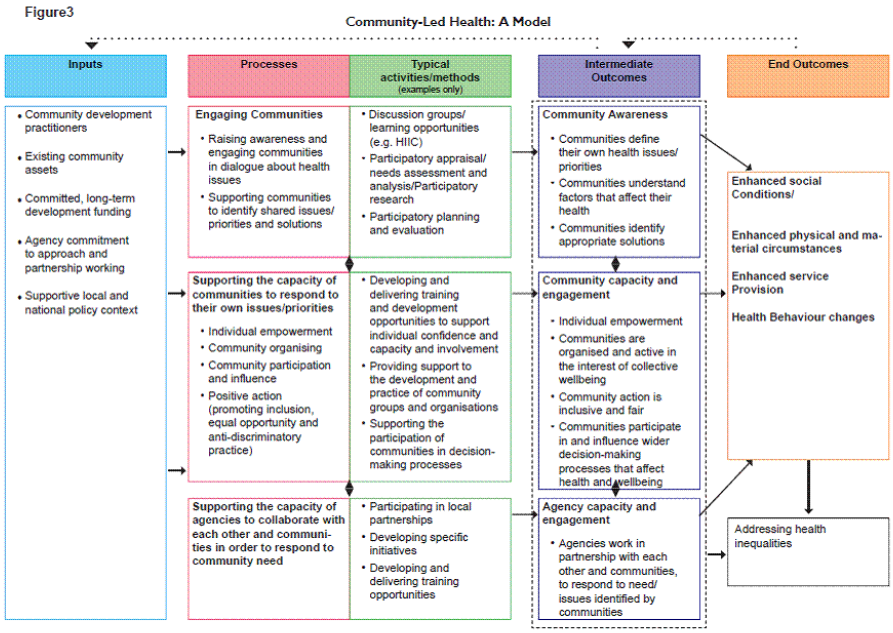
“A collaborative approach is needed that tackles the causes not just the symptoms of poor health” (Gilchrist & Taylor, 2016, p. 118).

“Policy makers are interested in ways of harnessing community ideas and energy to promote better health and find alternatives to caring for people who are ill, frail or temporarily incapacitated. These include volunteer schemes, peer education, social prescribing, public participation exercises, co-production models and strengthening community relationships” (Gilchrist & Taylor, 2016, p. 119).

“Community health programmes are therefore usually top-down and follow externally set agendas. As we have seen, community development takes a different approach, getting alongside and empowering people to identify and tackle the things that they collectively rank as most damaging to their wellbeing” (Gilchrist & Taylor, 2016, p. 121).

“Community Health Exchange (CHEX) believes in the right to good health for all. This includes personal empowerment, equity, social justice and sustainable development. We operate within a social model of health, based on the World Health Organisation's statement that health is 'a state of physical, social and mental wellbeing and not merely the absence of disease or infirmity'. Local community-led organisations support people to organise themselves on issues of joint concern. Supporting community members to:

- Recognise and organise around issues of common concern
- Work together on those issues
- Build organisations which are autonomous, strong, effective, sustainable and accountable to the wider community
- Work within values of equity, inclusiveness and cohesion
- Influence and transform public policies and services
- Build social capital, social economy and community assets”



http://www.chex.org.uk/who-we-are/our-approach/

9 Strategies for Combatting Health Inequalities

Attention is often focussed on "Individualistic, behavioural terms rather than in structural terms" (Jones, 2001, p. 161).

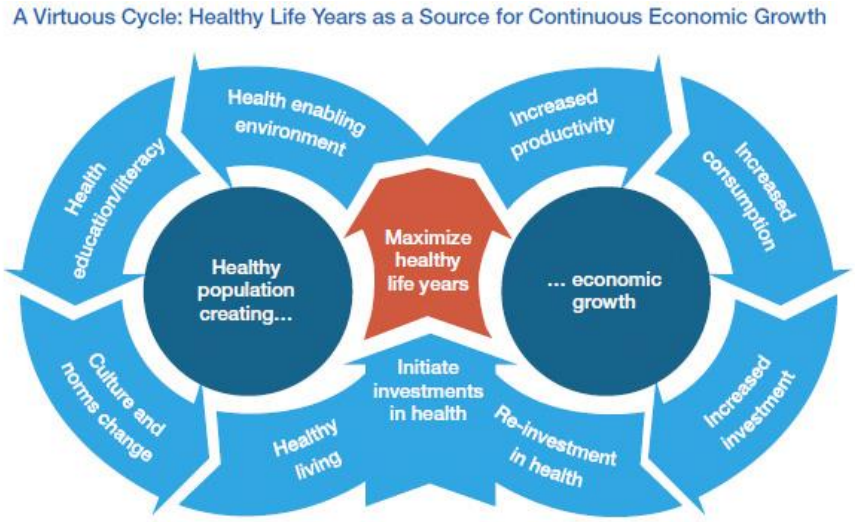
"As the government does not have targets for reducing class inequalities in standards of health, there are no agreed goals against with we may judge the success of its policies" (Jones, 2001, p. 160).

"Reducing health inequalities requires an integrated approach, as so many aspects of our lives affect our health, and this makes the problem more difficult to tackle" (Jones, 2001, p. 161).

9.1 Growth & Improved Living Standards

"Inequalities in health, which are a reflection of wider social and economic differences are a significant problem, which cannot be solved alone by economic growth and rising standards of living" (Jones, 2001, p. 161).

"Whereas at one time governments regarded health inequalities as unproblematic and not requiring a governmental response, the government now regards them as a social problem, for which it is developing a range of social policies. These policies need to be carefully monitored for their effectiveness, and to ensure that policy changes and a reduction in health inequalities match the government's rhetoric and promises" (Jones, 2001, p. 161).



"Healthy populations can create competitive advantages for economies, a newly released report by Bain & Company and the World Economic Forum shows. While unhealthy people put a strain on economies, healthy people result in higher productivity and lower healthcare costs. According to the researchers, economies should increase the number of 'Healthy Life Years' of their population by investing wisely while taking into account the 9 key inflection points that can impact an individual's health." http://www.consultancy.uk/news/1507/bain-investing-in-health-creates-competitive-advantage

9.2 Community Development Principles

Community development principles have "been used by community and public health practitioners, and [have] also found favour with policy makers as a way of involving patients and the wider public in making decisions about health services. More recently, the co-production model has attracted attention as a means of sharing responsibility for the wellbeing of individuals and communities between professionals, patients and ordinary (or perhaps lay) members of the public. Community development has much to offer here through supporting self-help groups or schemes such as 'good neighbours'" (Gilchrist & Taylor, 2016, p. 118).

"The government is interested in person- and community-centred approaches and in increasing 'health literacy' across the general population so that people are better able to navigate the health system. This should help people to access and understand information and advice about their health needs and treatments" (Gilchrist & Taylor, 2016, p. 118).

9.3 Empowerment

"By taking an empowering approach to health, community development can contribute to all of these policy aims through helping communities to tackle some of the causes of ill-health and create opportunities for living healthier (and happier) lives. Simply bolstering community networks, building capacity and reducing the social isolation caused by ill-health can improve wellbeing. One approach to improving social care, for example, has focused on strengthening community capital and neighbourliness" (Gilchrist & Taylor, 2016, p. 119).

"The TOUCH initiative and its many community partners are focused on creating support and strengthening healthy environments in Broward County," Michael De Lucca, MHM, President and CEO, Broward Regional Planning Council. "As we work together to make it easier for people to make healthier choices in what they eat, how they manage their health and encourage physical activity on a daily basis, we will also be able to reduce chronic conditions and early deaths from heart disease, cancer, and diabetes." http://touchbroward.org/community-health-empowerment/

9.4 Inclusion & Participation

"Individuals with particular interests, conditions and expertise may seek to be more involved in determining local priorities in health provision or to improve how services are delivered and taken up, especially in situations where some sections of the population appear to be disadvantaged or neglected entirely" (Gilchrist & Taylor, 2016, p. 120).

"Ensuring effective community engagement between patients and service users and health decision makers is an important role for community development, but communities can also be supported to develop their own self-help activities to address what they believe are the causes of poor health" (Gilchrist & Taylor, 2016, p. 120).

10 Summary

"Community development has a long tradition of helping people to campaign against local conditions that give rise to disease and reduce life expectancy" (Gilchrist & Taylor, 2016, p. 120).

"There are many opportunities to co-operate with health agencies to promote healthy choices to improve access to health services through outreach, peer education and patient participation groups" (Gilchrist & Taylor, 2016, p. 120).

“Residents invested in social capital – networks of cooperation and mutual trust – and reaped tangible economic returns” (Putnam, 2000, p. 324).

“Strong democracies require active citizens, ones who participate in civic affairs and who shoulder responsibilities for the common good. Recognising that the creation of a responsible citizenry is largely a matter of social ethos that cannot be dictated, communitarians will nonetheless seek to encourage those kinds of civic education and public rituals that contribute to this goal” (Thomas A. Spragens, JR in Etzioni, 1995, p. 51).

11 References

Bauman, Z. (2007). *Liquid Times - Living in an Age of Uncertainty*. Cambridge: Polity Press.

Bauman, Z., & Donskis, L. (2013). *Moral Blindness - The Loss of Sensitivity in Liquid Modernity*. London: Polity Press.

Etzioni, A. (Ed.) (1995). *New Communitarian Thinking - Persons, virtues, Institutions and Communities*. Charlottesville: University Press of Virginia.

Gilchrist, A., & Taylor, M. (2016). *The Short Guide to Community Development* (2nd ed.). Bristol: Policy Press.

Jones, H. (2001). Health Inequalities. In M. May, R. Page, & E. Brunsdon (Eds.), *Understanding Social Problems - Issues in Social Policy*. Oxford: Blackwell.

Pickett, K., & Wilkinson, R. (2010). *The Spirit Level: Why Equality is Better for Everyone*. London: Penguin.

Putnam, R. D. (2000). *Bowling Alone - The Collapse and Revival of American Community*. New York: Simon & Schuster.