

SUMMARY PAPER 1



'Health patterns and trends in New York: exploring the idea of fundamental social causes of health status'

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Overview:

Our enormous capacity to control disease and death combined with social and economic inequality creates health disparities. It does so because of a very basic principle: when we develop new insights or technologies for the prevention or control of ill health, the benefits of this new found capacity are not distributed equally throughout the population. Instead, they are harnessed more securely by those less likely to be exposed to discrimination and who have more knowledge, money, power, prestige and beneficial social connections. The result is persistent inequalities in health which transcend specific causes of disease and death.

Key idea:

Fundamental social causes: underlying and persistent phenomena in society and the economy – such as differential access to resources, networks, prestige etc – which help protect those possessing them from the burden of disease and death. This helps to explain the continuing nature of inequalities in health despite the changing nature of the primary causes of illness and death.

Summary:

Being careful not to present a “New York-centric view”, Professor Link introduced a range of data from New York, the USA, England, Wales and Scotland which highlighted the prevalent nature of inequalities in health across time and place in the modern era.

He then invited the audience to engage in a thought experiment about death rates in Rhode Island in 1865. This highlighted that while successful actions of various sorts had been taken to combat the major causes of illness and death at that time, the differences by socioeconomic status, discernible in 1865, remain. The causes of illness and death have changed but those of lower socioeconomic status continue to experience higher rates of illness and death.

He suggested that this could be explained by differential access to social resources such as knowledge, money, power, education and beneficial social connections. Those with more of these are able to avoid risks and adopt protective strategies to reduce illness and death. Because such resources can be used flexibly across time and space, fundamental causes affect of the pattern of disease and death as risk profile, disease prevalence and protective factors change radically.

These resources operate at an individual level as people use them to achieve healthy outcomes. Such resources also provide access to health supporting contexts – better neighbourhoods, occupational conditions, etc – which have positive consequences for health; “a whole package deal”.

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Professor Link then developed a perspective, using data from the USA and UK, which suggested that there have been tremendous gains in health during the course of the 20th century. Alongside this improvement, however, it is possible to see a shift in the burden of illness and disease towards those less able to respond to new knowledge, information or resources. Our capacity to control disease and death combined with social and economic inequalities creates inequalities in health outcomes, even when population health as a whole is improving.

He illustrated this idea by reference to changing patterns of smoking prevalence following new information about the link between cancer and smoking. The data clearly showed a slower reduction in prevalence rates among Americans with lower socioeconomic status, which in turn becomes reflected in differential cancer death rates.

This, he argued, illustrated three main points:

1. The social shaping of new knowledge creates inequalities in health by socioeconomic status.
2. Those US states which quickly adopted health knowledge also adopted other forms of innovation quickly.
3. The use of such knowledge is heavily influenced by context and is deeply social. It is not enough to simply *know* to be able to act; the *context* to support action also needs to be present.

Professor Link highlighted the power of the fundamental causes perspective by showing that where the preventability of a disease is low and/or evidence of effective treatment weak (eg brain cancer), little difference exists in its prevalence between rich and poor. Where preventability is high and/or treatment effective (eg heart disease), then significant differences in prevalence exist between rich and poor as the more affluent exercise their resources to avoid the illness.

He took the argument a stage further by showing in a further test that:

- as new and effective treatments for a disease emerge over time, or the disease becomes more preventable, the prevalence of the disease changes with a greater burden emerging on those of low socioeconomic status; and
- if new treatments do not emerge, the distribution of the disease burden remains broadly the same over time.

He illustrated these arguments with striking data showing trends in specific cancers and heart disease. For example, low socioeconomic status (SES) men used to have much lower rates of colorectal cancer than higher SES men aged between 25 and 64. This pattern has now reversed as treatment and prevention have improved.

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In concluding Professor Link suggested that three types of policy approach might help reduce such disparities:

1. Firstly, interventions which focus on getting resources to the resource poor. This might include reducing the gap between the extremes of resource distributions or reducing the severity of the distribution overall.
2. Secondly, working on the improvement of health contexts for the whole population, so that no decision is necessarily needed by individuals eg the provision of clean water, legislation of various types
3. And finally, improving the contexts in which risks and decisions are taken by individuals e.g. what kind/quality of food is available to eat.

The views expressed in this paper are those of the speaker and do not necessarily reflect the views of the Glasgow Centre for Population Health.

Summary prepared by the Glasgow Centre for Population Health.