
Article:
Ford, J., Black, M. orcid.org/0000-0002-8358-9150 and Morling, J. (2023) Health inequality: time to get smart about our language. Public Health in Practice, 5. 100369. ISSN 2666-5352

https://doi.org/10.1016/j.puhip.2023.100369

Public Health in Practice 5 (2023) 100369

Contents lists available at ScienceDirect

Public Health in Practice

journal homepage: www.sciencedirect.com/journal/public-health-in-practice

Editorial

Health inequality: Time to get smart about our language

Health inequalities means different things to different people. For some people it is about rich and poor, for others race or ethnicity, for others still it is about specific disadvantaged groups, such as those with learning disability or autistic spectrum disorders. For others, differences in healthcare access and experience are health inequalities or the difference in priority given to different health problems, e.g. physical and mental health. We need to get smarter about using the term health inequalities: understanding when it is useful and when it adds to the confusion.

Most definitions of health inequalities coalesce around the concepts of unfair and avoidable differences between groups or across a gradient. McCartney and colleagues synthesised the literature examining health inequalities definitions and produced the following:

"the systematic, avoidable and unfair differences in health outcomes that can be observed between populations, between social groups within the same population or as a gradient across a population ranked by social position are proposed" [1].

Definitions of health inequalities make it easier for practitioners, policy makers and researchers to rally around as a call to action and shared frustration at the injustices in the society. But this high-level definition makes the concept difficult to operationalise. For practitioners looking after individuals, the definition of health inequalities is at an abstract population level which they feel passionate to address, but powerless to influence. For health policy makers the definition is so broad everything could be a health inequality, from differences in access to and experience of public services, to difference in priority between health conditions or geographical differences in the delivery of services. For most researchers, the term is too imprecise; they are looking for an accurate description of exposure, outcome and intervention or to explore the lived experience of a particular community.

Policy makers, practitioner and researchers also use the term indirectly to refer to supporting disadvantaged groups or conditions which are intrinsically associated with poverty. When these population groups and conditions are also included, health inequalities becomes even more vast and nebulous. This was picked up in the Health Development Authority in 2000 categorisation of health inequalities into three groups; health gradient, health gap and poor health of poor people [2]. This final category referred to people who face multiple disadvantages: people on low incomes, those who belong to minoritised ethnic groups, individuals who are homeless, street-based sex workers, etc. Targeting these groups will indirectly address health inequalities because even though the problem is not conceptualised as a health gap between two groups - supporting these groups will improve the health of the most vulnerable. There are also those conditions which we know go hand-in-hand with poverty, such as smoking, obesity, addiction and severe mental illness [3]. Incorporating actions on these conditions in our efforts to address health inequalities, while merited, further adds to plethora of possible population groups and conditions to target.

The broad and nebulous approach has advantages – it appeals to more people, making it easier to build momentum and a shared vision. However, it makes policy open to unfair advocacy, lobbying and value judgements. Community and patient groups with strong and well-funded advocacy are likely to have more traction than less vocal groups, such as street-based sex workers or undocumented migrants. Oliveria and colleagues found this when looking at local health system plans with some disadvantaged groups, such as people with learning disabilities, featuring more than others, such as prison populations or people who are transgender [4]. With so much need and no systematic approach, there is a risk that policy makers or practitioners make judgements about the deservedness of different groups instead of taking an objective approach; the well-known deserving versus undeserving poor situation.

The term health inequalities has its uses as a rallying cry and call to action, especially to win hearts and minds of policy makers and practitioners who are left leaning politically, but is less useful for developing policy or engaging with practitioners across political divides. This is because political ideology shapes our view about who is primarily responsible for health and the ensuring inequalities across populations – is it society or the individual? One way in which we can deliver meaningful action as policy makers, practitioners and researchers is to be smarter about our language – are we aiming to close the gap in smoking between the 20% and bottom 20% of area-based socio-economic groups or reduce HB1Ac in south Asian women with diabetes? In the UK, we have seen progress with policy makers being more specific about minority ethnic groups rather than using unhelpful collective terms, such as BAME (Black, Asian and Minority Ethnic) [5], but more is needed. The more precise we can become in terms of describing the population groups and health outcomes we are trying to improve, the more likely we are to making meaningful progress. Let us get smart about when the term health inequalities is useful in building momentum behind the common goal of creating a fairer and more equal society and when it hampers progress on the ground.

References

[1] G. McCartney, F. Popham, R. McMaster, A. Cumbers, Defining health and health inequalities, Publ. Health 172 (2019) 22–30.

[2] M.P. Kelly, Health inequalities: concepts, frameworks and policy; Health inequalities: concepts, frameworks and policy. www.hda.nhs.uk/evidence, 2014. (Accessed 3 February 2023).

https://doi.org/10.1016/j.puhip.2023.100369

Available online 21 February 2023

[3] D. Lewer, W. Jayatunga, R.W. Aldridge, et al., Premature mortality attributable to socioeconomic inequality in England between 2003 and 2018: an observational study, Lancet Public Health 5 (2020) e33–41.
[4] J. Olivera, J. Ford, S. Sowden, C. Bambra, Conceptualisation of Health Inequalities by Local Health Care Systems: a Document Analysis, Under peer Rev, 2020.
[5] Writing about ethnicity - GOV.UK. https://www.ethnicity-facts-figures.service.gov.uk/style-guide/writing-about-ethnicity#bame-and-bme. (Accessed 3 February 2023).

John Ford*
Wolfson Institute, Queen Mary University London, London, UK

Michelle Black
School of Health and Related Research (ScHARR), The University of Sheffield, Sheffield, UK

Jo Morling
Faculty of Medicine & Health Sciences, University of Nottingham, Nottingham, UK

* Corresponding author.
E-mail address: j.a.ford@qmul.ac.uk (J. Ford).